Calendar Year 2024 Results

Benchmark Trend Report

State of Delaware
Department of Health and Social Services

Contents

1. Executive Summary

Each year, pursuant to House Amendment 1 for House Bill 442, the Department of Health and Social Services (DHSS) produces the annual Benchmark Trend Report (Report) which summarizes the spending and quality data collected from all payers who participated in the benchmark data collection process. Throughout 2024, Delaware's health care landscape was defined by rising costs, uneven quality outcomes, and persistent workforce challenges. Health care costs are expected to increase further in 2026 due to federal policy changes. This report highlights both progress and ongoing structural issues that continue to shape access, affordability, and equity across the health care system.

Delaware exceeded the health care cost growth benchmark for the fourth year in a row, with key pressures including inflation, pharmaceutical costs, inpatient and outpatient spending, and behavioral health utilization. Total Medical Expenses (TME) -- Delaware's metric of spending on health care goods and services -- grew to $11.3 billion. This reflects an increase of $876 million, or 8.4% compared to calendar year 2023. Measured on a per capita basis using Delaware's historic methodology, TME grew by 6.4%, exceeding the 3.0% benchmark growth rate by 3.4 percentage points. Updating to per capita calculations based on member enrollment, as discussed elsewhere in this report, reflects a 12.2% per capita growth rate for TME, more than four times greater than the benchmark.

This report presents an integrated view of health care spending trends, access and affordability and key quality measures. Unless otherwise noted, the data contained herein represents spending and quality data incurred (i.e., dates of service) in: Calendar Year (CY) 2024 Estimate (spending), CY 2023 Final, and CY 2022 Final.

The DHSS 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. The spending benchmark is not intended to be a predictor of health care spending, but instead, a target rate of change

CY 2024 TME Increase

8.4%

Total Medical Expenses grew to $11.3 billion in 2024, an 8.4% increase compared to 2023.

Total Medical Expenses

In 2024, health care spending per resident (medical only) reached $10,714, a 6.4% increase from 2023. Delaware's total medical expense (TME) reached $11.3 billion in 2024. This is an increase of over $876 million from 2023's $10.4 billion.

On a service category level, all claims-based service categories experienced growth from 2023 to 2024. Hospital Inpatient – Not Pharmacy is the largest service category, coming in at $2.2 billion or 19.7% of TME (excluding Veterans Health Administration [VHA]). This service category increased 8.2% from 2023 to 2024. The second largest service category is Pharmacy – Prescription Drug Benefit (net of rebates). This service represents 18.6% of TME, at $2.0 billion, representing an increase of 6.9% from 2023 to 2024. Long-Term Care ($1.5 billion in 2024) increased 12.2% from 2023 to 2024, which is the second highest percentage change next to the Pharmacy Medical Benefit (net of rebates) ($458 million) at 15.6%.

Private Commercial Insurance

In CY 2024, TME for private commercial health insurance exceeded $3.1 billion. This is a 12.0% increase from 2023 to 2024. The Hospital Outpatient service category remains the highest within this market for the third year in a row. In 2024, it almost exceeded $800 million, increasing 10.7% year over year. Hospital Inpatient – Not Pharmacy continues to be a large driver of overall TME, coming in at $575 million in 2024 and increasing 13.2% from 2023. Long-Term Care is the only service category that did not increase from 2023 to 2024.

Quality Metrics

Consistent with spending targets, quality metrics identify areas where patient experiences and outcomes can be strengthened. 2024 was a challenging year for quality performance, with most measures falling short of their benchmarks. Only two measures — Breast Cancer Screening in the Commercial population and Colorectal Cancer Screening in Medicaid — managed to surpass their targets. Even so, the year wasn't without meaningful progress. Several measures showed notable improvement, including Opioid-Related Overdose Deaths per 100,000, Emergency Department Utilization, Persistence of Beta Blocker Treatment After a Heart Attack for Commercial members, Breast Cancer Screening (Commercial and Medicaid), as well as Cervical Cancer Screening within the Medicaid population. Together, these gains signal areas of momentum despite an overall difficult landscape.

Components of the Benchmark

The spending benchmark examines total medical expense in Delaware on a gross and per capita basis. This report also considers total health care expenditures (THCE), a metric which sums TME and the estimated net cost of private health insurance (NCPHI).

Delaware is one of eight states that has established statewide health care cost growth targets to monitor and evaluate annual changes in health care spending. Benchmark targets vary across states, but general methodology and focus areas remain similar.

Please see the Glossary in Section 7 for more information about the terms used throughout this Report.

Quality and Spending Interactive Dashboard

The online and interactive quality and spending dashboard posted to DHSS's website is live and updated with the most recent data. This website allows the public to view and download benchmark data. The dashboard is expected to be updated annually to further support the data collection and summarization process.

Contextual Notes

The benchmark data collection process has its own unique reporting requirements and methodology. 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.

We acknowledge the importance of complying with the 508 compliance standards set forth by the federal government. We understand that it is necessary to ensure that our documents and templates meet the accessibility requirements outlined in these standards. Our goal is to provide accessible and inclusive documents that meet the needs of all individuals. All data within this report is accessible on the DHCC Benchmark homepage at: https://dhss.delaware.gov/dhss/dhcc/global.html.

More information on the development of the benchmarks, the data collection process, and the implementation manual can be found on DHSS's website at https://dhss.delaware.gov/dhcc/global.html. As an addition to this Report, DHSS will post an Appendix 1 - Benchmark Data Tables CY 2024 that is an Excel-based document containing all the underlying data that were used to create this Report.

Table 1-1: Spending Data Sources

Spending Data	Data Source	Notes
Commercial Data	Carriers serving Delaware: • Aetna • AmeriHealth (ACDE) • Cigna • Delaware First Health (DFH) • Highmark • United Health care (UHC)	Carriers with multiple lines of business were required to provide data on all lines.
Medicaid Data[1]	• Delaware's Division of Medicaid and Medical Assistance (DMMA) • ACDE, DFH, and Highmark	DMMA was the source of Medicaid fee-for-service (FFS) spending data. The insurers provided data on the Medicaid managed care program. DFH entered the Medicaid managed care program in CY 2023; therefore, CY 2023 is the first year data has been reported by the insurer.
Medicare Data	• Centers for Medicare and Medicaid Services (CMS) • Aetna • ACDE • DFH • Health Care Service Corporation (HCSC) • Highmark • Humana • UHC	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 (VHA) 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 2024 = CY 2024.
NCPHI	• Insurer reported data	NCPHI was computed using insurer-submitted revenue and expenditure data via Supplemental Health Care Exhibits and Medical Loss Ratio reporting submissions.

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.

2. Total Medical Expense (TME) Data

TME is defined as the sum of the allowed amount of total claims spending and total non-claims paid to providers, incurred by Delaware residents for all health care services. Aggregated TME by market will reflect Statewide TME results.

KEY FINDINGS

TME PER CAPITA TREND

6.4%

From CY 2023 to CY 2024, TME increased by over $876 million from $10.4 billion to $11.3 billion in total. On a per capita basis using the Statewide enrollment population, this is a 6.4% increase.

Using the historic methodology, the results of the TME per capita, with a population increase of 1.9%, show a change of 6.4% compared to the 2024 benchmark of 3.0%, and a per capita amount of $10,714.

When calculating the benchmark using TME divided by cost growth enrollment data provided by each of the payers, TME remains at an 8.4% increase, estimated members decreased by 3.4%, and the overall per capita change in TME lands at 12.2%. The TME per capita amount in 2024 was $12,100.

Both measurements of the change in TME per capita greatly exceed the 2024 benchmark of 3.0%.

Within the Commercial market specifically, the Self-Insured line of business (LOB) represents the largest among Individual, Small Group, Large Group, and the Student Market. The Self-Insured TME increased 8.0% from CY 2023 to CY 2024; however, the Individual LOB increased 36.8% as the second largest LOB in the market.

Medicare continues to be the largest market within the State, representing almost $4.9 billion. In CY 2023, Medicaid represented the second largest payer in terms of TME, with the commercial market as a close third. Moving into CY 2024, while both Medicaid and commercial markets saw an overall increase in TME, the commercial market surpassed Medicaid to become the second largest payer.

In CY 2024, Commercial TME increased 12.0%, Medicaid increased by 4.3%, Medicare increased by 8.9%, and VHA increased by 7.7%.

Hospital Inpatient/Outpatient (Not Pharmacy) represents over $3.9 billion in CY 2024. This represents 35.9% of TME (excluding VHA).

Section 2A: Includes summaries of the benchmark spending data on an aggregated Statewide basis. Data will be presented in total and across major service category per instructions in the Implementation Manual provided to the insurers and DMMA.

TME displayed by major category of service in this section does not include NCPHI or Veteran's Health Administration (VHA) data. NCPHI is reported separately (See Section 3). The VHA market has limited data available and thus only aggregate health care spending is obtainable.

Section 2B: Includes summaries of the benchmark spending data on the four Markets for which data was collected. This breaks out the aggregate level of detail in Section 2A by market. Note that VHA data is included in these summaries:

• 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.).

In the Medicaid market, the vast majority of individuals are mandatorily enrolled in managed care resulting in most spending being reported by the three insurers under contract with DMMA in CY 2024. However, DMMA did provide Medicaid FFS spending information on individuals not enrolled in managed care as well as FFS spending on services that were excluded from managed care (e.g., pediatric dental services).

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.

As a reminder, VHA data is obtained and reported in aggregate; therefore, it is not reflected in the service category comparisons.

Note that in this year's reporting templates for the insurers and DMMA, pharmacy rebates were collected with regard to the pharmacy service category they were related to (e.g., rather than including one aggregate pharmacy rebate category in previous years, there is now a pharmacy rebate – medical benefit and pharmacy rebate – prescription drug benefit breakout). This removes the previously-noted allocation in the CY 2023 trend report and better aligns the rebate amount to the specific service category.

Figure 2A-1: State Level TME Per Capita Based on Estimated Members from Cost Growth Data

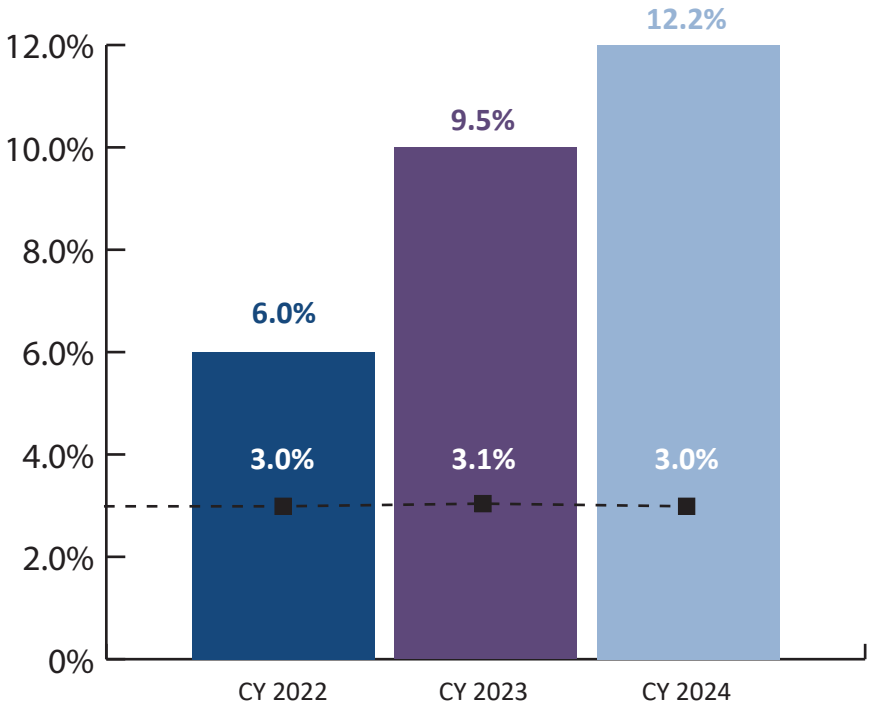
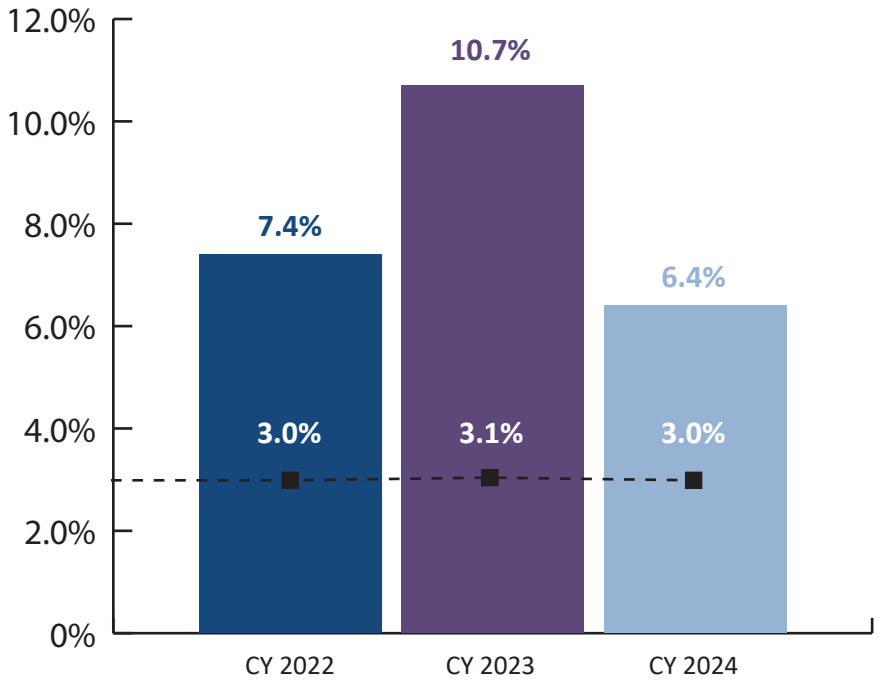


Figure 2A-2: State Level TME Per Capita Based on Census Enrollment

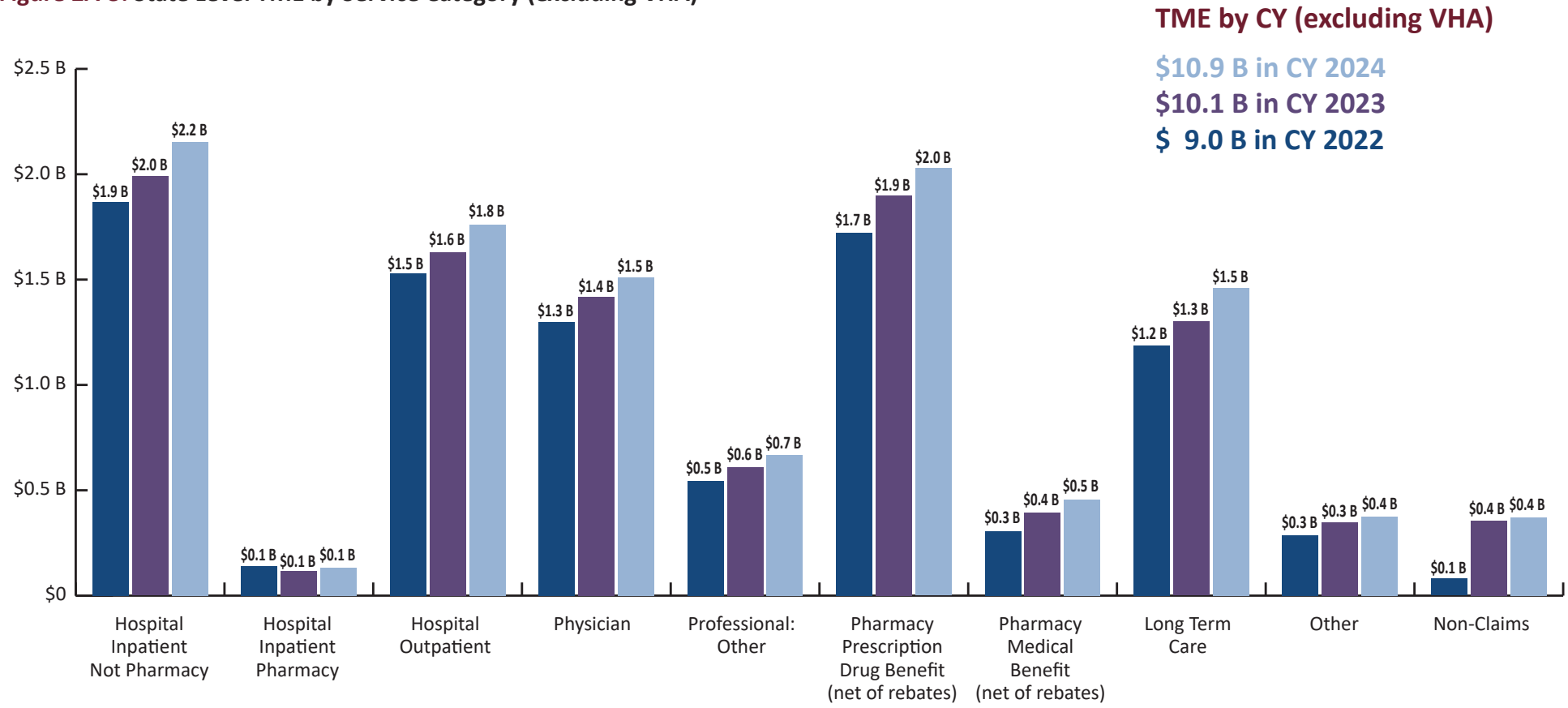


To best analyze the per capita change in TME for health care enrollees in the State of Delaware, Figure 2A-1 utilizes estimated members from the cost growth data. For a broader statewide view that includes Delaware's total population, Figure 2A-2 utilizes statewide population figures from census.gov. Moving forward, the State plans to analyze the per capita change using the enrolled-members as reflected in Figure 2A-1.

Overall, TME per capita increased at a rate higher than the CY 2024 benchmark in both scenarios. Both calculations utilize the same numerator; however, the higher increase observed in Figure 2A-1 is due to a decrease in estimated enrolled members in CY 2024 compared to CY 2023. Due to the COVID-19 continuous coverage unwinding, it is assumed that there is a higher level of uninsured or employer-based self insured members not reflected within the estimated CY 2024 cost growth enrollment data, and a decrease in members that became dually enrolled in Medicaid and another source of health insurance during the period where Medicaid was not disenrolling members. Statewide, Delaware's overall population increased 1.9% from CY 2023 to CY 2024.

Note 1: Spending is net of pharmacy rebates.
Note 2: Estimated members are calculated based on member months provided within benchmark spending data submissions from payers.
Source: Payer-reported data to DHCC and other public sources.

Figure 2A-3: State Level TME by Service Category (excluding VHA)



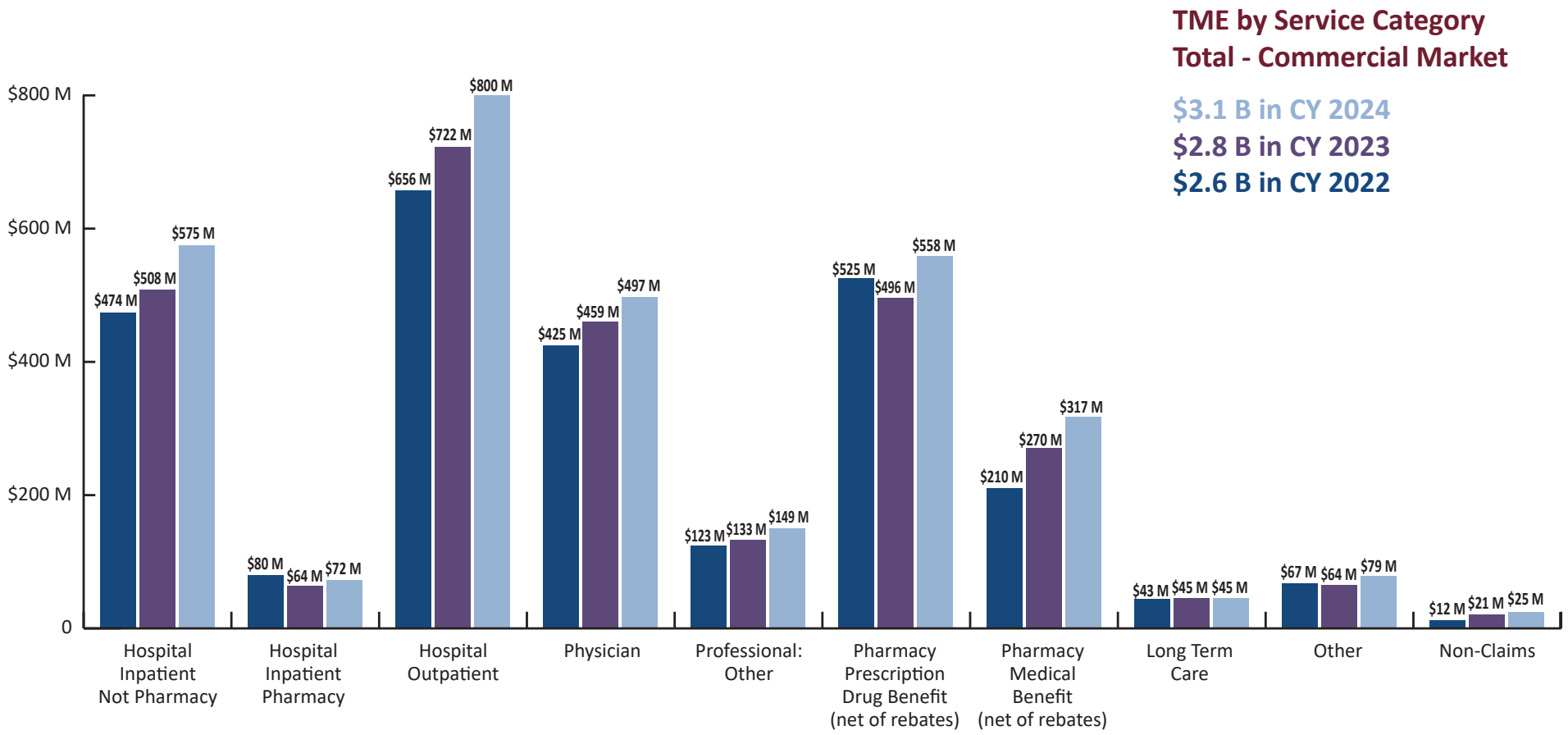
	Hospital Inpatient Not Pharmacy	Hospital Inpatient Pharmacy	Hospital Outpatient	Physician	Professional: Other	Pharmacy Prescription Drug Benefit (net of rebates)	Pharmacy Medical Benefit (net of rebates)	Long Term Care	Other	Non-Claims
CY 2024 % Change	8.2%	11.2%	8.0%	6.5%	9.4%	6.9%	15.6%	12.2%	8.4%	3.9%

8.5%

TME increased 8.5% in total in CY 2024.

In CY 2024, the Inpatient Hospital - Not Pharmacy service category is over $124M higher than the second largest category, Pharmacy Prescription Drug benefit (net of rebates). It increased 8.2% year over year.

Figure 2B-1: TME by Service Category - Commercial Market

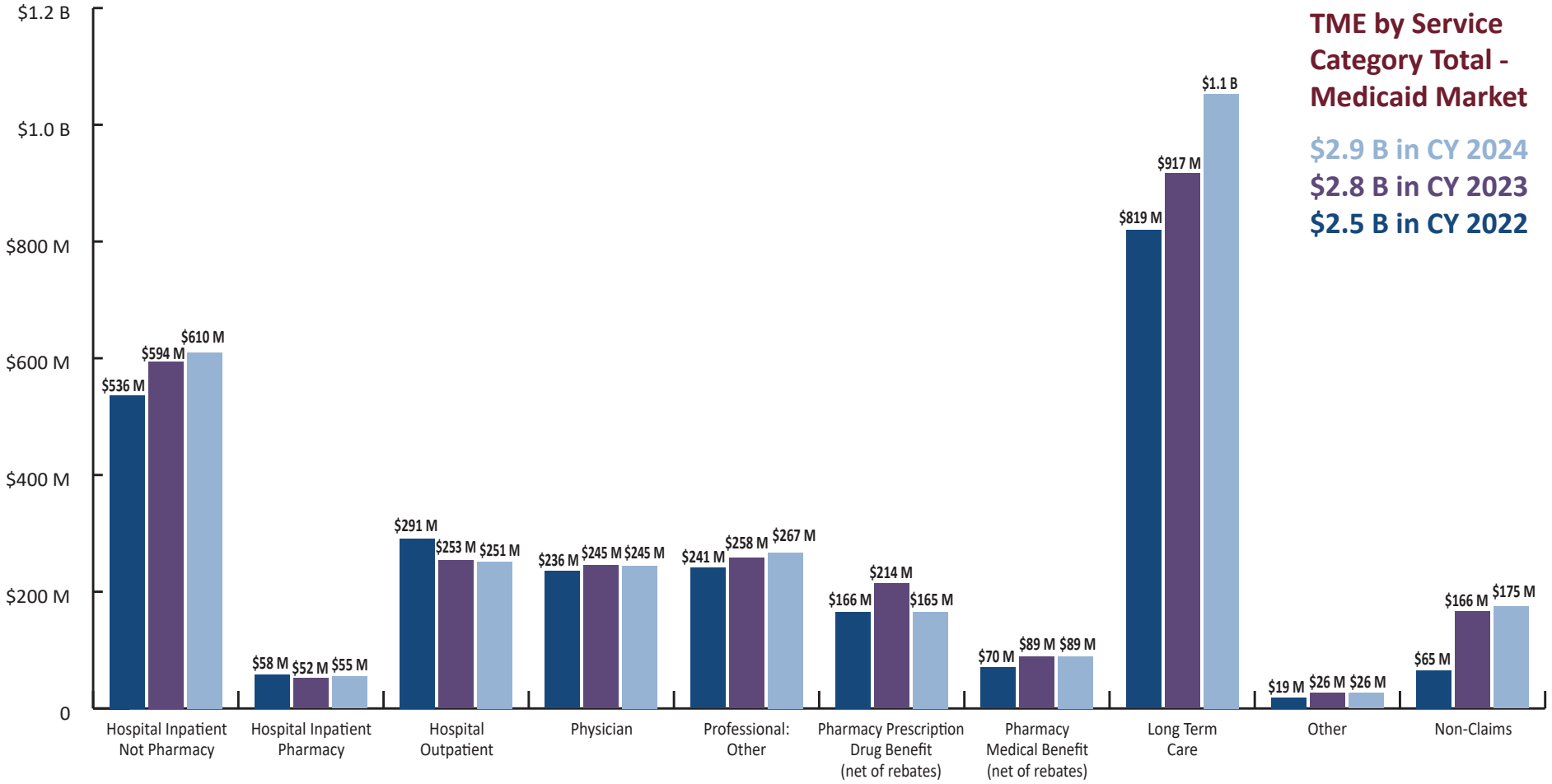


Commercial Market

12.0% TME increased 12.0% in CY 2024.

Hospital Outpatient, the largest service category for the Commercial population, increased 10.7% from CY 2023 to CY 2024. Hospital Inpatient - Not Pharmacy, the second largest category, increased 13.2%.

Figure 2B-2: TME by Service Category - Medicaid Market



Medicaid Market

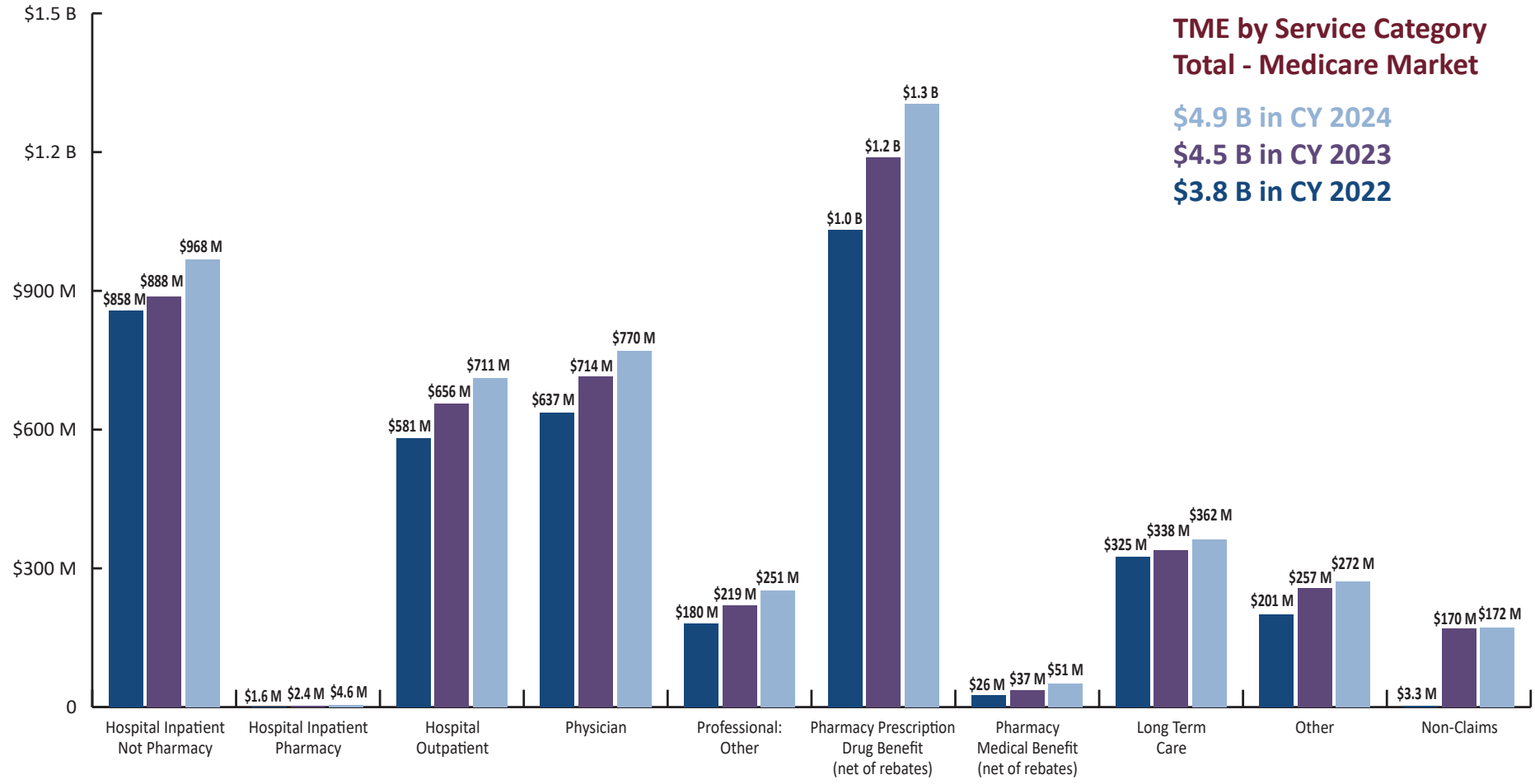
4.3%

TME increased 4.3% in CY 2024.

Long term care, the largest service category for the Medicaid population, increased 14.8% or $136M from CY 2023 to CY 2024.

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

Figure 2B-3: TME by Service Category - Medicare Market



Medicare Market

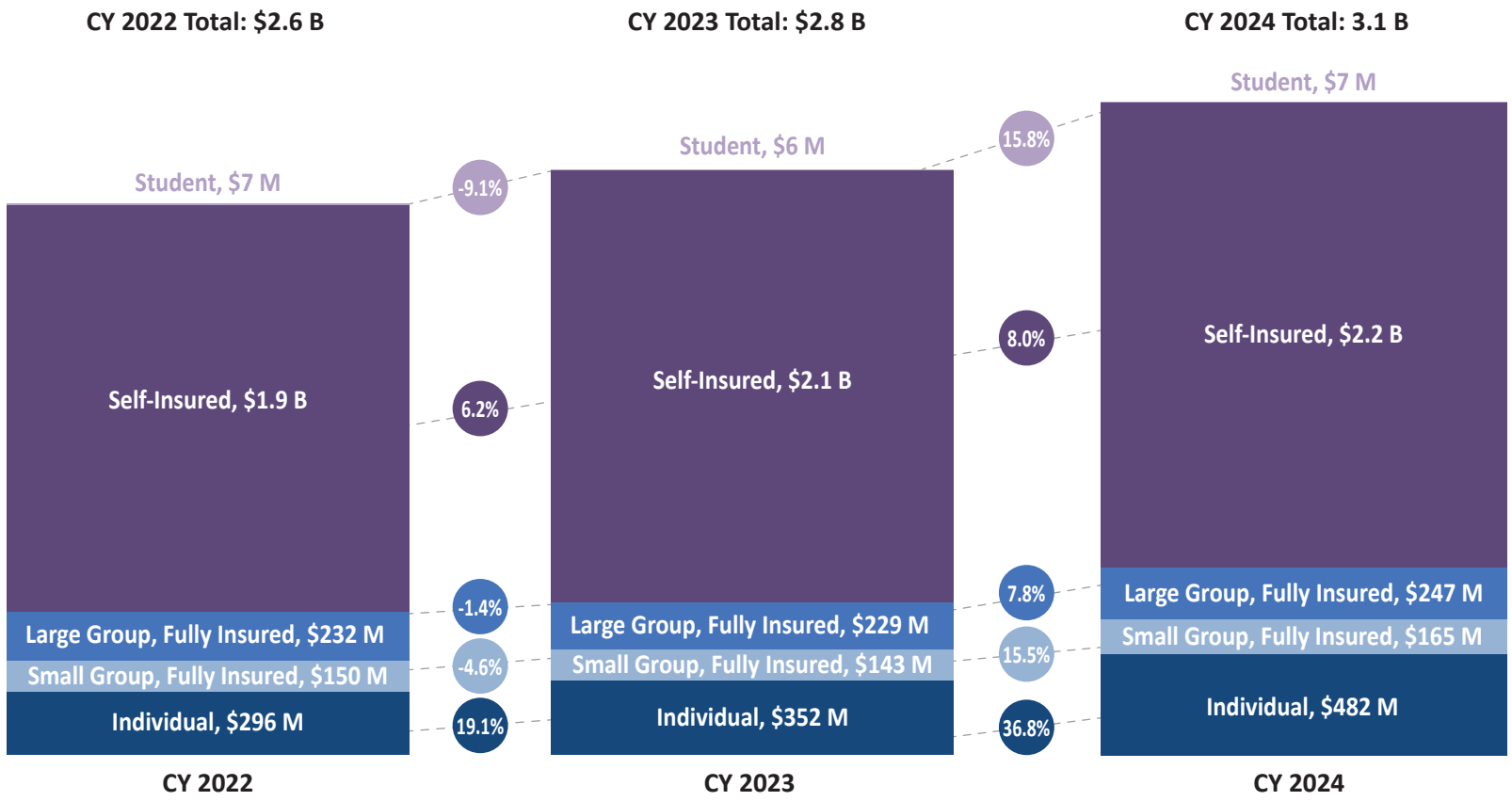
8.9%

TME increased 8.9% in total in CY 2024.

Pharmacy Prescription Drug Benefit (net of rebates) remains the highest service category for the Medicare market, with an increase of 9.8% from CY 2023 to CY 2024.

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

Figure 2B-4: TME by CY - Commercial Market



Across all Commercial lines of business, TME increased by over $334M. This is mostly driven by increases in the Self-Insured and Individual groups. The Self-Insured line of business makes up 71.1% of the total Commercial market in CY 2024.

3. 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. In other words, NCPHI highlights the relative proportion of total health care expenditures that were not directly for services/benefits to individuals.

KEY FINDINGS

ESTIMATED NCPHI

-48.4%

Estimated NCPHI decreased by $316 million or 48.4% in CY 2024, totaling $337 million.

As observed in the 2024 benchmark trend report, NCPHI has decreased from 2023 to 2024. Nationally, 2024 was a difficult year across the health care landscape. For the 2024 Report, DHSS has observed that NCPHI across nearly all markets is down in 2024 compared to 2023. This is both on a total dollar basis and per member per year (PMPY). PMPY values were computed as total CY expenditures divided by estimated number of members in the respective CY. While DHSS does not have direct line of sight into the root cause of NCPHI decreasing from 2023 to 2024, on the surface it appears that generally the increase in cost outpaced any increases in Premium Revenues.

On a PMPY basis, the Small Group, Fully Insured insurance segment saw the largest decrease from $2,063 in CY 2023 to $837 in CY 2024.

Self-Insured is the only market segment that increased in CY 2024. PMPY values for this segment increased from $240 to $277, which is a 15.2% increase.

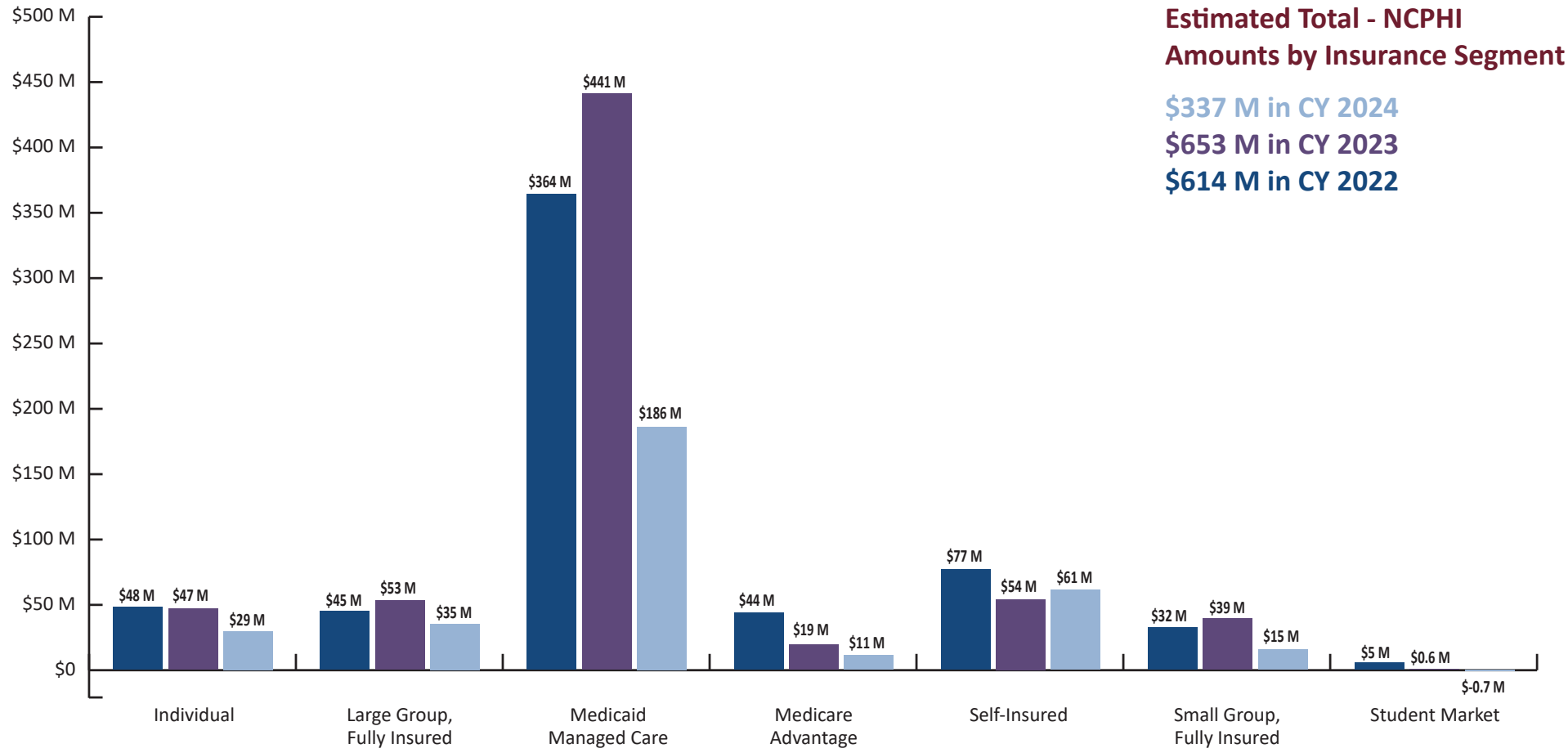
NCPHI is only applicable to insurers. NCPHI is not reported by CMS for the Medicare market nor DMMA for the Delaware Medicaid FFS program. If an insurer participates in Medicare Advantage and/or Delaware's Medicaid managed care program, the NCPHI applicable to those lines of business are included herein.

As a notable change in this year's trend report, the calculation of the NCPHI has been adjusted. Previously, we relied on insurer-provided Premium Revenues and Total Net Paid Expenditures by line of business to compute, standardize, and simplify the NCPHI methodology. For this year's Report, each insurer's Supplemental Health Care Exhibits (SHCE) and Medical Loss Ratio (MLR) reports were utilized for the calculation of NCPHI. This results in a similar calculation of taking the difference between Premium Revenues and Total Net Paid Expenditures, but from a different data source. As SCHEs are not reported on a Delaware-specific basis, adjustments were made to appropriately scale NCPHI impacts relative to the Delaware-specific population. CY 2023-24 NCPHI figures are comparable and calculated on the same basis, but 2022 is calculated on the previous method.

From year to year, it is normal to observe upward or downward changes in overall NCPHI, both on a market and insurer level. NPCHI is a complex component of the calculation, and gaining insights into the drivers of change can be difficult. Administrative and operating costs vary by line of business based on contractual requirements, needs of members, complexity of care, etc. Therefore, comparisons across insurance products are not recommended and the focus should be on the year-over-year changes within a line of business. Gains and losses will also vary from year to year.

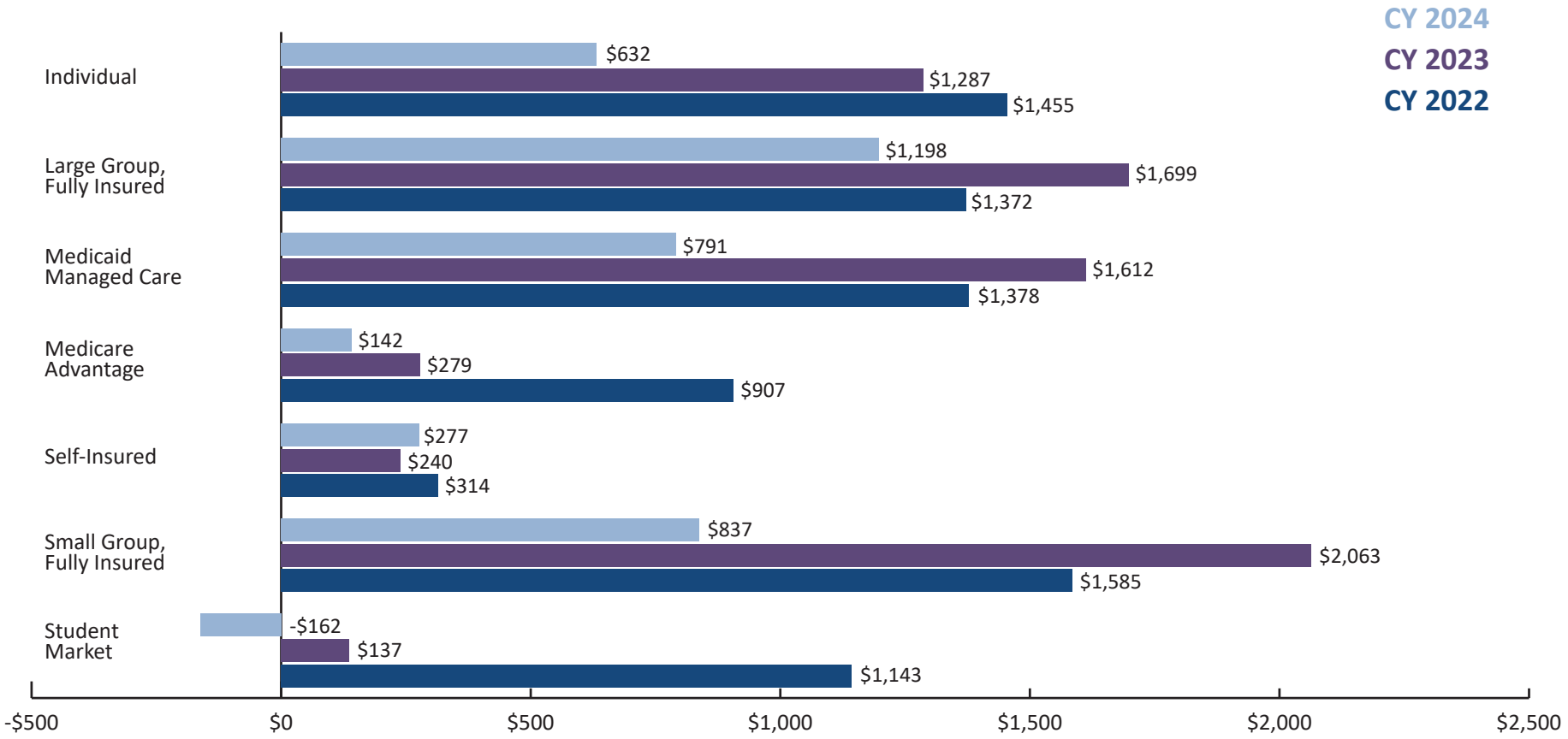
Additional details around NCPHI are found in the forthcoming slides.

Figure 3-1: Estimated NCPHI Amounts by Insurance Segment



For both CY 2023 and CY 2024, NCPHI is based on methodology that calculates the difference between premium revenues and expenditures provided within the SHCE and MLR reports from the insurers, pro-rated on a Delaware-specific basis.

Figure 3-2: Estimated PMPY NCPHI by Insurance Segment



The Individual and Small Group, Fully Insured insurance segments decreased by 50.9% and 59.4%, respectively, from CY 2023 to CY 2024.

Almost all market segments observed a decrease in NCPHI from CY 2023 to CY 2024, with the exception of Self-Insured with a small increase.

Note: PMPY = per member per year.

4. Total Health Care Expenditures (THCE)

THCE are defined as the sum of all reported health care spending as well as insurers' administrative and operating costs and their respective gains/losses. This is calculated by taking the sum of TME and NCPHI as previously displayed within this Report.

KEY FINDINGS

THCE TREND

5.1%

THCE on a dollar basis increased annually from $11.0 billion in 2023 to $11.6 billion in 2024, or 5.1%.

When calculating the benchmark using THCE divided by cost growth enrollment data provided by each of the payers, THCE remains at a 5.1% increase, estimated members decreased by 3.4%, and the overall per capita change in health expenditures lands at 8.7%, which more significantly exceeds the benchmark of 3.0%.

For members enrolled in private commercial health insurance, which include fully and self-insured coverage, THCE increased 9.4% from 2023 to 2024. During the same period, private commercial enrollment increased 2.0%. On a per member per year (PMPY) basis, private commercial health care expenditures increased 7.3%.

Using the historic methodology, the results of the THCE per capita, with a population increase of 1.9%, show a change of 3.1% compared to the 2024 benchmark of 3.0%, and a per capita amount of $11,034. Of the $11.6 billion THCE, TME represented $11.3 billion in 2024.

Spending data within this Report does not include out-of-pocket payments not covered by health insurance, including over the counter medication and standalone vision/dental plans.

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 4A-5. Other year-over-year comparisons are for informational purposes only.

Section 4A: Includes summaries of the benchmark spending data on an aggregated Statewide basis, displayed by major market component (including NCPHI and VHA), year, and per capita.

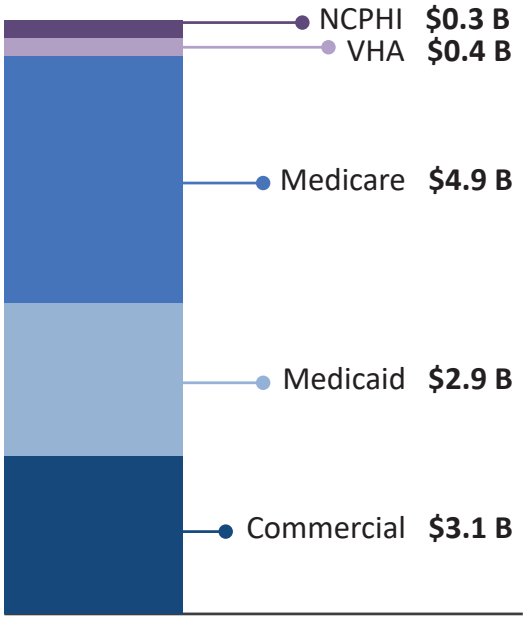
Section 4B: Includes summaries of the benchmark spending data broken out by major market component differentiated by TME, NCPHI, and THCE overall. This section provides insight into how PMPYs change from year to year, but note that these are for informational purposes only.

PMPY values were computed as total CY expenditures divided by estimated number of members in the respective CY.

Section 4C: Includes summaries of the benchmark spending data broken out by insurer. Health risk adjusted PMPYs take each insurers' risk adjusted data divided by the estimated number of members. This is shown in aggregate across all LOBs and not all insurers have the same LOBs. Both the annual change and adjusted PMPYs are summarized in this section.

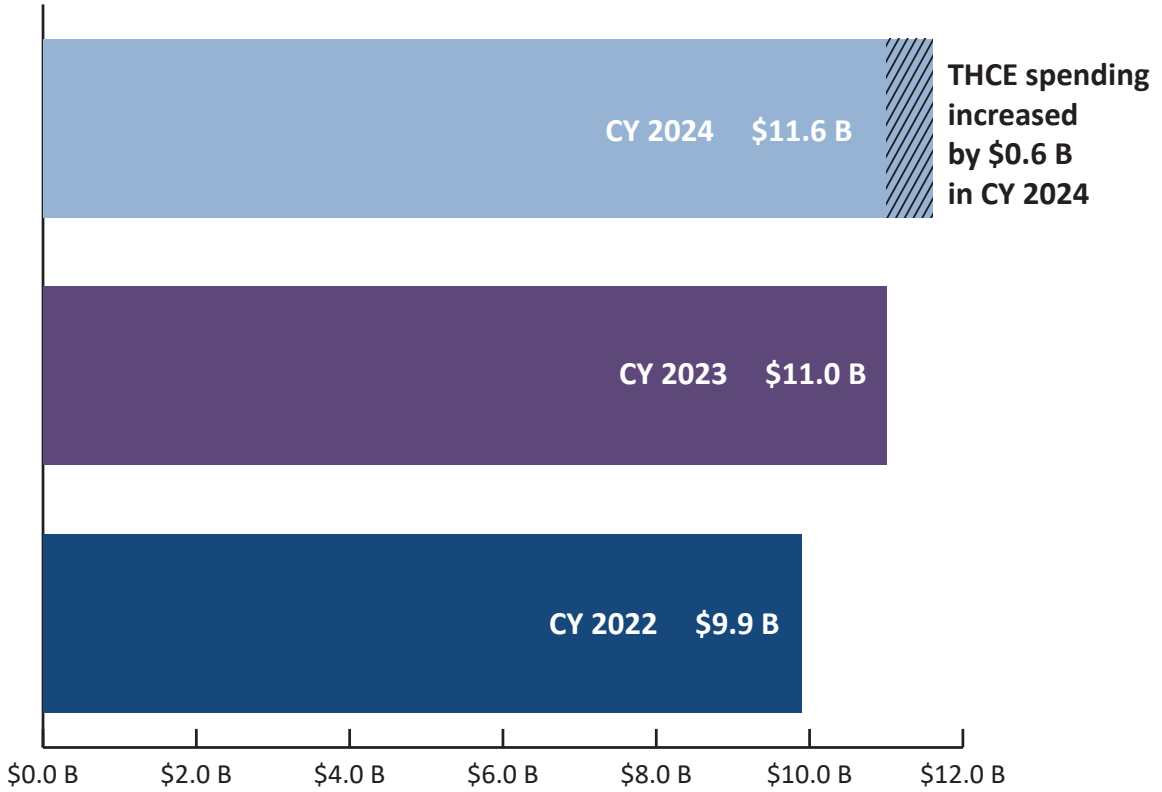
Additional information on the changes in THCE can be found in the forthcoming exhibits of this Report.

Figure 4A-1: CY 2024 State Total Health Care Expenditures
Aggregate and Per Capita (Cost Growth)



Total Overall Spending **$11.6 B**
THCE per capita $12,462

Figure 4A-2: State Level Total Health Care Expenditures

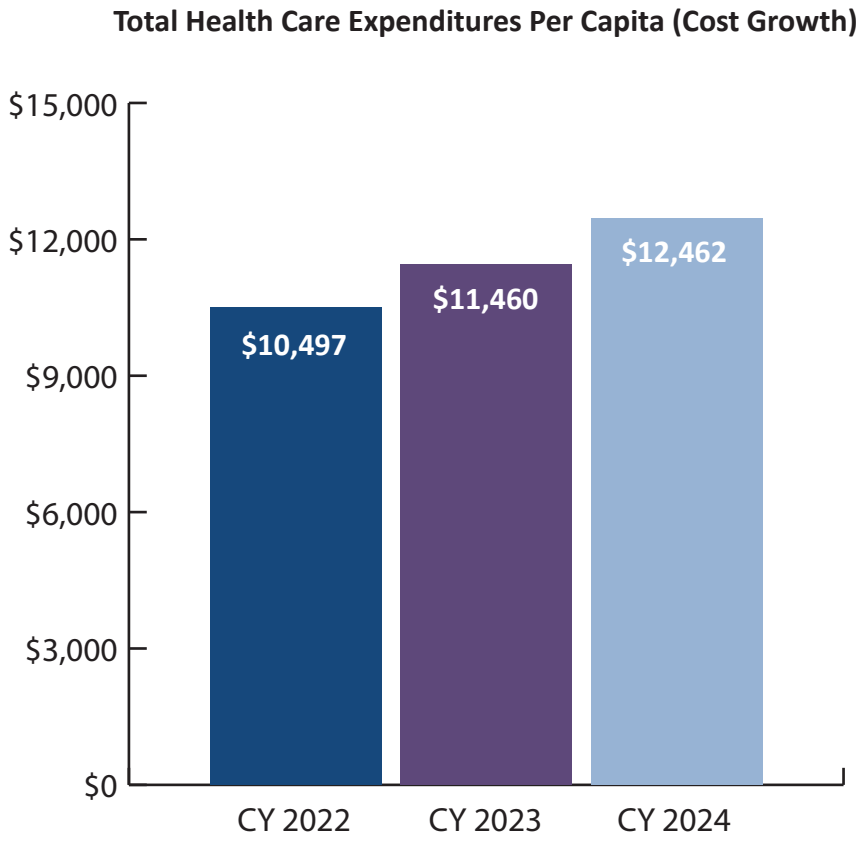


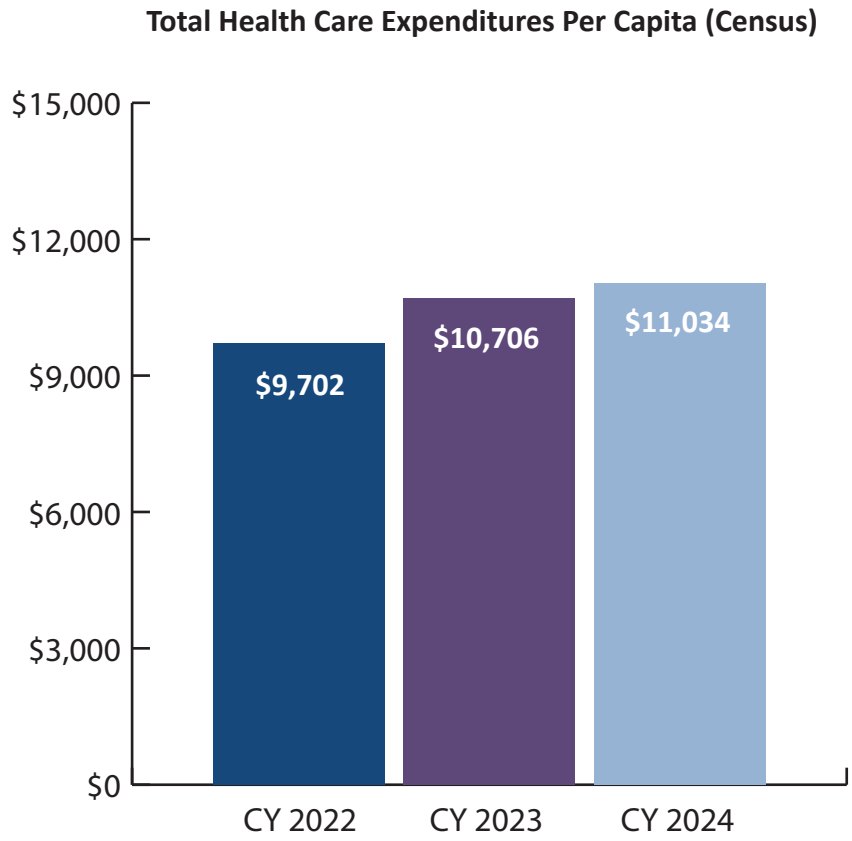
As a proportion of THCE, the Medicare market increased from 40.5% in CY 2023 to 41.9% in CY 2024. Annual Medicare dollars increased by 8.9% in CY 2024. The Commercial market increased by 12.0% in CY 2024.

Medicare continues to be the largest component of health care spending in CY 2024. In previous years, the Commercial and Medicaid markets have competed for the second largest.

Note: Spending is net of pharmacy rebates.
Source: Payer-reported data to DHCC and other public sources.

Figure 4A-3: **State Level Total Health Care Expenditures, Per Capita**





There are two major components that calculate the total health care spending per capita: Total Health Care Expenditures (THCE) divided by enrollment. To calculate the CY 2024 percentage change in per capita THCE, take the CY 2024 THCE per capita divided by the CY 2023 THCE per capita minus one.

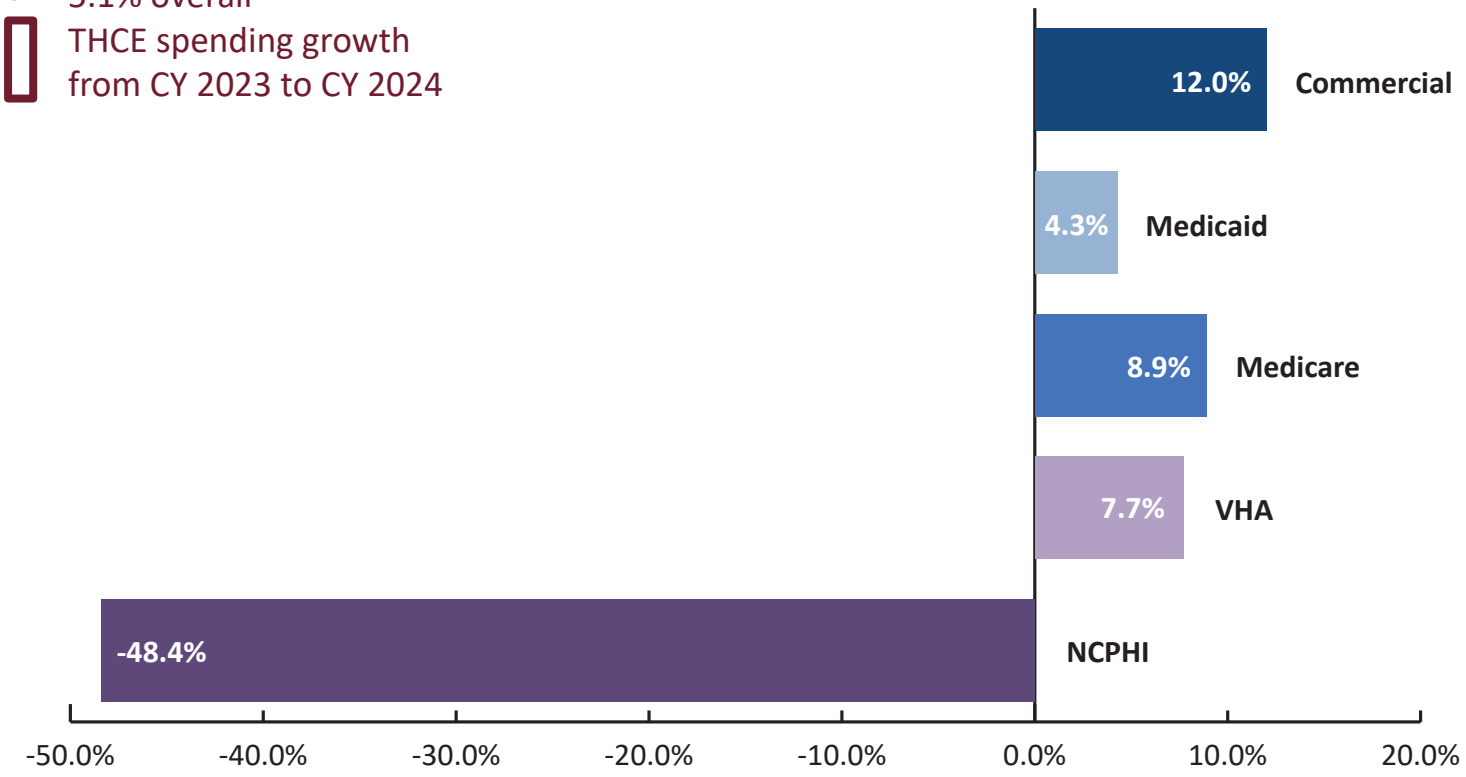
To best analyze the per capita change in THCE for health care enrollees in the State of Delaware, the cost growth exhibit utilizes estimated members from the payer-reported spending data. For a broader statewide view that includes Delaware's total population, the census exhibit utilizes statewide population figures from census.gov. Moving forward, the State plans to analyze the THCE per capita change using the enrolled-members as reflected in the cost growth exhibit above.

THCE per capita increased within both views of the data. Each calculation utilizes the same THCE numerator. Similar to the TME exhibits within Figures 2A-1 and 2A-2, the higher per capita figures observed in the cost growth exhibit is due to a decrease in estimated enrolled members in CY 2024 compared to CY 2023. Delaware's overall population (utilized as the census data denominator) increased 1.9% from CY 2023 to CY 2024, leading to a smaller per capita increase.

Note 1: Cost growth results based on member months provided within benchmark spending data submissions from payers.
Note 2: Census results based on enrollment from census.gov.

Figure 4A-4: State Level Total Health Care Expenditures, Annual Change in Statewide THCE by Component

5.1% overall
THCE spending growth
from CY 2023 to CY 2024

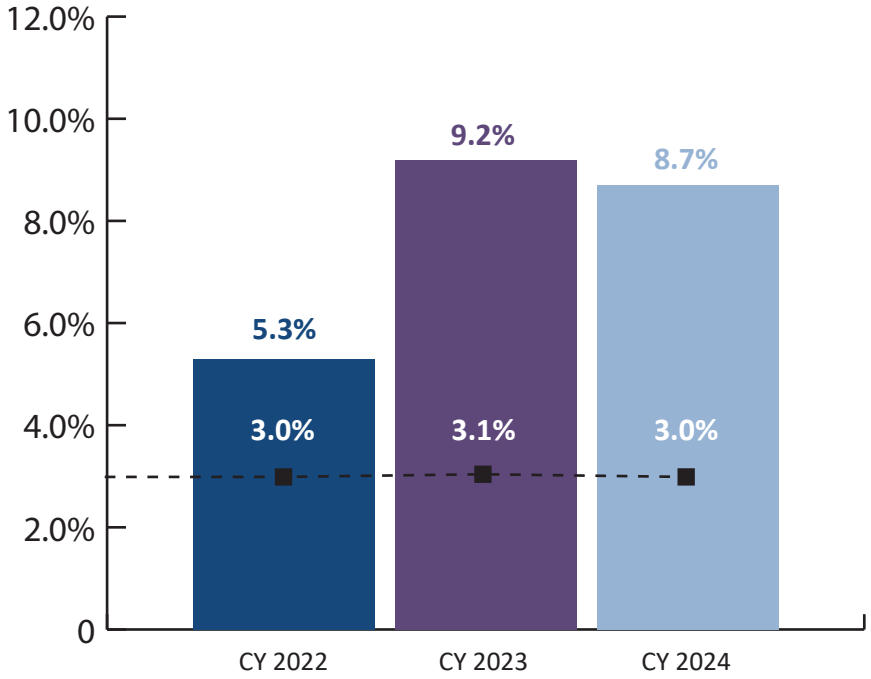


Commercial had the largest reported percentage increase in THCE spending at 12.0% in CY 2024.

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

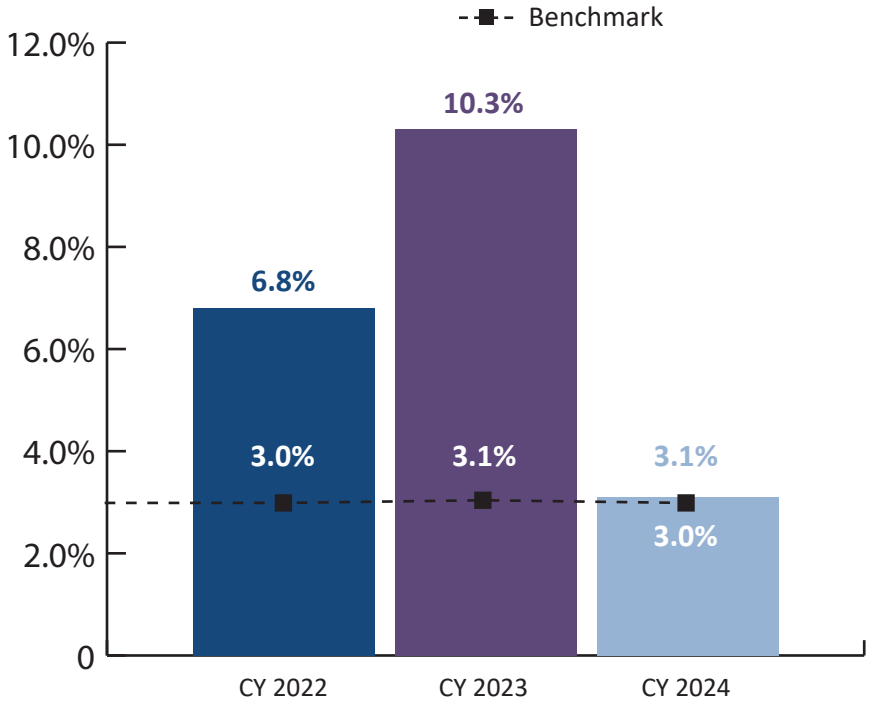
Note 1: Medicaid and Medicare are inclusive of both fee-for-service and managed care.
Note 2: Spending is net of pharmacy rebates.

Figure 4A-5: State Level Total Health Care Expenditures, Per Capita Based on Estimated Members from Cost Growth Data



Note 1: Spending is net of pharmacy rebates.
Note 2: Estimated members are calculated based on member months provided within benchmark spending data submissions from payers.

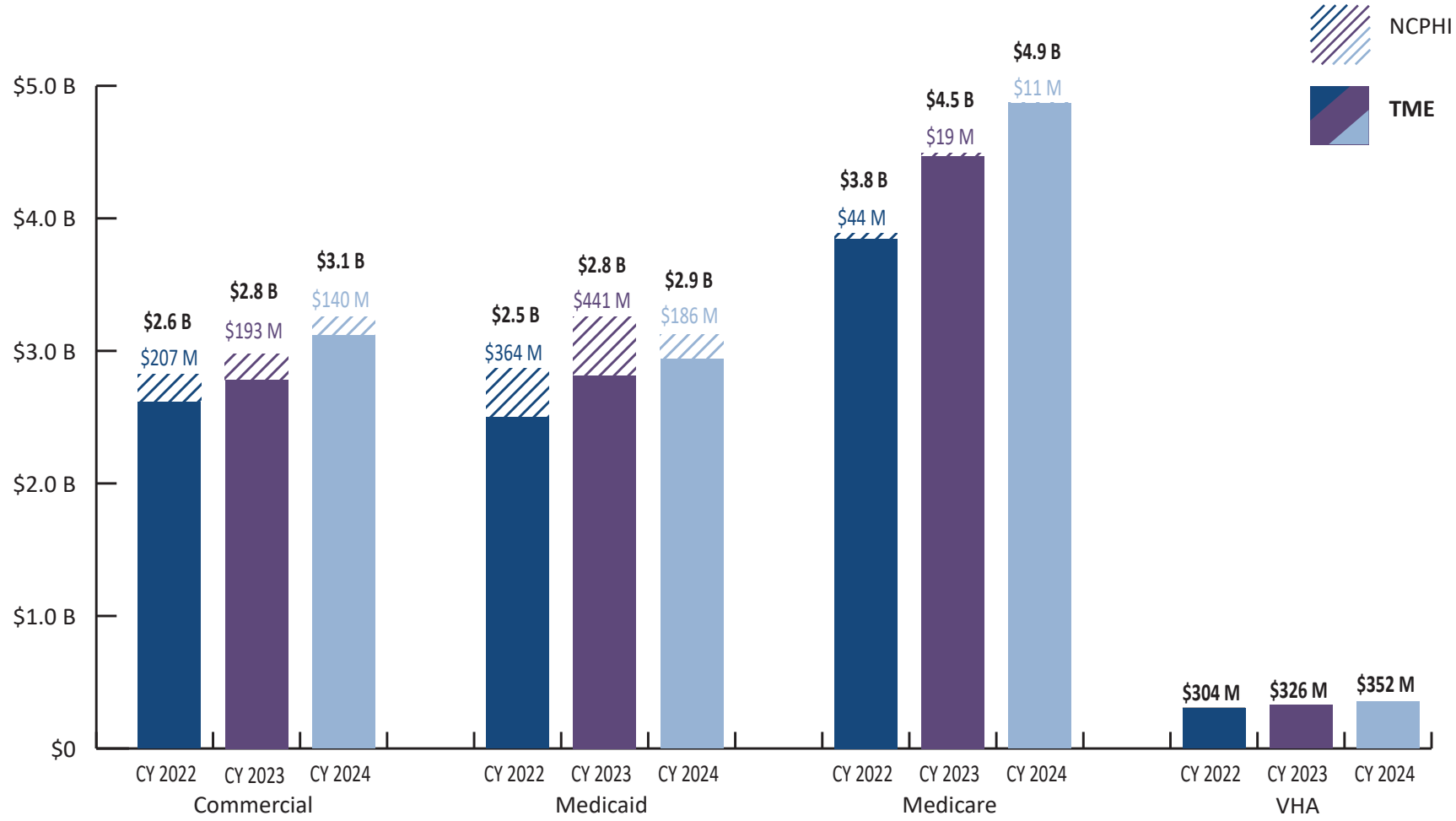
Figure 4A-6: State Level Total Health Care Expenditures, Per Capita Based on Census Enrollment



Note 1: Spending is net of pharmacy rebates.
Note 2: Enrollment shown above comes from census.gov.
Source: Payer-reported data to DHCC and other public sources.

Per EO25 and HA1 for HB442, the spending benchmark is compared against the per capita change in THCE from one year to the next. For CY 2024, the benchmark was set at 3.0%. Delaware did not meet the CY 2024 benchmark.

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

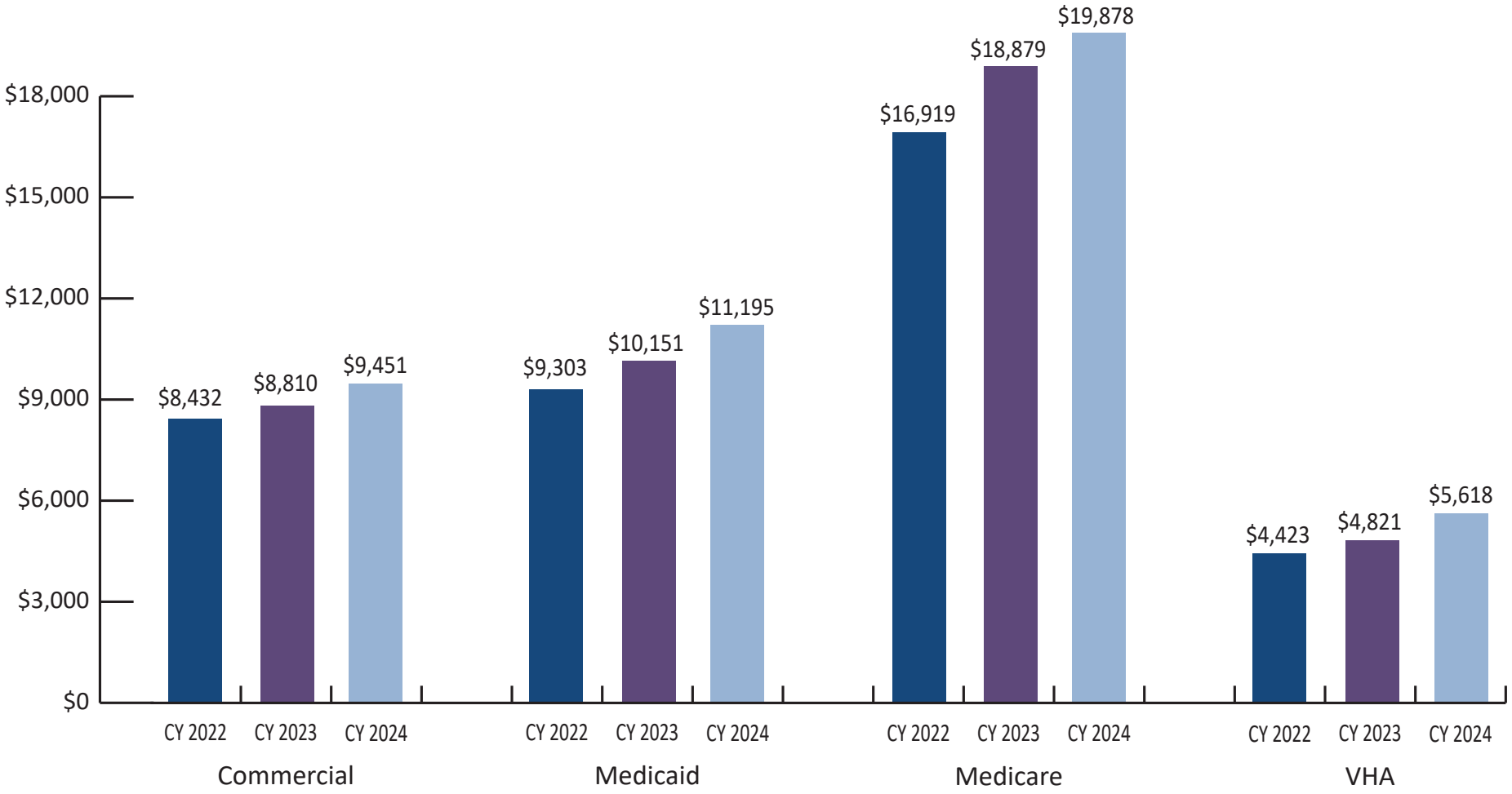


In CY 2024, Commercial THCE increased 9.4%, Medicaid decreased by 4.1%, Medicare increased by 8.6%, and VHA increased by 7.7%.

NCPHI for the Medicaid and Medicare Markets reflects the managed care plans only.

Note 1: Medicaid and Medicare are inclusive of both fee-for-service and managed care. NCPHI is not applicable to FFS.
Note 2: Spending is net of pharmacy rebates.

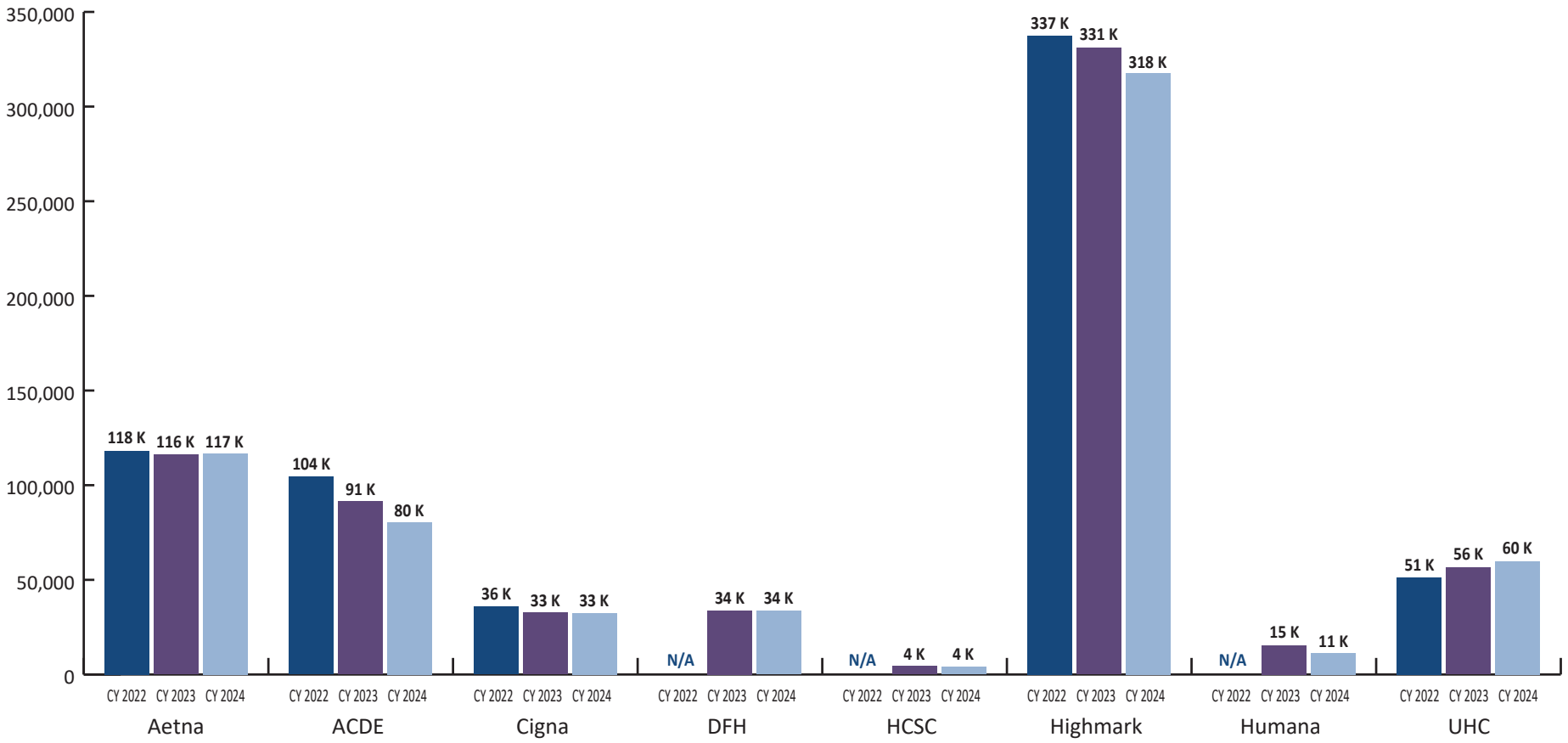
Figure 4B-2: Total Health Care Expenditures, THCE Per Member Per Year by Market



PMPY THCE across all market components increased in CY 2024: Commercial increased by 7.3%, Medicaid increased by 10.3%, Medicare increased by 5.3%, and VHA increased by 16.5%.

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.

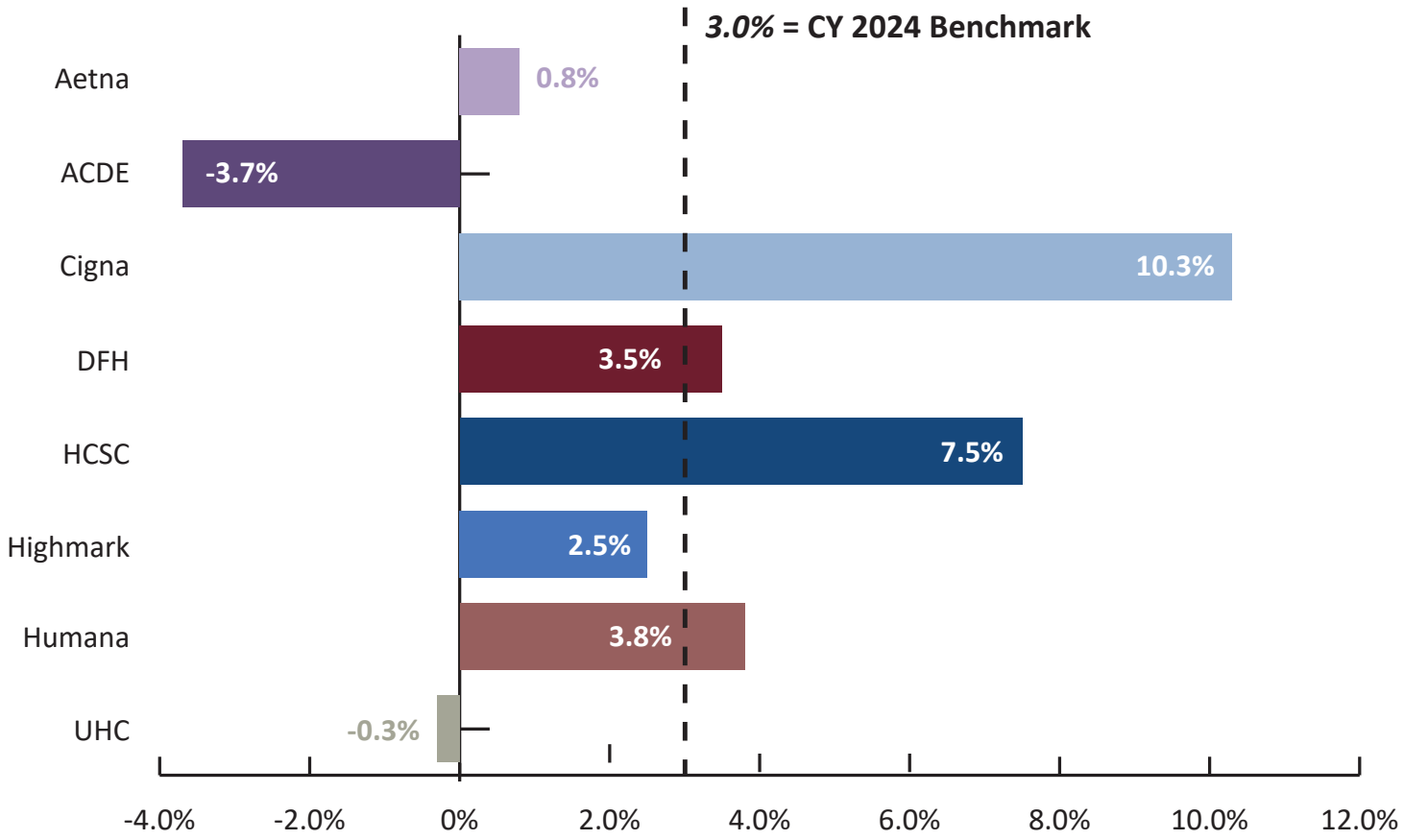
Figure 4C-1: Estimated Membership by Insurer



Estimated membership by insurer is displayed for informational purposes and is calculated by taking insurer-reported member months from the cost growth data divided by 12. These member counts do not include individuals in other markets who are not enrolled within a health plan or those who are uninsured/employer-based self insured.

Note 1: DFH entered the Medicaid managed care program in CY 2023
Note 2: For the CY 2024 data collection cycle, this was the first year data was received for HCSC and Humana.

Figure 4C-2: **Total Health Care Expenditures, CY 2024 Change in Health Risk Adjusted THCE PMPY by Insurer**

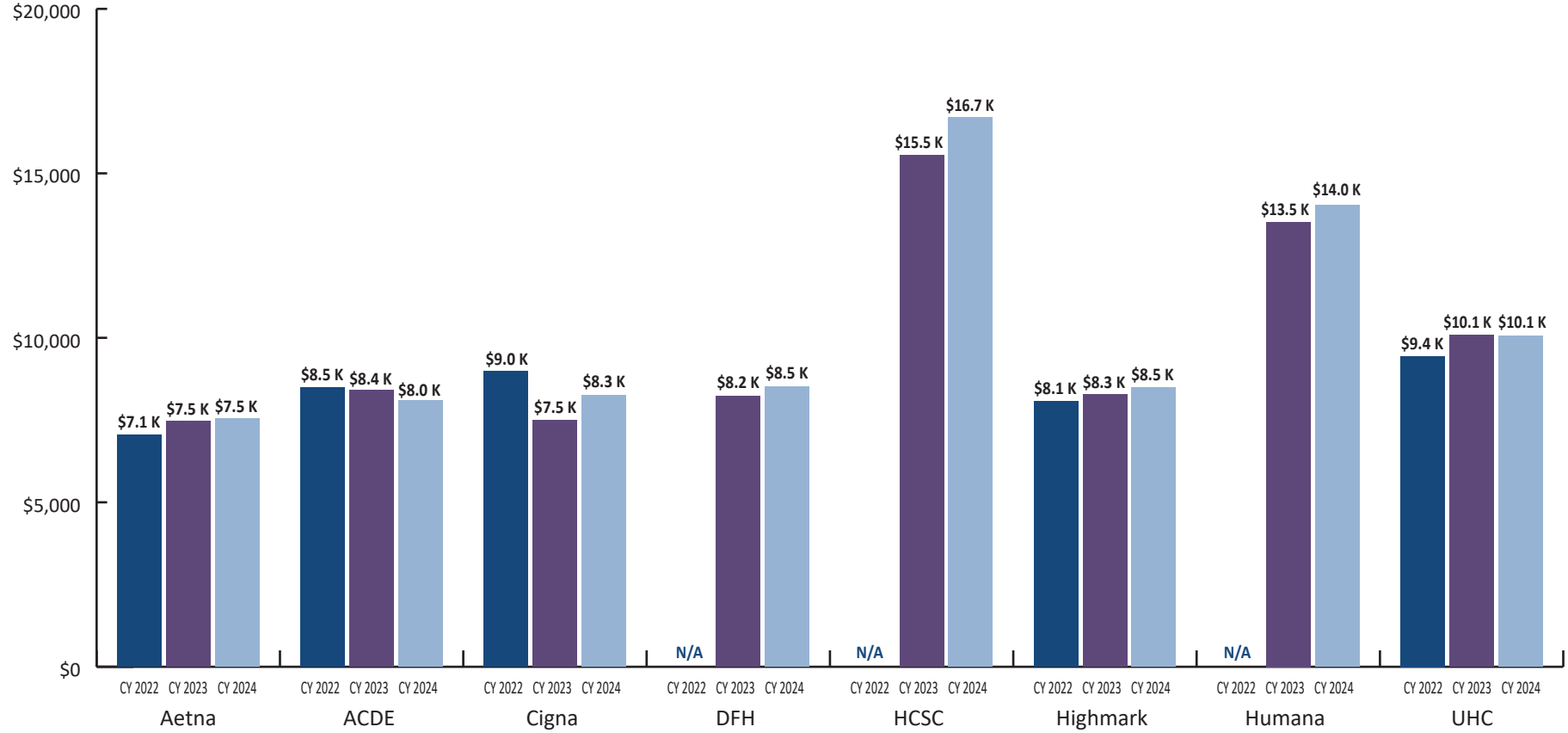


The THCE per capita change relative to the benchmark is measured at the State level and was 3.0% in CY 2024 as shown in Figure 4A-5.

The CY 2024 change in health risk adjusted THCE PMPY by insurer is reflected for informational purposes only.

Note 1: Spending is net of pharmacy rebates.
Note 2: PMPY = per member per year.

Figure 4C-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.

HCSC and Humana reflect the highest health risk adjusted THCE PMPYs in CY 2024. These plans are both Medicare Advantage plans only.

Note 1: DFH entered the Medicaid managed care program in CY 2023.
Note 2: For the CY 2024 data collection cycle, this was the first year data was received for HCSC and Humana.

5. Age/Gender Risk Adjustment

Section 5 provides information on annual changes across the population, Age/Gender Risk Scores, and PMPM spending with and without Age/Gender Risk Adjustment.

KEY FINDINGS

The Age/Gender Risk Score increased slightly from 2023 (Baseline Year) to 2024 (Performance Year) for the Commercial and Total populations, whereas it decreased slightly for the Medicare and Medicaid populations.

An increased Age/Gender Risk Score means that the population changed in a way that costs were expected to increase due to a higher proportion of members in more costly age/gender categories and a lower proportion of members in a less costly age/gender categories. In contrast, a decreased Age/Gender Risk Score means that the population changed in a way that costs were expected to decrease due to a lower proportion of members in more costly age/gender categories and a higher proportion of members in less costly age/gender categories.

On a statewide basis for the information received, Ages 65-74 and 75+ are growing in aggregate distribution from year to year, while the younger populations are shrinking. In CY 2024, as a proportion of total enrollment, individuals between the ages of 0-39 decreased by 1.1% from CY 2023. In turn, individuals ages 65 to 74 and 75+ increased by 0.6%, respectively. The aggregate 65+ population increased by 1.2% in total from CY 2023 to CY 2024.

The 2023 to 2024 PMPM spending amounts were adjusted by the Age/Gender Risk Scores to be able to compare expenditures between the two years while controlling for how the population changed with respect to enrollment across age and gender categories.

Overview

New to this year's Report, Age/Gender Risk Adjustment is a method used to normalize health care spending data across years by accounting for changes in age and gender mix and its estimated impact on expenditures. This methodology allows for year-over-year comparisons of health care spending growth by controlling for population changes.

This spending data adjustment is based on an age/gender category's average baseline year per member per month (PMPM) cost and its proportion of enrollment relative to the total. Therefore, if a more-costly age/gender category has an increased proportion of enrollment, and a less-costly age/gender category has a decreased proportion of enrollment, this analysis is meant to capture these types of changes and reflect that the overall population became more costly. Therefore, in this example, this analysis adjusts the performance year's PMPM expenditures downwards to be able to compare to the baseline year's less costly population. In summary, this adjustment allows for a comparison of the baseline and performance year PMPMs by adjusting the performance year to have the same age/gender population mix as the baseline year.

Section 5 provides information on annual changes across the population, Age/Gender Risk Scores, and PMPM spending with and without Age/Gender Risk Adjustment.

Methodology

Statewide Weights

For purposes of this analysis, this methodology assigned a state-wide weight to each age/gender category within each major market (Commercial, Medicare, Medicaid, Total) based on its Baseline Year (2023) average PMPM divided by the total Baseline Year (2023) average PMPM for that market. Therefore, an age/gender category with a higher average PMPM has a higher weight, and an age/gender category with a lower average PMPM has a lower weight. Note that the insurers and DMMA were asked to report this information with truncation applied to remove outliers above a specific threshold.

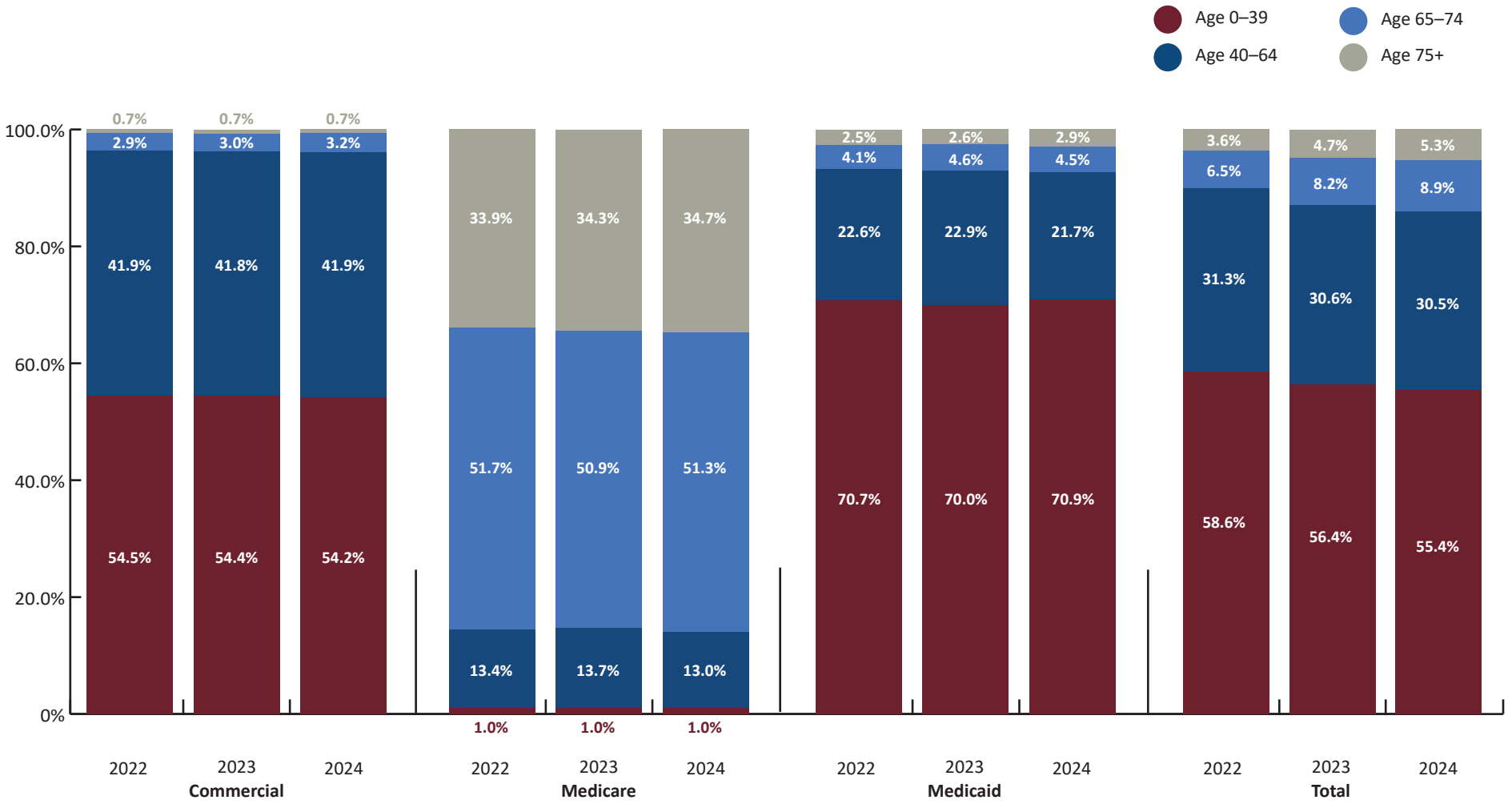
Age/Gender Risk Score

The Age/Gender Risk Score was calculated for both the Baseline Year (2023) and the Performance Year (2024) by multiplying the proportion of each age/gender category's enrollment by the statewide weights mentioned above and then summing these amounts for the total population. By definition, the Baseline Year (2023) Age/Gender Risk Score is equal to 1.

Age/Gender Adjusted Spending PMPMs

The actual 2024 (Performance Year) PMPMs were divided by the 2024 (Performance Year) Age/Gender Risk Scores to adjust the spending PMPMs for age/gender and allow for a comparison with the 2023 (Baseline Year) PMPMs that controls for age/gender mix changes across both years.

Figure 5-1: Population Changes from 2022-2024 (Percentage of Member Months by Category)

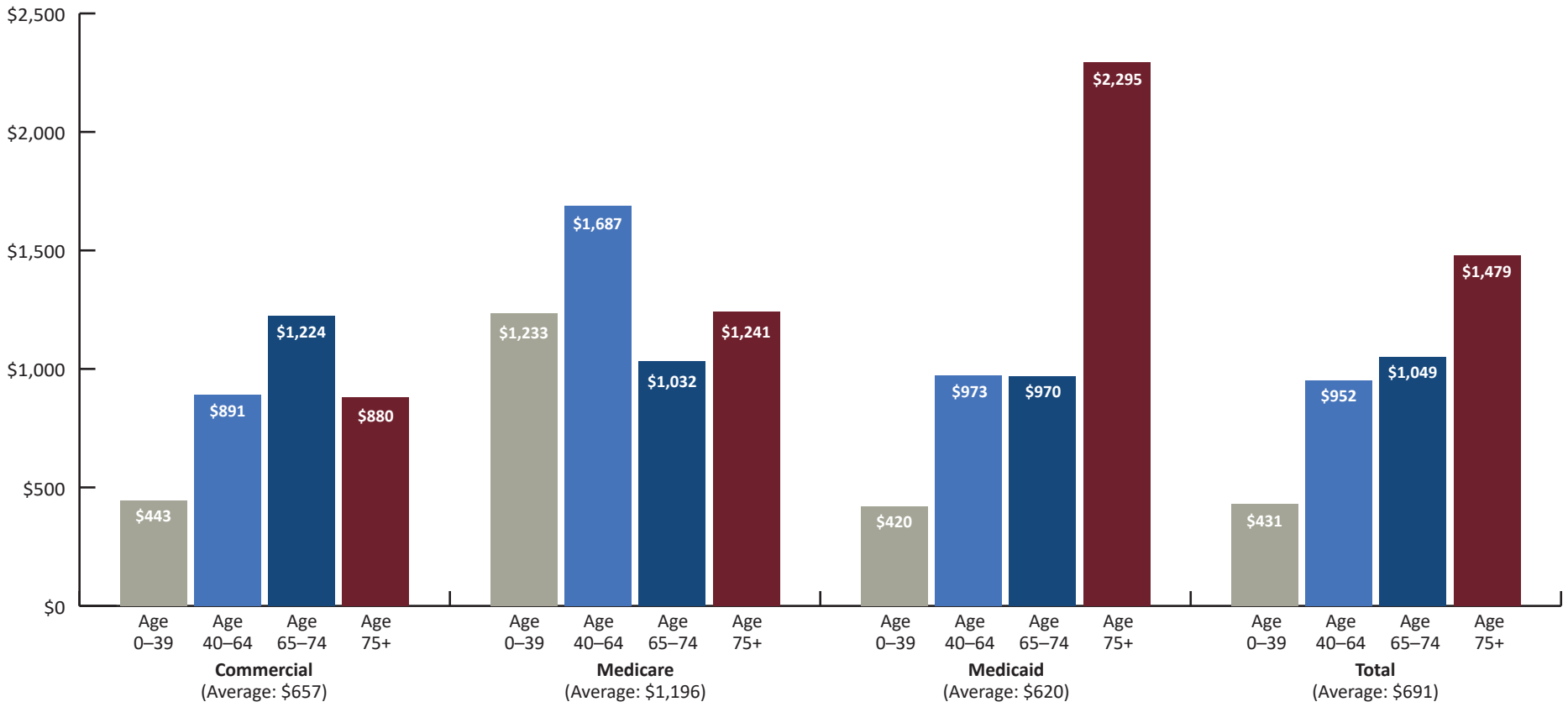


Reflected in this exhibit are the percentages of members within certain age categories across the Commercial, Medicare, Medicaid and Total populations. Note the Medicare and Total population percentages do not include Medicare Fee-For-Service or VHA members. The uninsured and employer-based self insured members are also not included in these totals.

Overall, from year to year, there are not significant enrollment changes among the above-specified age groups for each market. On a statewide basis for the information received, Ages 65-74 and 75+ are growing in aggregate distribution from year to year, while the younger populations are shrinking.

Note: Medicare FFS members are not included.

Figure 5-2: Baseline Year (2023) Average PMPMs which Impact Age/Gender Adjustment



This exhibit outlines the CY 2023 (Baseline Year) average PMPMs by age categories, major market component, and in total. Note the Age/Gender Risk Scores are calculated based on a more detailed breakout of age categories and gender than shown in this section.

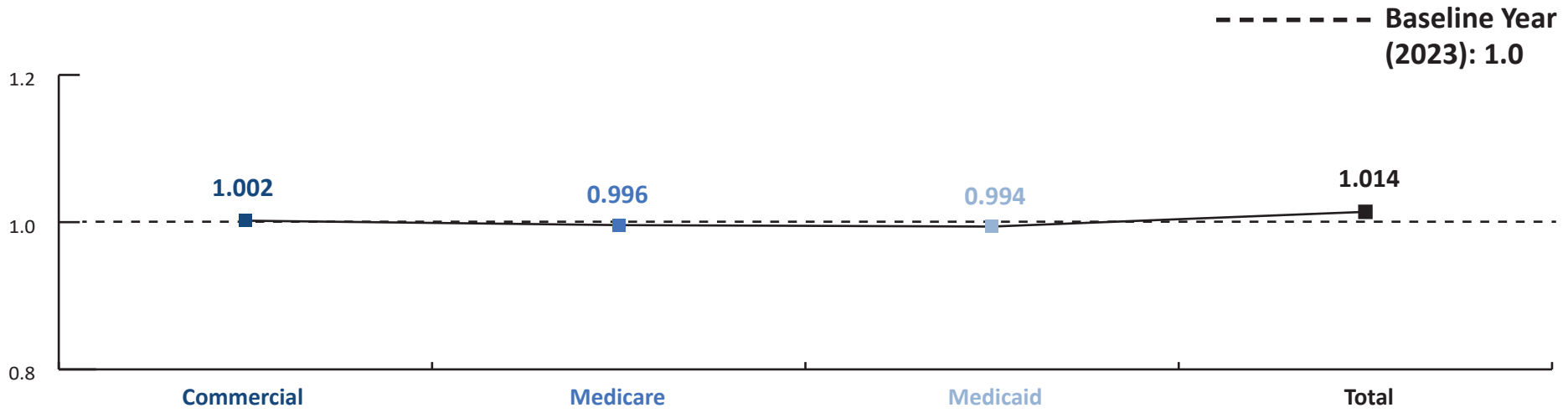
The CY 2023 (Baseline Year) average PMPMs provide a summary of how expenditures differ across certain age categories within each market.

For the Total and Medicaid population, the average PMPM increases with age. For the Commercial population, the average PMPM generally increases with age with the exception of members 75+ years old. For the Medicare population, the average PMPM is highest for the 40 to 64 years old and lowest for the 65 to 74 years old.

Market averages are impacted by the distribution of enrollment across each age category.

Note 1: The age/gender adjustment factors are based on the baseline CY 2023 PMPMs by age/gender categories.
Note 2: PMPMs are based on supplemental information from the payers after truncation is applied.

Figure 5-3: Age/Gender Risk Score Changes from Baseline Year (2023) to Performance Year (2024)



An Age/Gender Risk Score of 1 represents an average risk score which is why the CY 2023 (Baseline Year) Age/Gender Risk Scores are 1 for all major market components and in total.

The CY 2024 (Performance Year) Age/Gender Risk Score changes based on how the age/gender categories changed from CY 2023 to CY 2024. An Age/Gender Risk Score greater than 1 means that the population changed in a way that costs were expected to increase due to a higher proportion of members in more costly age/gender categories and a lower proportion of members in less costly age/gender categories. In contrast, an Age/Gender Risk Score less than 1 means that the population changed in a way that costs were expected to decrease due to a lower proportion of members in more costly age/gender categories and a higher proportion of members in a less costly age/gender categories.

Total:

The Total CY 2024 (Performance Year) Age/Gender Risk Score is 1.014. This represents that the Total CY 2024 age/gender population is expected to be 1.4% more costly than the CY 2023 (Baseline Year) population. From CY 2023 to CY 2024, the proportion of members that are older and more costly increased, while the proportion of members that are younger and less costly saw a decrease. This results in a risk score greater than 1.000.

Commercial:

The Age/Gender Risk Score increased by 0.2% in CY 2024 since the population had an increased proportion of the highest cost population (65 to 74 years old) and a decreased proportion of the lowest cost population (0 to 39 years old).

Medicare:

The Age/Gender Risk Score decreased by 0.4% in CY 2024 since the population has a decreased proportion of the highest cost population (40 to 64 years old) and an increased proportion of the lowest cost population (65 to 74 years old).

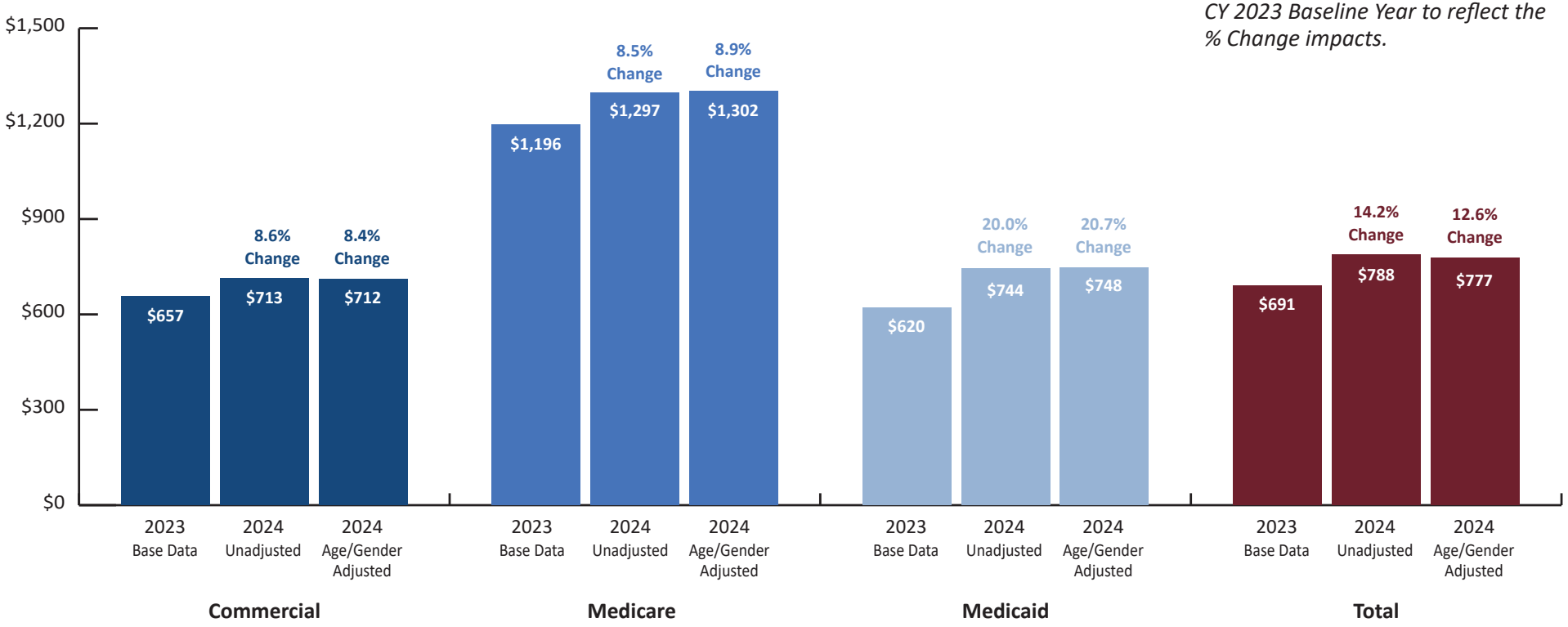
Medicaid:

The Age/Gender Risk Score decreased by 0.6% in CY 2024 since the population has an increased proportion of the lowest cost population (0 to 39 years old) and decreasing proportion of a higher cost population (40 to 74 years old). Even though the highest cost population (75+ years old) has an increased proportion, the impact of this is offset by a more significant increase in the lowest cost population and decrease in the higher cost population.

Note: The baseline year (CY 2023) is 1.000 by definition, whereas the performance year (CY 2024) shows the age/gender risk score change relative to the baseline year.

Figure 5-4: PMPM Spending Changes from 2023 to 2024 (Unadjusted vs Adjusted for Age/Gender)

CY 2024 Unadjusted and Adjusted PMPMs are compared against the CY 2023 Baseline Year to reflect the % Change impacts.



This exhibit summarizes the average PMPMs with and without Age/Gender Risk Adjustment. The CY 2024 (Performance Year) average PMPM is divided by the population's Age/Gender Risk Score. If the Age/Gender Risk Score is greater than 1.000, the CY 2024 (Performance Year) average PMPM is adjusted down to control for the increased acuity. Whereas if the Age/Gender Risk Score is less than 1.000, the CY 2024 (Performance Year) average PMPM is adjusted up to control for the decreased acuity.

Note 1: The table above shows the unadjusted and age/gender adjusted PMPMs.
Note 2: If the CY 2024 age/gender adjustment risk score was higher than the CY 2023 baseline year (greater than 1), the CY 2024 PMPM was adjusted downwards to reflect the higher acuity. Whereas if the CY 2024 age/gender adjustment risk score was lower than the CY 2023 baseline year (less than 1), the PMPM was adjusted upwards to reflect the lower acuity.
Note 3: The percentage change between the age/gender adjustment PMPMs is intended to represent the changes between CY 2023 and 2024 controlling for changes in age/gender.

6. Quality Data and Benchmarks

KEY FINDINGS

29.4

DEATHS PER 100,000

A notable improvement from 2023, Opioid Related Overdose Deaths fell rapidly in 2024, declining by nearly 40 percent.

Two quality measures managed to surpass their targets in 2024.

Where a higher result is better:

- Breast Cancer Screening for the commercial population exceeded its target at 79.4% compared to the benchmark target of 79.3%.
- Colorectal Cancer Screening for the Medicaid population exceeded its target at 37.4% compared the benchmark target of 34.4%.

For the Persistence of Beta-Blocker Treatment After a Heart Attack measure, a higher result than the established benchmark is better. For the Medicaid population, CY 2024 results were 21.2% lower than CY 2023. This puts the Medicaid results for CY 2024 43.9% below the benchmark rate of 86.8%.

The Emergency Department Utilization, Persistence of Beta Blocker Treatment After a Heart Attack (Commercial), Breast Cancer Screening (Commercial and Medicaid), and Cervical Cancer Screening (Medicaid) measures all achieved improvement from 2023 to 2024.

Results for the Emergency Department Utilization measure for Commercial insurers decreased by 7.6 visits per 1,000 in CY 2024. This is 5.8 visits per 100k higher than the CY 2024 benchmark, but improvement was made.

CY 2024 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 2024.

DHSS added Breast Cancer Screening, Cervical Cancer Screening, Colorectal Cancer Screening, and Percentage of Eligibles Who Received Preventive Dental Services as new quality benchmarks beginning with the CY 2022 performance period.

The Percentage of Eligibles Who Received Preventive Dental Services measure was retired by CMS in 2021, thus there is no data available to report for the Report. DHSS is replacing this measure for the next 3-year cycle of quality benchmarks.

As seen in the table below, relative to each respective quality benchmark, CY 2024 results across the nine quality measures were mixed:

Table 6-1: Quality Measures CY 2024 Benchmark and Results

Quality Measures	CY 2024 Benchmark	CY 2024 Results	Benchmark Met?
Adult Obesity	30.5%	36.6%	No
Use of Opioids at High Dosages	10.0%	10.6%	No
Opioid-related Overdose Deaths	28.0 deaths per 100,000	29.4 deaths per 100,000	No
Emergency Department Utilization	156.1 visits per 1,000 Commercial only	161.9 visits per 1,000 Commercial only	No
Persistence of Beta-Blocker Treatment After a Heart Attack	91.7% Commercial 86.8% Medicaid	81.0% Commercial 42.9% Medicaid	No No
Statin Therapy for Patients with Cardiovascular Disease	85.2% Commercial 78.5% Medicaid	78.5% Commercial 64.4% Medicaid	No No
Breast Cancer Screening	79.3% Commercial 61.8% Medicaid	79.4% Commercial 57.3% Medicaid	Yes No
Cervical Cancer Screening	82.1% Commercial 65.5% Medicaid	72.6% Commercial 52.0% Medicaid	No No
Colorectal Cancer Screening	68.1% Commercial 34.4% Medicaid	62.0% Commercial 37.6% Medicaid	No Yes

Prior to the 2021 data collection cycle, data was voluntarily submitted by payers. However, HA 1 for HB 442, signed on August 19, 2022, by Governor Carney, mandated the provision of benchmark data.

Quality measures are reviewed and adjusted on a three-year cycle. The 2025 Report will report out on newly selected measures that are part of the benchmarks initiative for the 2025-27 cycle.

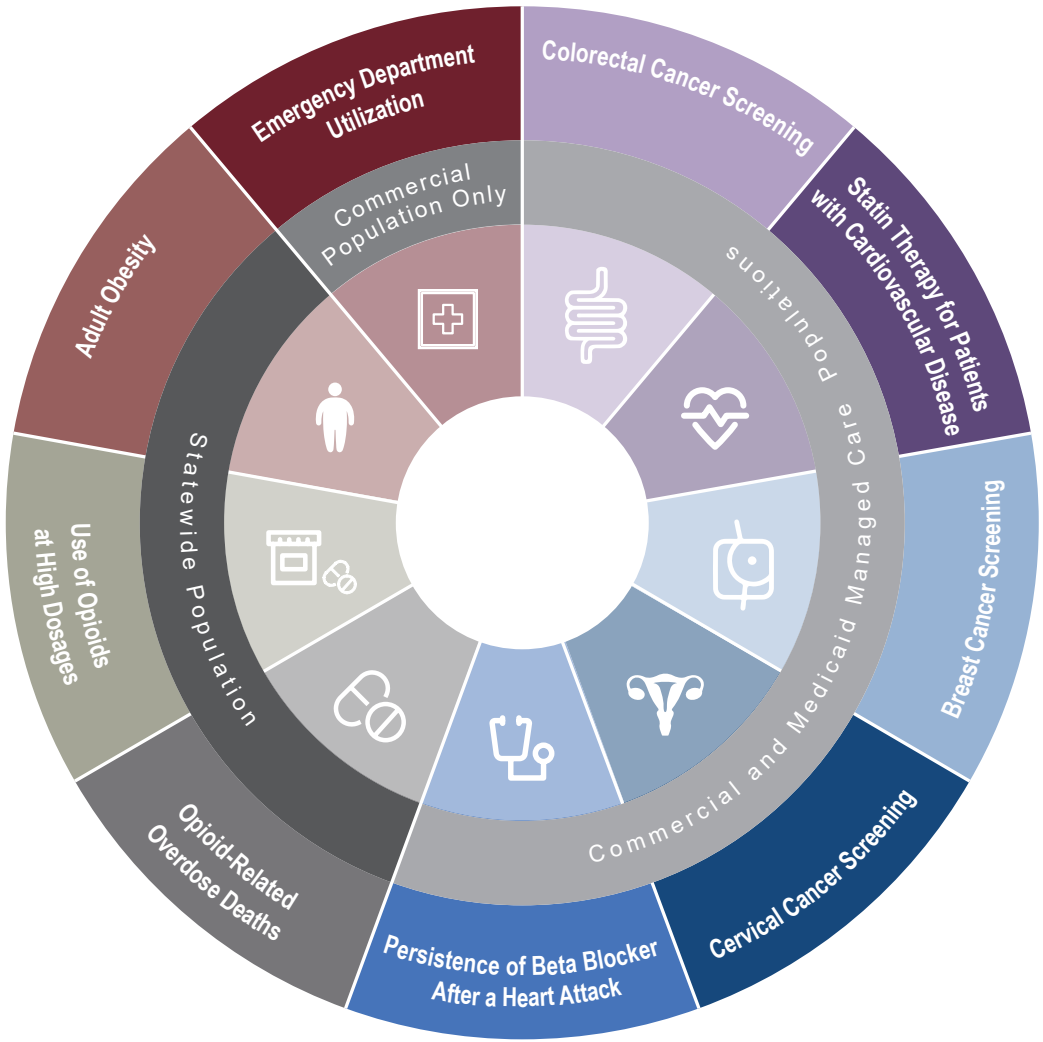
6-1 through 6-4: Includes summaries of the Statewide-only quality data results. These measures do not have insurer-specific detail.

6A and 6B: Includes summaries of the quality data results by market, insurer, and additional stratifications where applicable.

For the six 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.

Note that not all insurers have quality data to report on the Commercial or Medicaid markets. Insurers shown are based on those that had data to report; therefore, the listed insurers across measures may differ.

Additional information on overall results is provided in the forthcoming exhibits.



Quality Data and Benchmarks

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

DHSS added Breast Cancer Screening, Cervical Cancer Screening, Colorectal Cancer Screening, and Percentage of Eligibles Who Received Preventive Dental Services as new quality benchmarks beginning with the CY 2024 performance period.

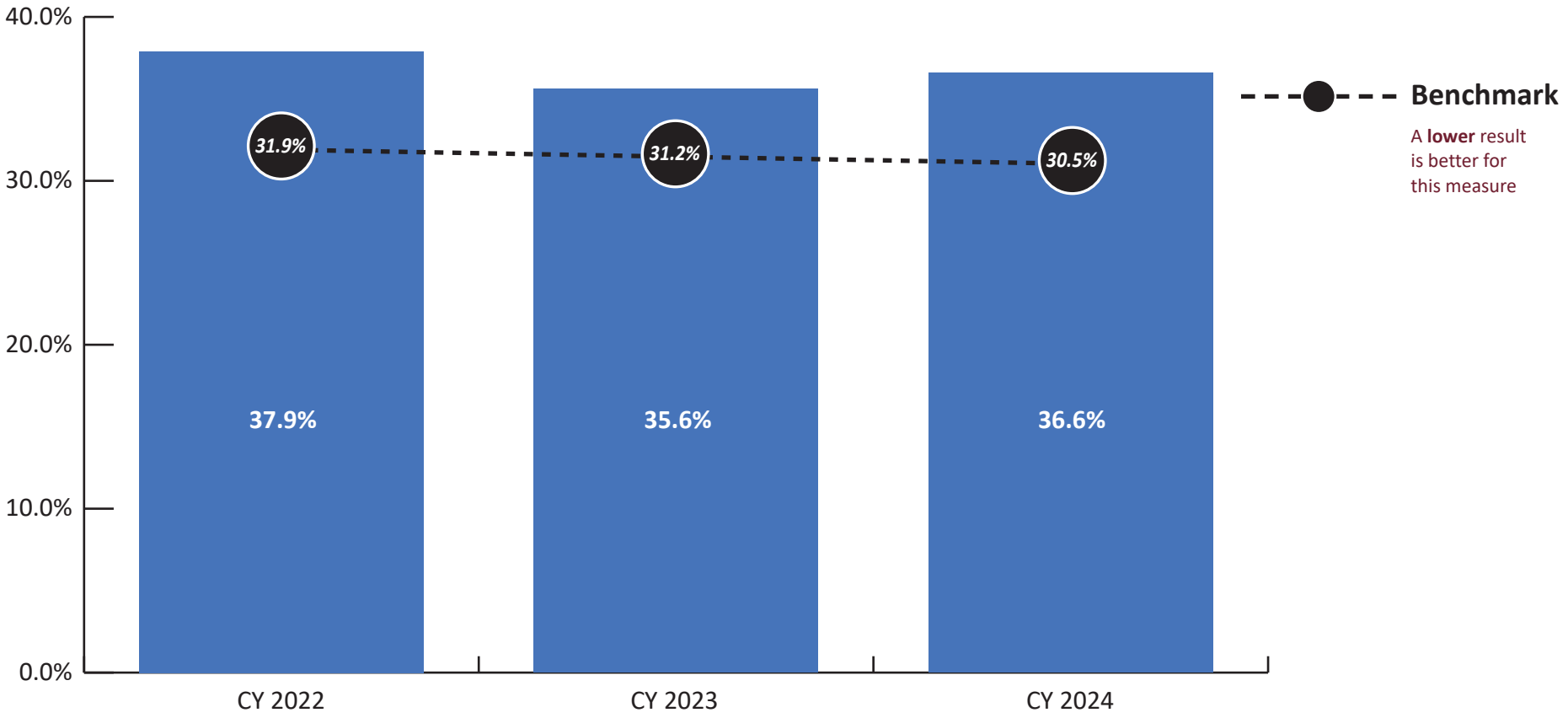
The Percentage of Eligibles Who Received Preventive Dental Services measure was retired by CMS in 2021, thus there is no data available to report for the CY 2024 Report. DHSS is replacing this measure for the next 3-year cycle of quality benchmarks.

Prior to the CY 2021 data collection cycle, data was voluntarily submitted by payers. However, HA 1 for HB 442, signed on August 19, 2022 by Governor Carney, mandated the provision of benchmark data.

Table 6-2: Quality Measures, Population, Data Sources and CY 2024 Benchmark

Quality Measure	Population	Data Source	CY 2024 Benchmark
Adult Obesity	• Statewide (all populations)	• CDC public report	30.5 percent
Use of Opioids at High Dosages	• Statewide (all populations)	• Delaware Prescription Monitoring Program	10.0 percent
Opioid-related Overdose Deaths	• Statewide (all populations)	• CDC public report	28.0 deaths per 100,000
Emergency Department Utilization	• Commercial market	• Delaware insurers	156.1 visits per 1,000 (Commercial only)
Persistence of Beta-Blocker Treatment After a Heart Attack	• Commercial market • Medicaid market (managed care only)	• Delaware insurers	• 91.7 percent (Commercial) • 86.8 percent (Medicaid)
Statin Therapy for Patients with Cardiovascular Disease	• Commercial market • Medicaid market (managed care only)	• Delaware insurers	• 85.2 percent (Commercial) • 78.5 percent (Medicaid)
Breast Cancer Screening	• Commercial market • Medicaid market (managed care only)	• Delaware insurers	• 79.3 percent (Commercial) • 61.8 percent (Medicaid)
Cervical Cancer Screening	• Commercial market • Medicaid market (managed care only)	• Delaware insurers	• 81.2 percent (Commercial) • 65.5 percent (Medicaid)
Colorectal Cancer Screening	• Commercial market • Medicaid market (managed care only)	• Delaware insurers	• 68.1 percent (Commercial) • 34.4 (Medicaid)

Figure 6-1: Adult Obesity Quality Measure - Actual Results versus Benchmark

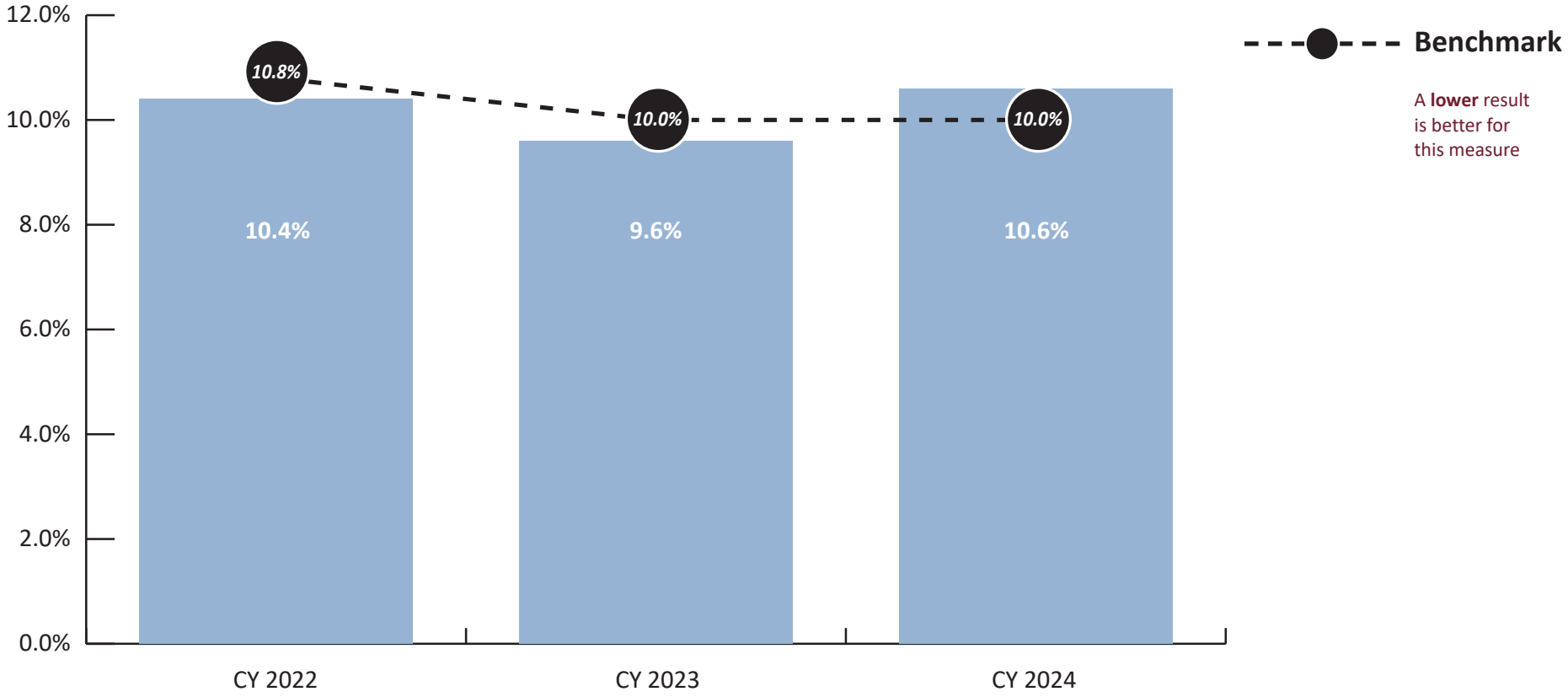


Adult Obesity

6.1% Points
above the benchmark

Results increased by 1.0% in CY 2024 and were 6.1 percentage points above the benchmark.

Figure 6-2: Use of Opioids at High Dosages Quality Measure - Actual Results versus Benchmark

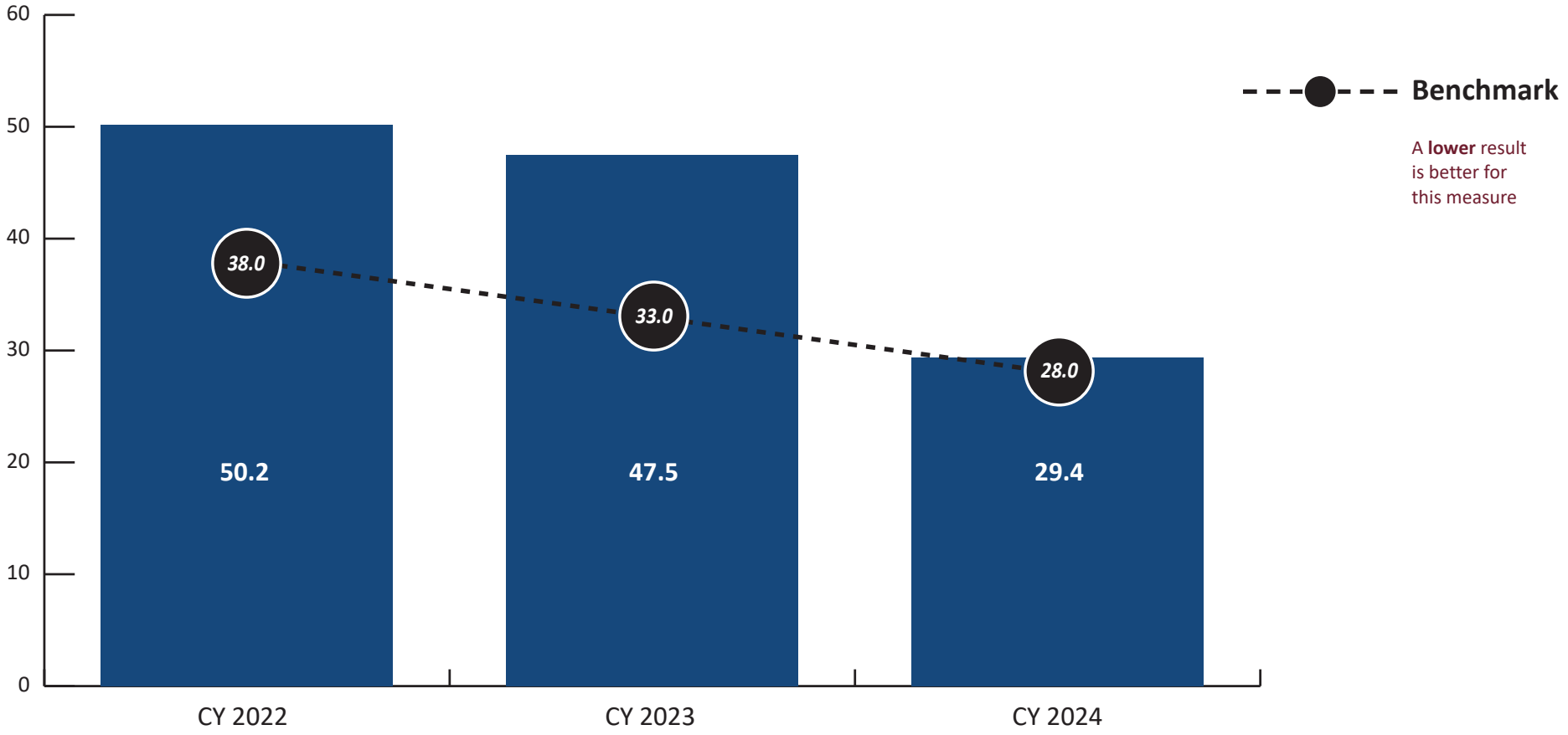


Use of Opioids at High Dosages

0.6% Points
above the benchmark

Results increased by 1.0% in CY 2024 and were 0.6 percentage points above the benchmark.

Figure 6-3: Opioid-related Overdose Deaths per 100,000 Quality Measure - Actual Results versus Benchmark

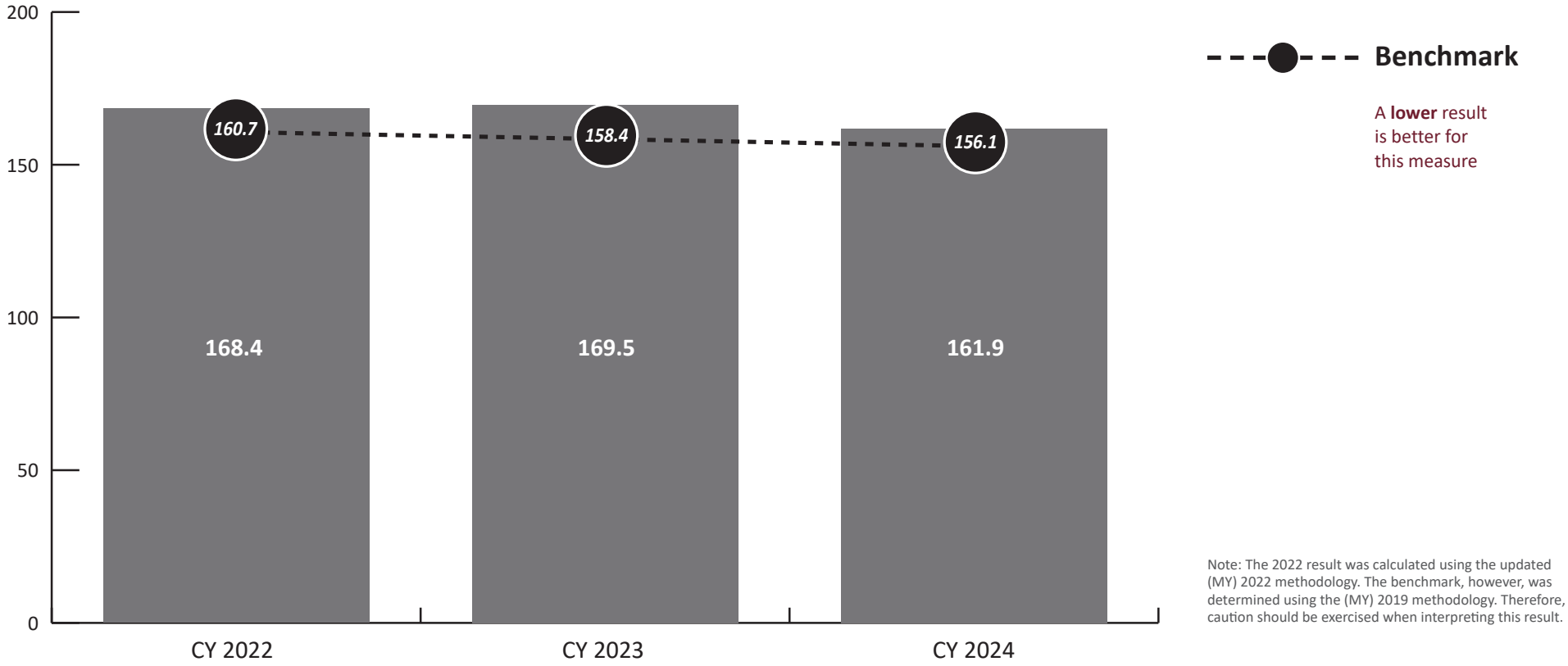


Opioid-related Overdose Deaths per 100,000

1.4 Deaths
above the benchmark

Results decreased by 18.1 deaths per 100k in CY 2024 with 1.4 deaths per 100k higher than the CY 2024 benchmark, however, significant improvement was made.

Figure 6-4: Emergency Department Utilization Quality Measure - Actual Results versus Benchmark: Commercial



Note: The 2022 result was calculated using the updated (MY) 2022 methodology. The benchmark, however, was determined using the (MY) 2019 methodology. Therefore, caution should be exercised when interpreting this result.

Emergency Department Utilization

5.8 Visits
above the benchmark

Results decreased by 7.6 visits per 1,000 in CY 2024 with 5.8 visits per 1,000 higher than the CY 2024 benchmark, however, improvement was made.

Figure 6-5 A: Persistence of Beta-Blocker Treatment After a Heart Attack Quality Measure - Actual Results versus Benchmark: Commercial

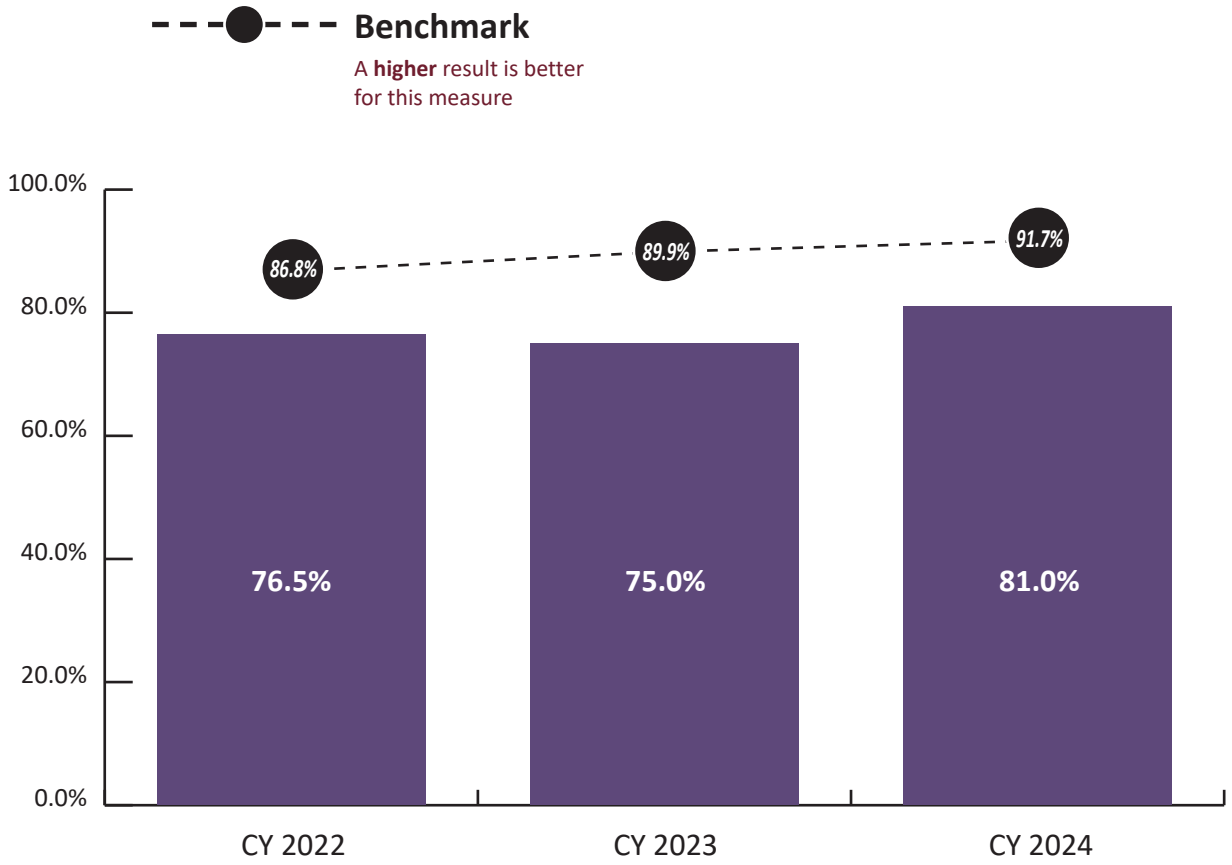
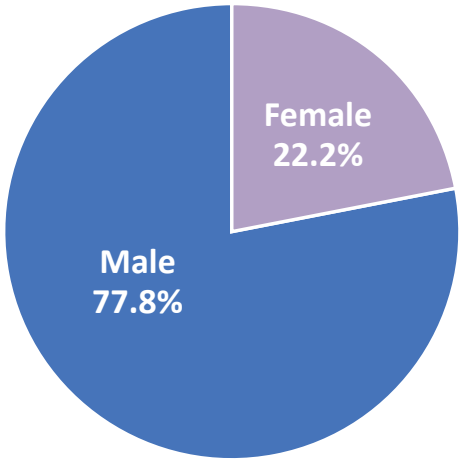


Figure 6-5 A1:

Persistence of Beta-Blocker Treatment After a Heart Attack Quality Measure - Actual Results versus Benchmark: Commercial - Sex



Persistence of Beta-Blocker Treatment After a Heart Attack

The Commercial market was 10.7 percentage points lower (worse) than the CY 2024 benchmark.

Figure 6-5 B: Persistence of Beta-Blocker Treatment After a Heart Attack Quality Measure - Actual Results versus Benchmark: Medicaid

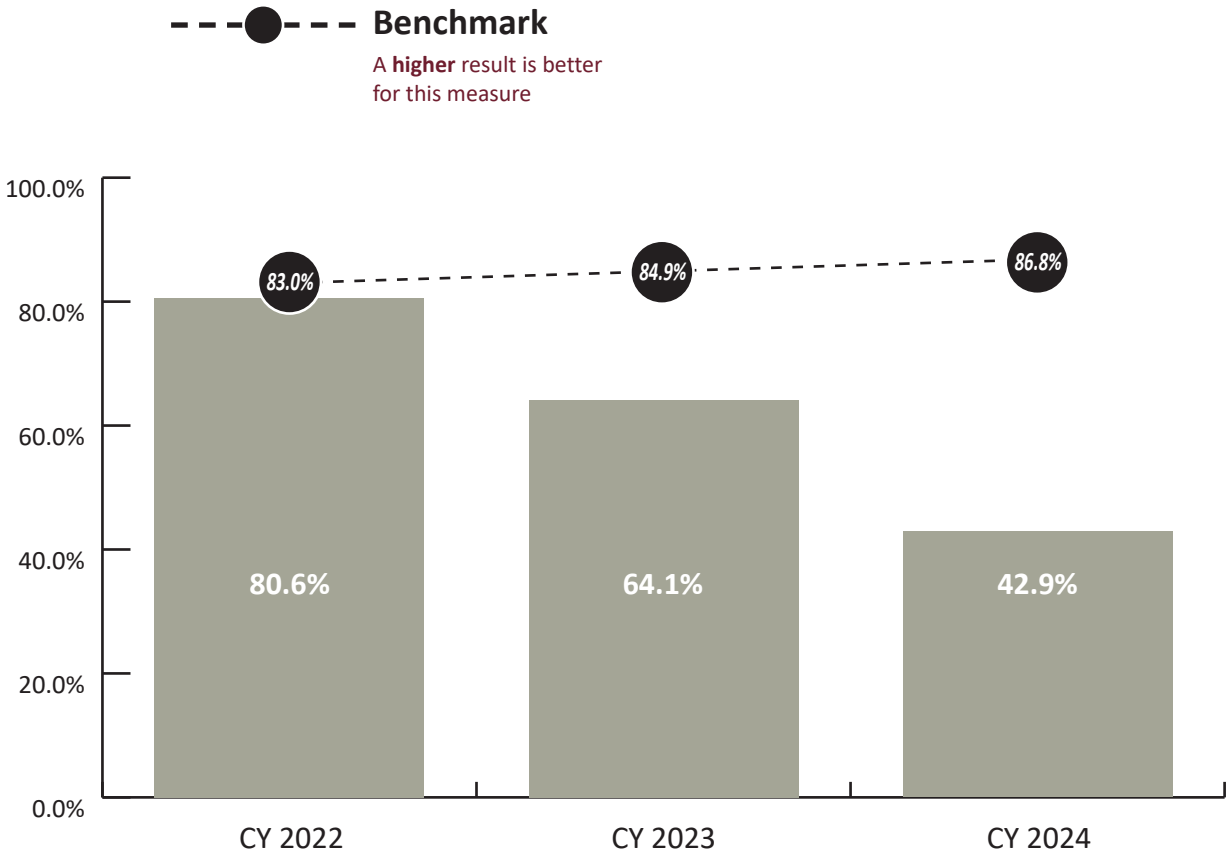
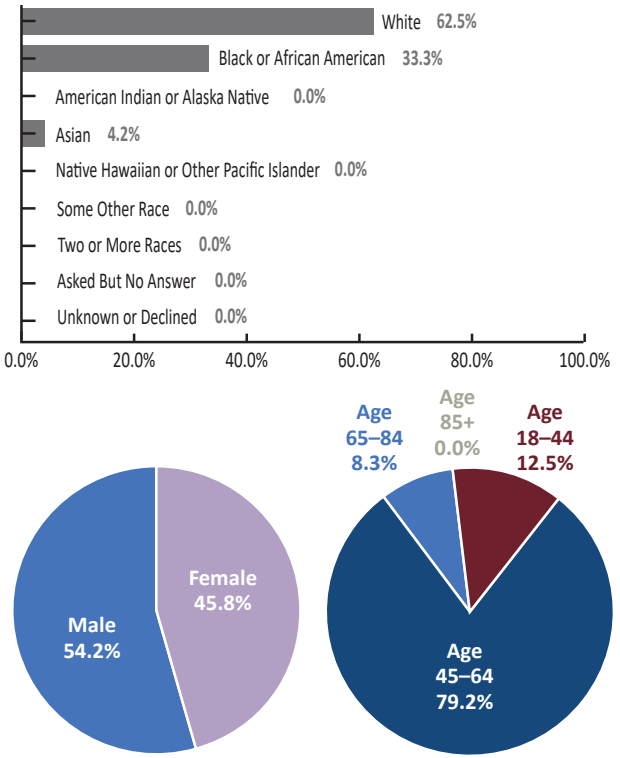


Figure 6-5 B1:

Individuals within the Medicaid Population who Received Persistent Beta-Blocker Treatment After a Heart Attack - Race, Sex, and Age



Persistence of Beta-Blocker Treatment After a Heart Attack

The Medicaid market was 43.9 percentage points lower (worse) in CY 2024 than the benchmark.

Note: For this quality measure, Medicaid market is only managed care.

Figure 6-6 A: Statin Therapy for Patients with Cardiovascular Disease Quality Measure - Actual Results versus Benchmark: Commercial

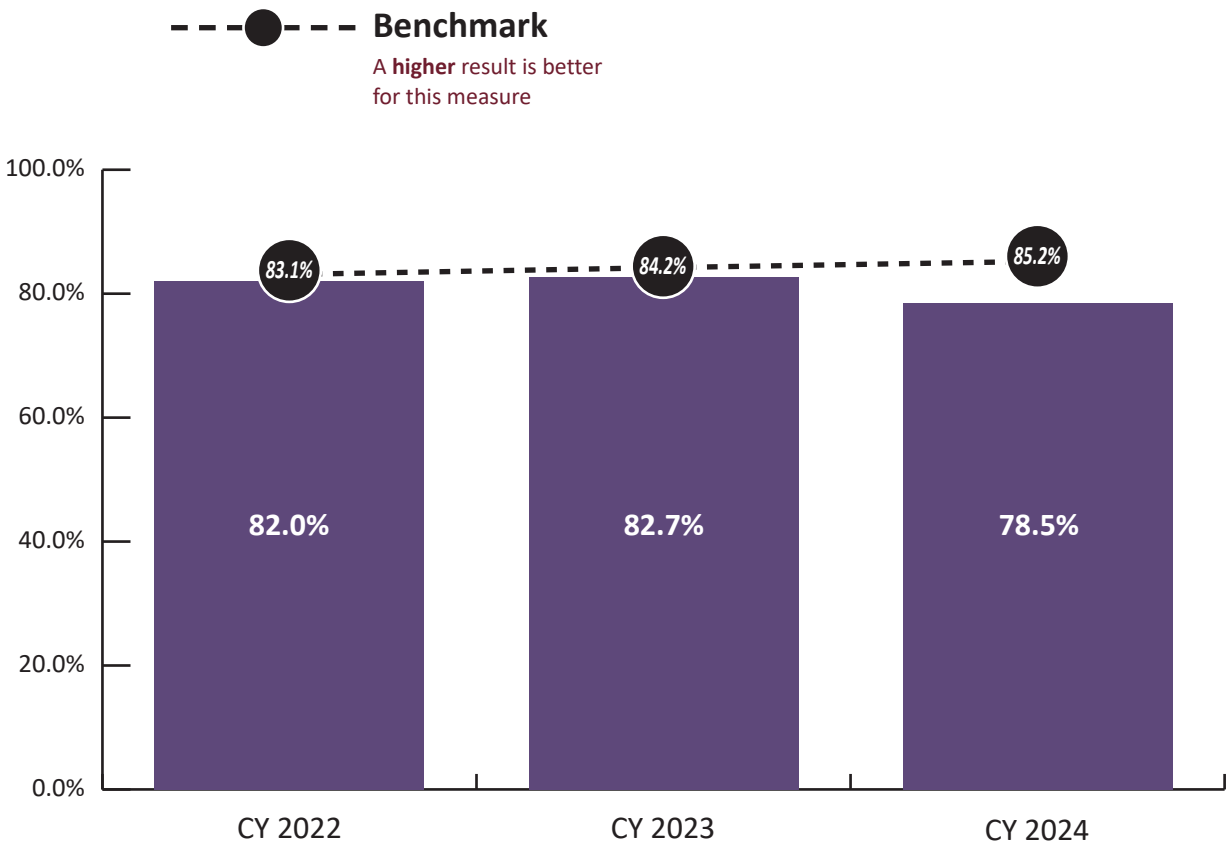
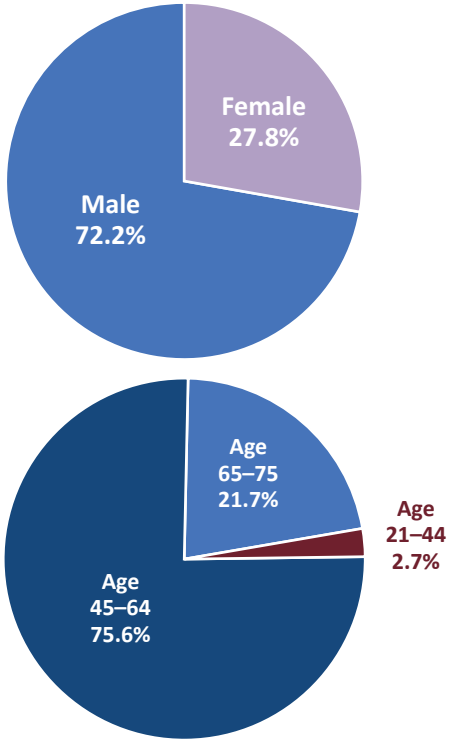


Figure 6-6 A1:

Individuals within the Commercial Population with Cardiovascular Disease who Received Statin Therapy - Sex and Age



Statin Therapy

Results for this measure in CY 2024 decreased from CY 2023, and fell below the CY 2024 benchmark by 6.7 percentage points.

Figure 6-6 B: Statin Therapy for Patients with Cardiovascular Disease Quality Measure - Actual Results versus Benchmark: Medicaid

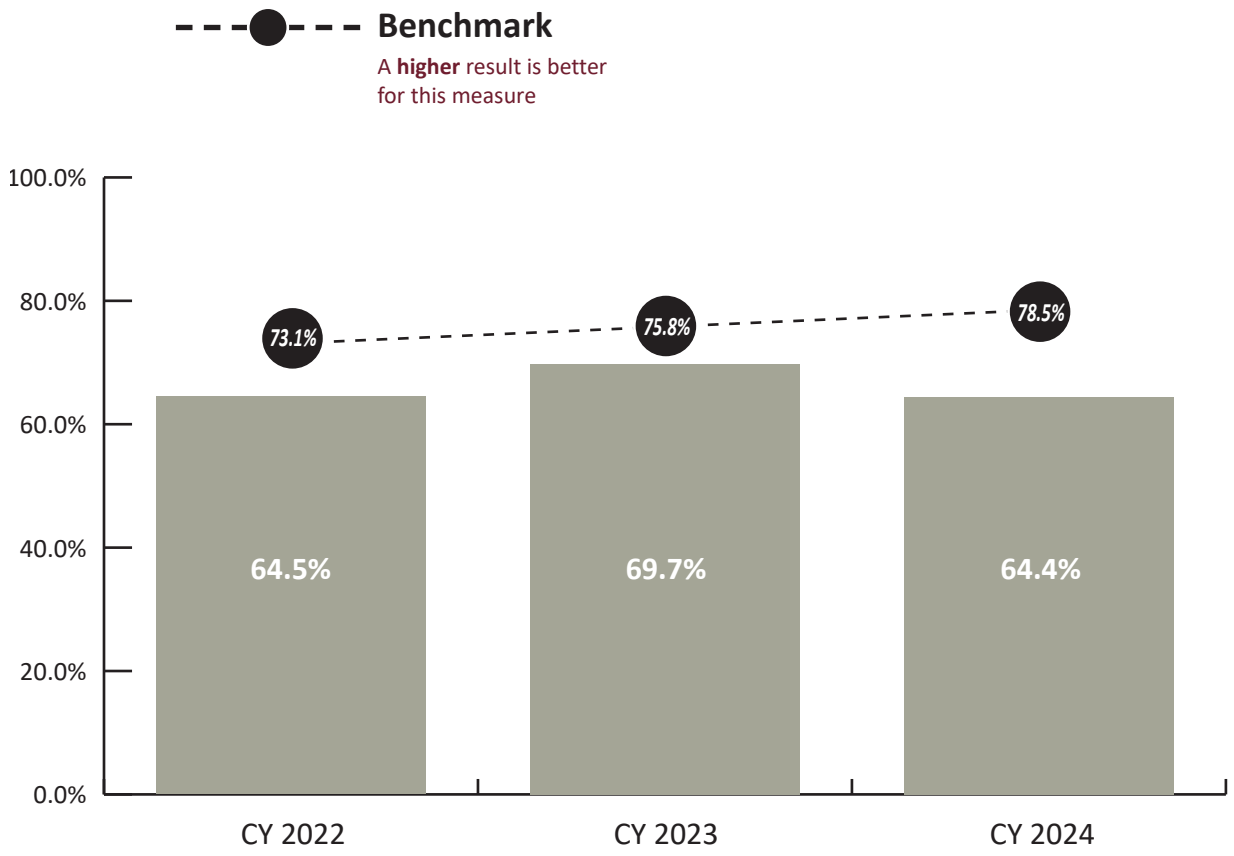
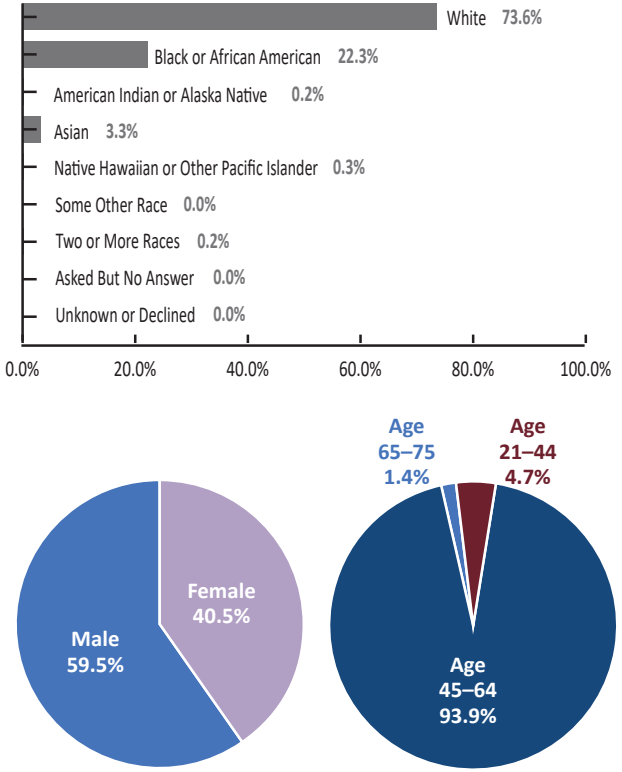


Figure 6-6 B1:

Individuals within the Medicaid Population with Cardiovascular Disease who Received Statin Therapy - Race, Sex, and Age



Statin Therapy

The Medicaid market was 14.1 percentage points lower (worse) than the CY 2024 benchmark.

Note: For this quality measure, Medicaid market is only managed care.

Figure 6-7 A: Breast Cancer Screening Quality Measure - Actual Results versus Benchmark: Commercial

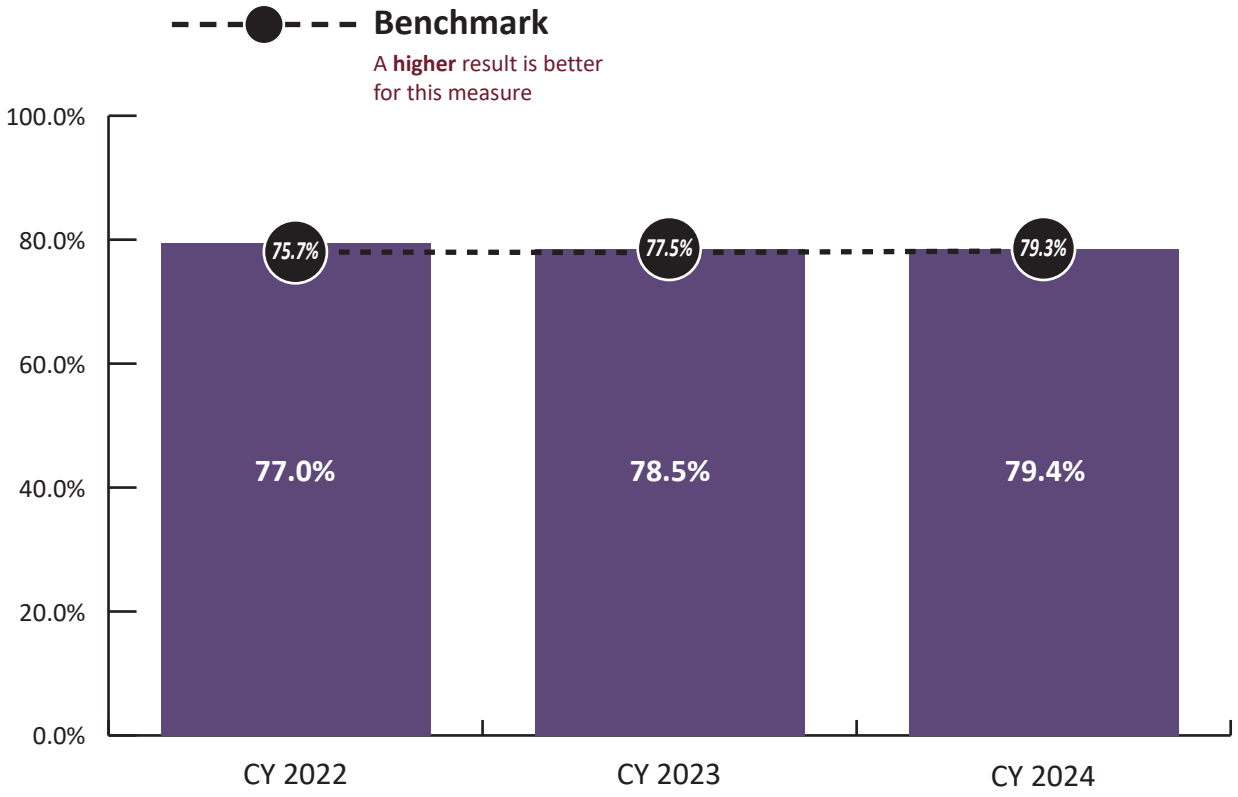
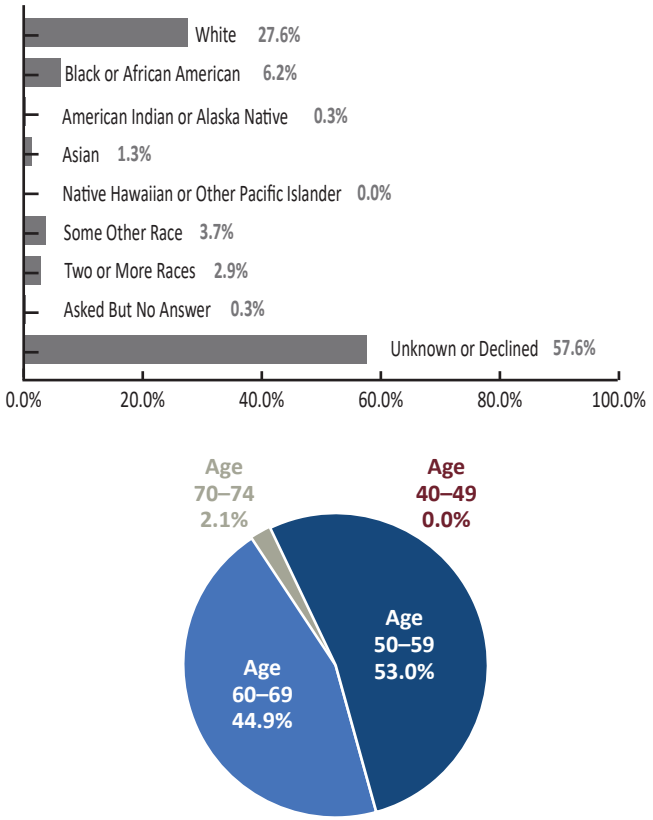


Figure 6-7 A1: Breast Cancer Screening Quality Measure - Race and Age: Commercial



Breast Cancer Screening

The Commercial market exceeded the CY 2024 benchmark by 0.1 percent.

Figure 6-7 B: Breast Cancer Screening Quality Measure - Actual Results versus Benchmark: Medicaid

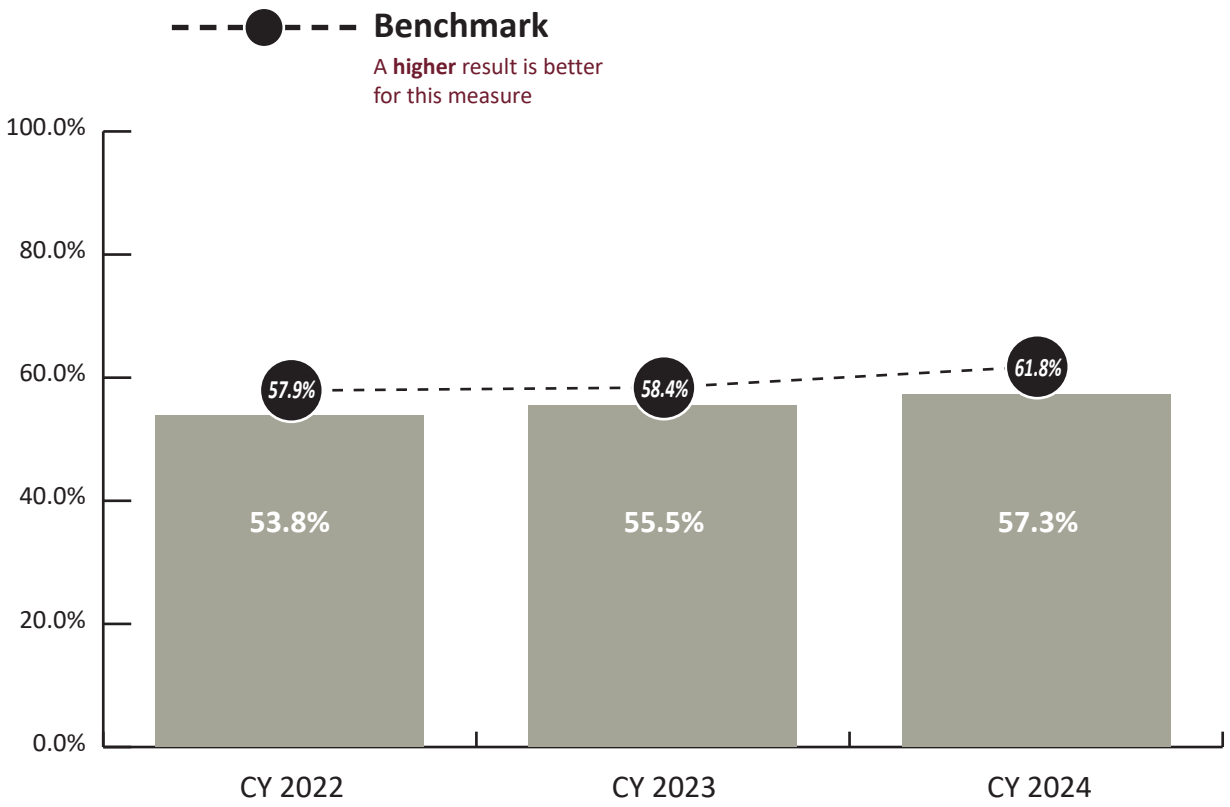
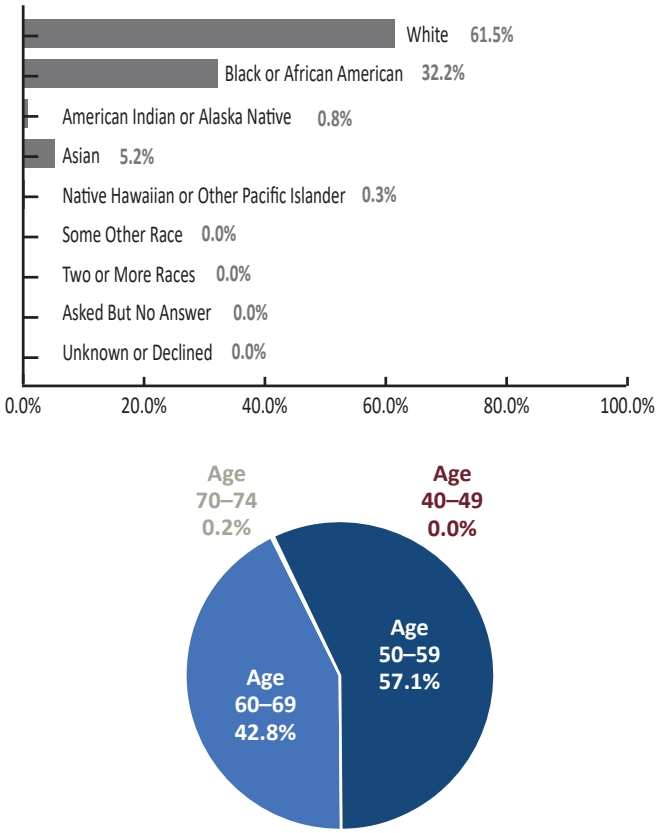


Figure 6-7 B1: Breast Cancer Screening - Race and Age: Medicaid



Breast Cancer Screening

The Medicaid market was 4.5 percent below the CY 2024 benchmark.

Note: For this quality measure, Medicaid market is only managed care.

Figure 6-8 A: Cervical Cancer Screening Quality Measure - Actual Results versus Benchmark: Commercial

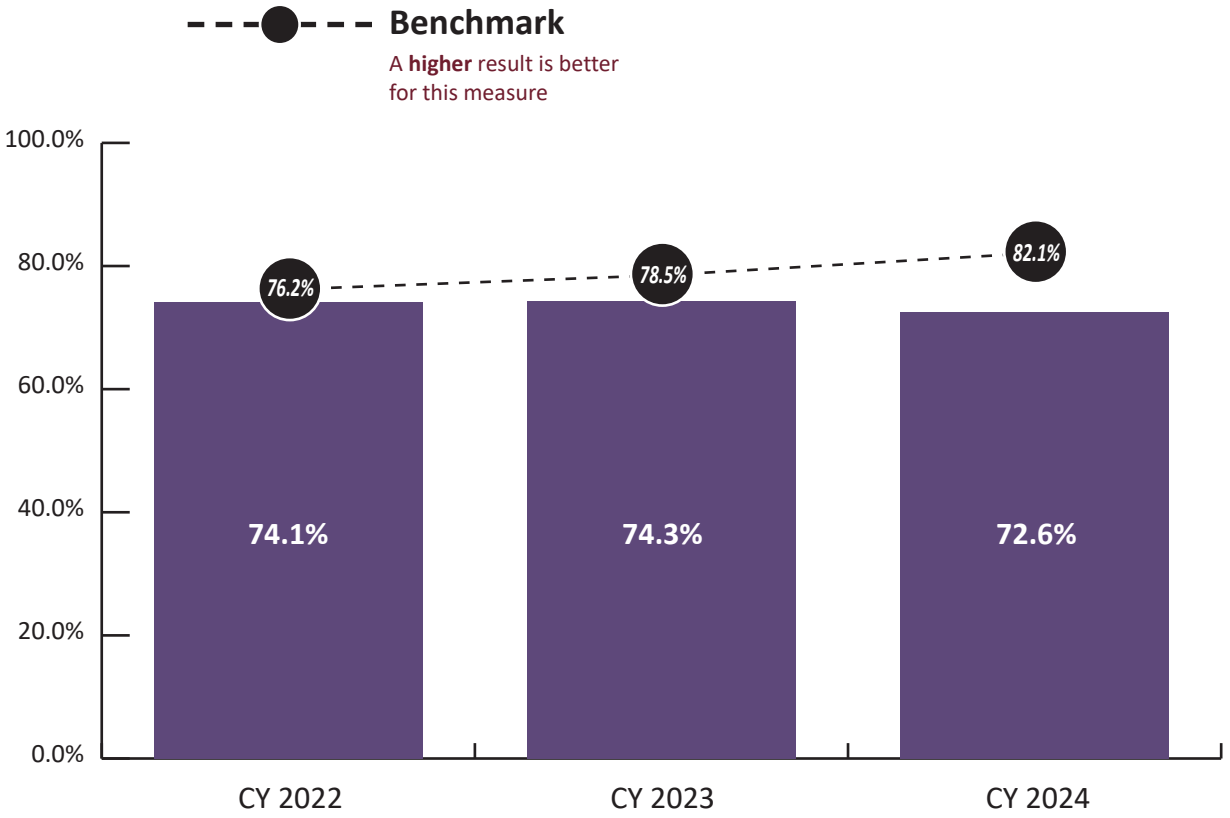
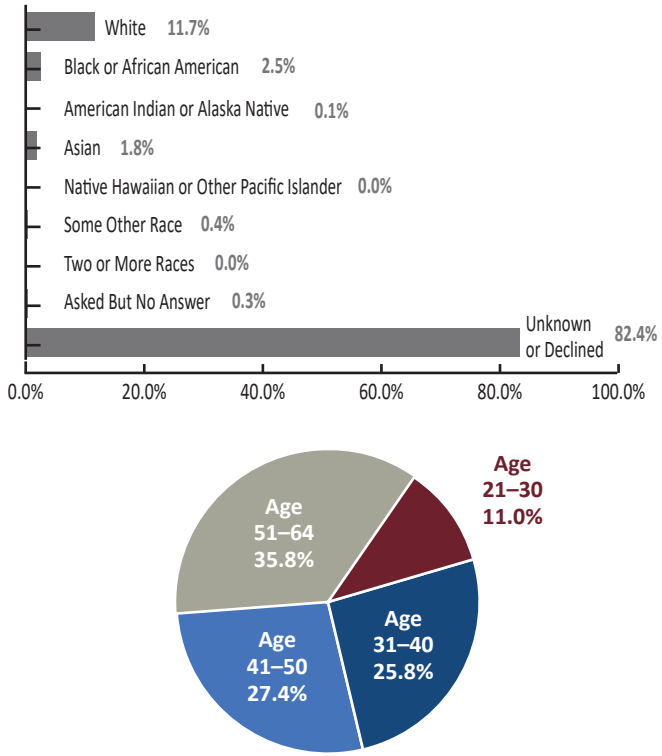


Figure 6-8 A1: Cervical Cancer Screening - Race and Age: Commercial



Cervical Cancer Screening

The Commercial market was 9.5 percent below the CY 2024 benchmark.

Note: The state result is a combination of administrative and hybrid methodologies.

Figure 6-8 B: Cervical Cancer Screening Quality Measure - Actual Results versus Benchmark: Medicaid

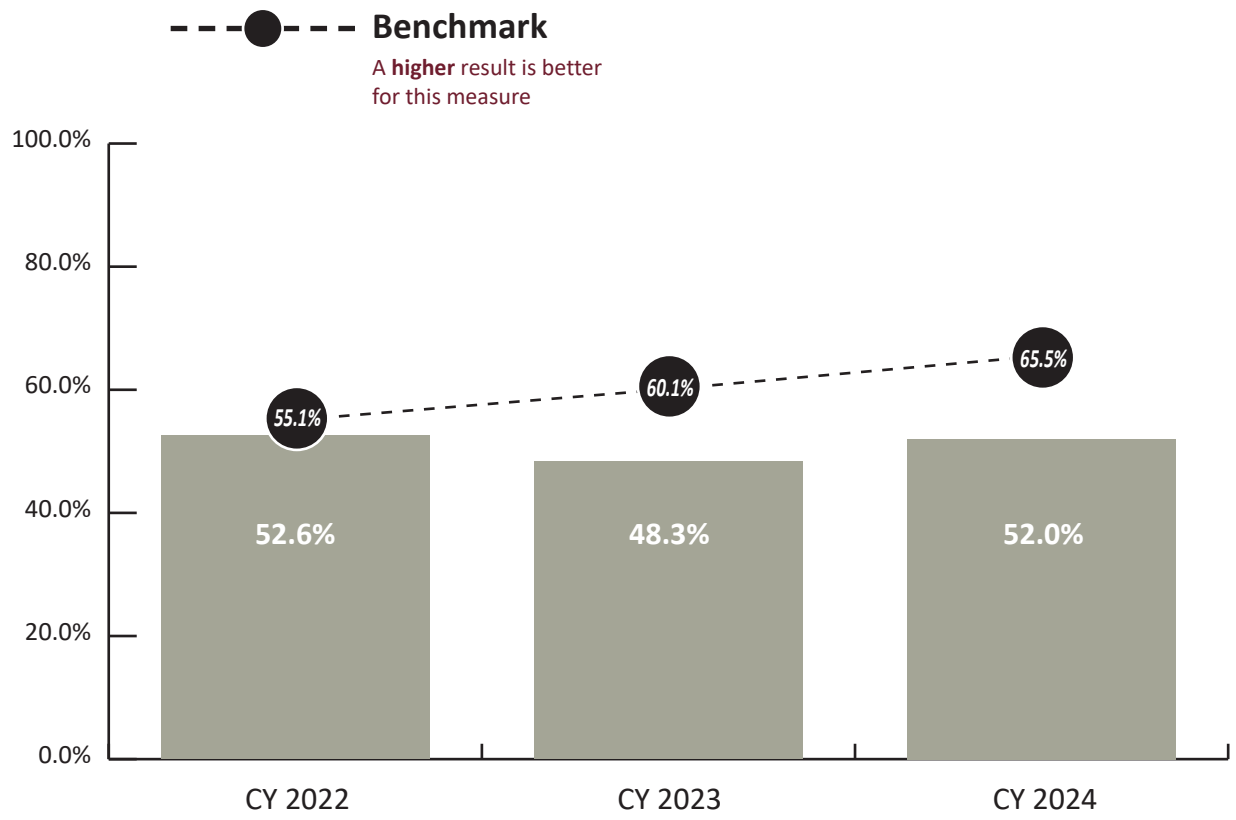
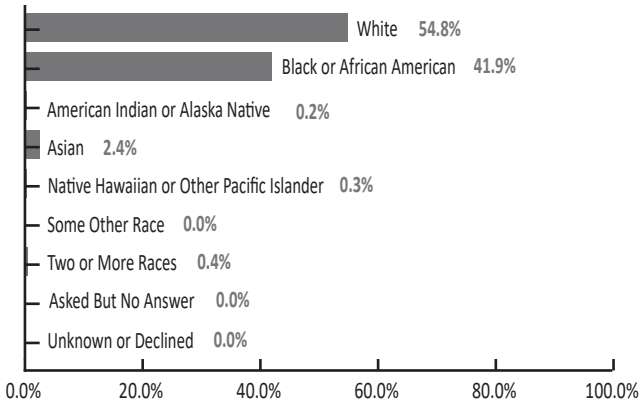
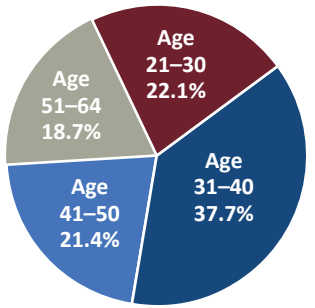


Figure 6-8 B1: Cervical Cancer Screening - Race, and Age: Medicaid





Cervical Cancer Screening

The Medicaid market was 13.5 percent below the CY 2024 benchmark.

Note: For this quality measure, Medicaid market is only managed care. The state result is a combination of administrative and hybrid methodologies.

Figure 6-9 A: Colorectal Cancer Screening Quality Measure - Actual Results versus Benchmark: Commercial

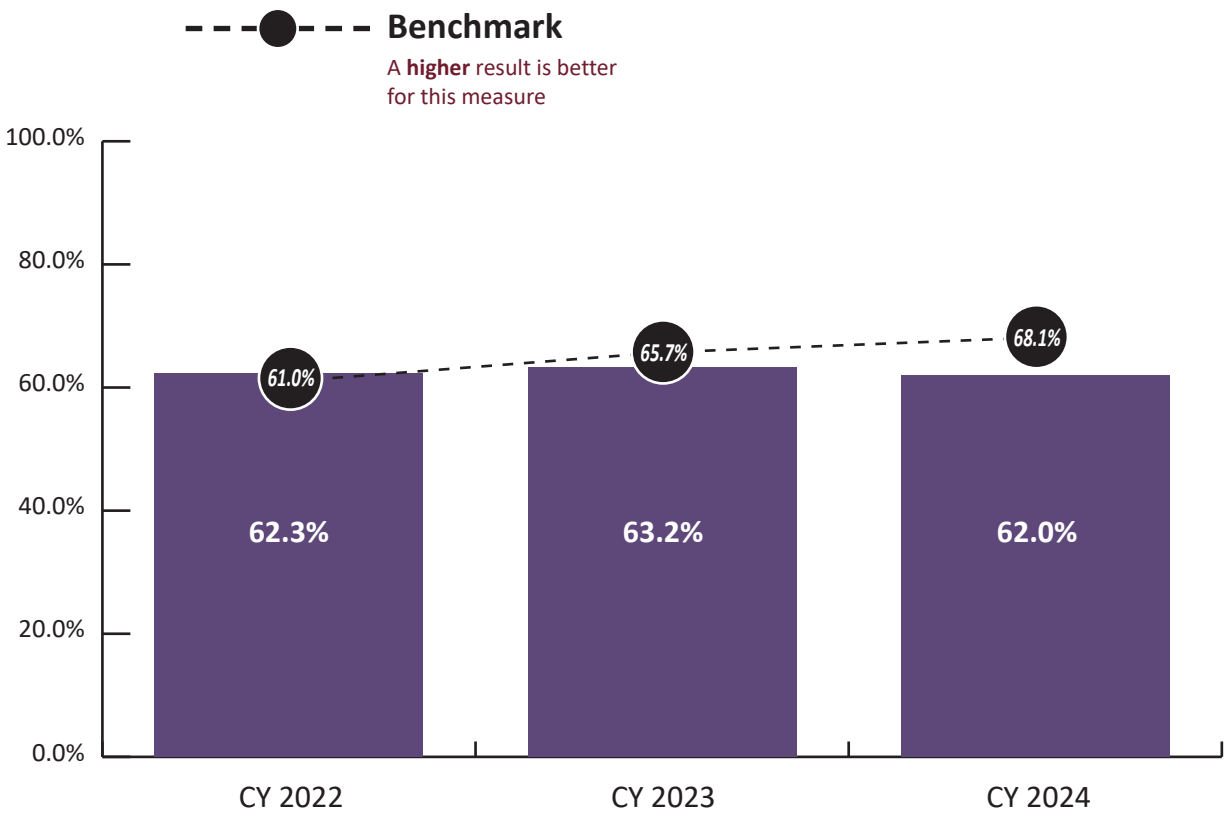
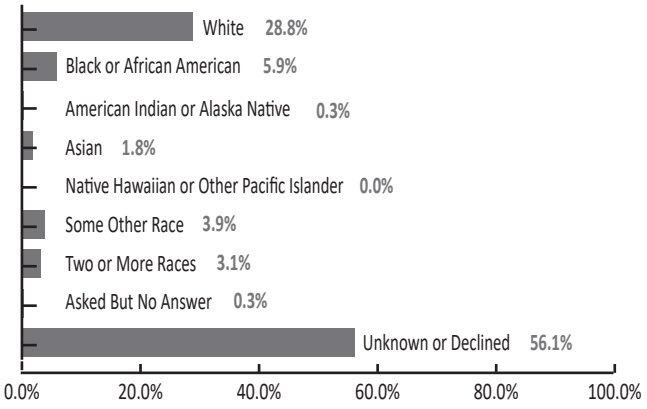
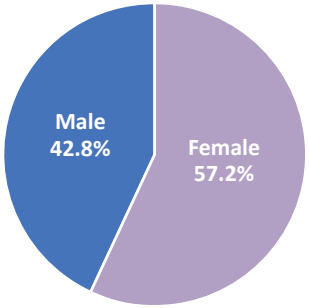
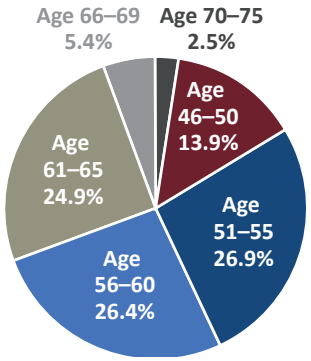


Figure 6-9 A1: Colorectal Cancer Screening - Race, Sex and Age: Commercial







Colorectal Cancer Screening

The Commercial market did not meet the CY 2024 benchmark by 6.1 percentage points.

Note: The state result is a combination of administrative and hybrid methodologies.

Figure 6-9 B: Colorectal Cancer Screening Quality Measure - Actual Results versus Benchmark: Medicaid

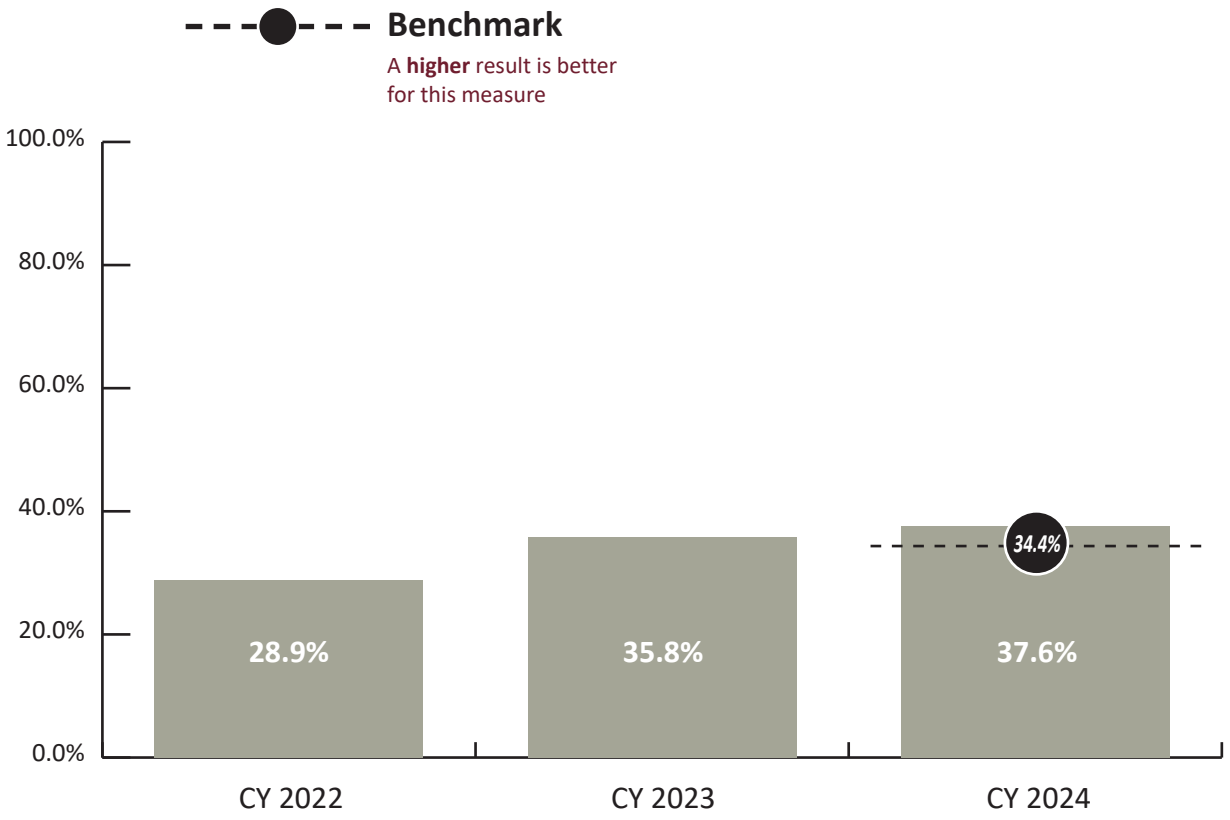
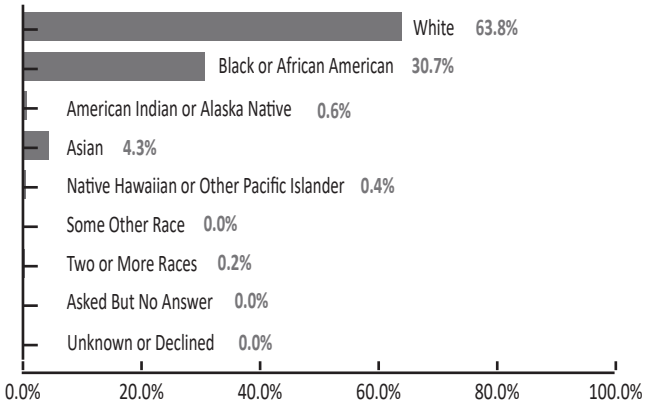
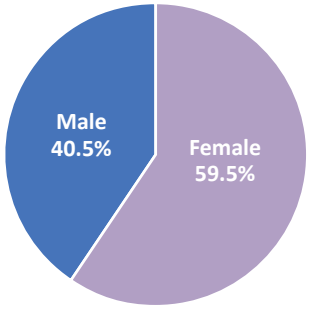
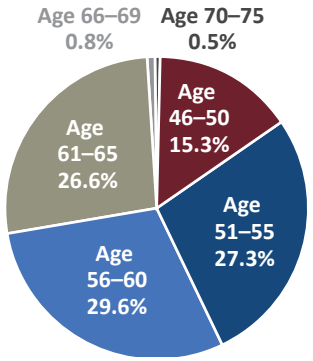


Figure 6-9 B1: Colorectal Cancer Screening - Race, Sex, and Age: Medicaid



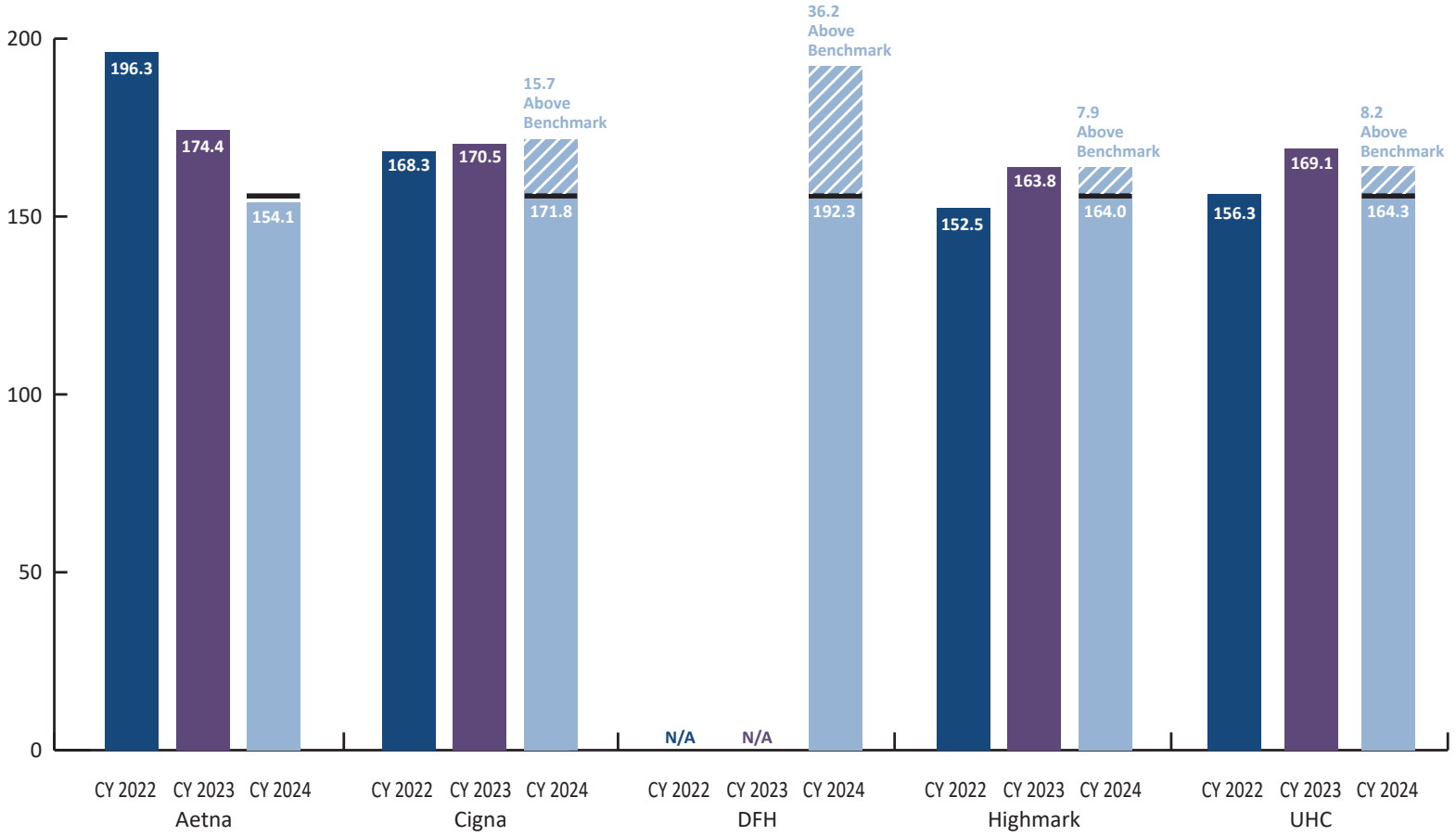




Colorectal Cancer Screening

CY 2024 is the first year in which a benchmark was set for the Medicaid population. The benchmark was exceeded by 3.2 percentage points.

Figure 6-10: Emergency Department Utilization Quality Measure - Actual Results versus Benchmark



156.1
2024 Benchmark

158.4
2023 Benchmark

160.7
2022 Benchmark

Note: This quality measure was only applicable to the Commercial Market.

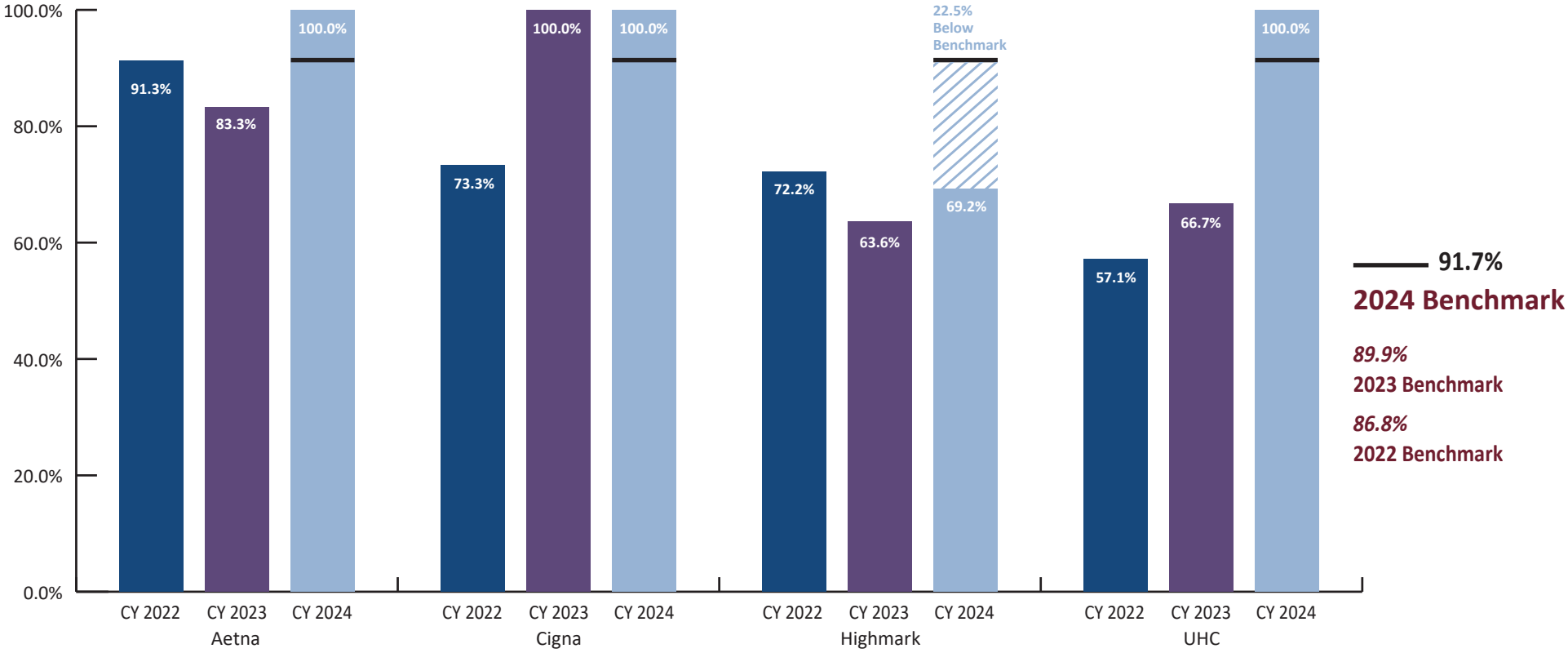
Per the national Committee for Quality Assurance (NCQA), the measures steward, this measure was given first year status for measure year (MY) 2022 due to significant changes in the methodology. No public reporting of EDU data for 2022.

Emergency Department Utilization

A lower result is better for this measure.

Aetna is the only Commercial insurer to perform better than the benchmark in CY 2024.

Figure 6-11: Persistence of Beta-Blocker Treatment After a Heart Attack Quality Measure - Actual Results versus Benchmark

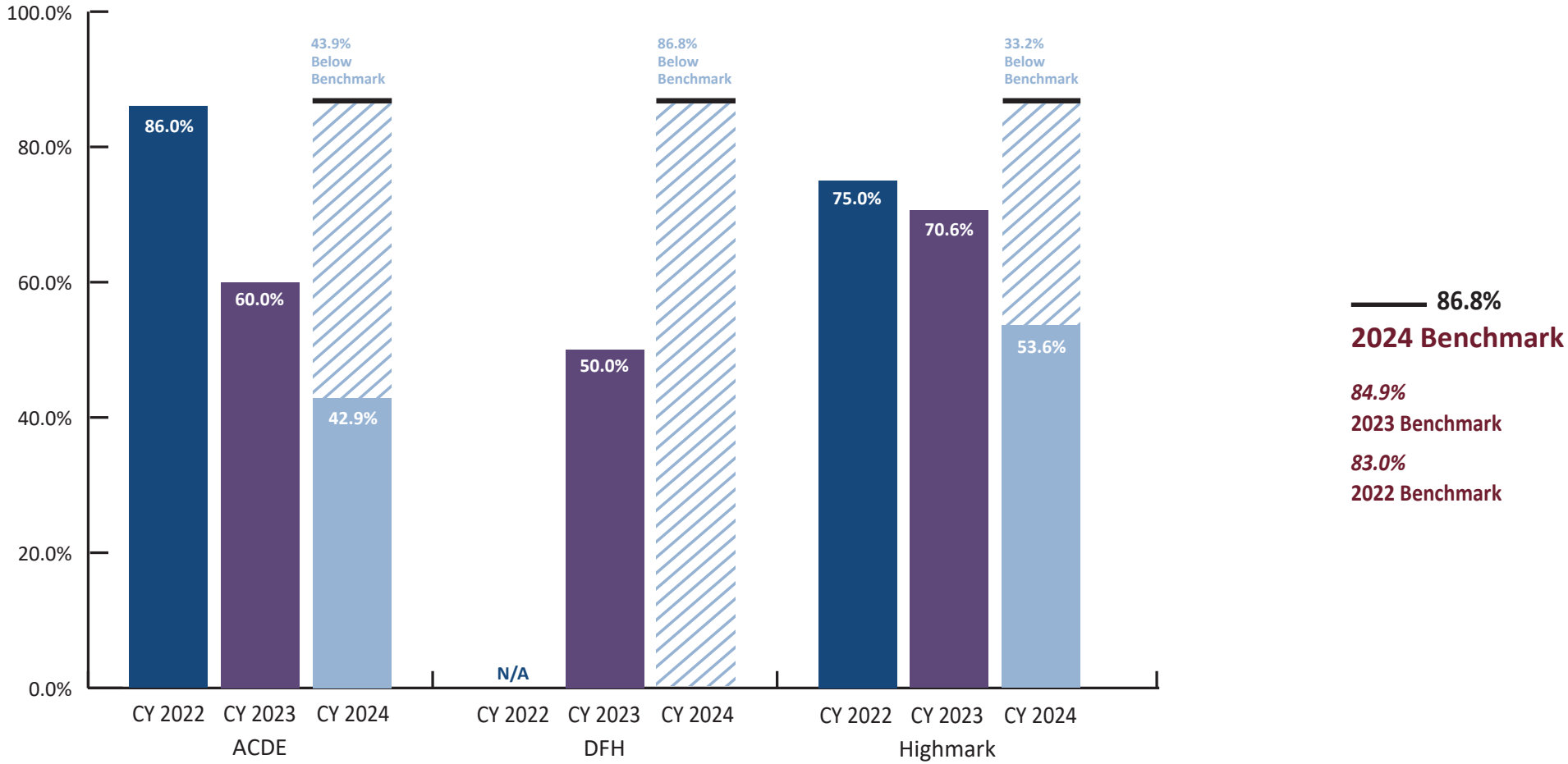


Persistence of Beta-Blocker Treatment After a Heart Attack

A higher result is better for this measure.

Highmark is the only Commercial insurer that did not meet the benchmark in CY 2024.

Figure 6-12: Persistence of Beta-Blocker Treatment After a Heart Attack Quality Measure - Actual Results versus Benchmark

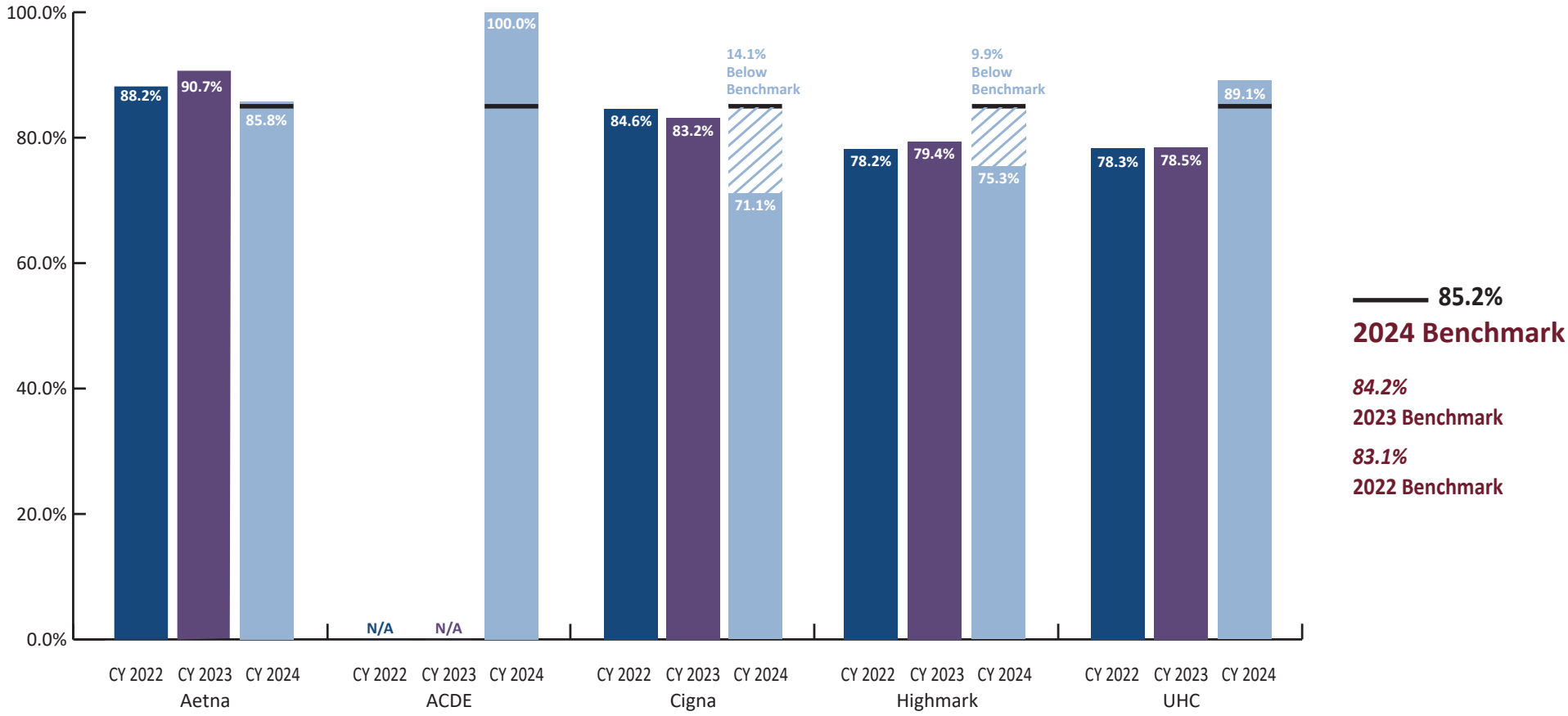


Persistence of Beta-Blocker Treatment After a Heart Attack

A higher result is better for this measure.

No Medicaid insurer met the benchmark in CY 2024.

Figure 6-13: Statin Therapy for Patients with Cardiovascular Disease Quality Measure - Actual Results versus Benchmark

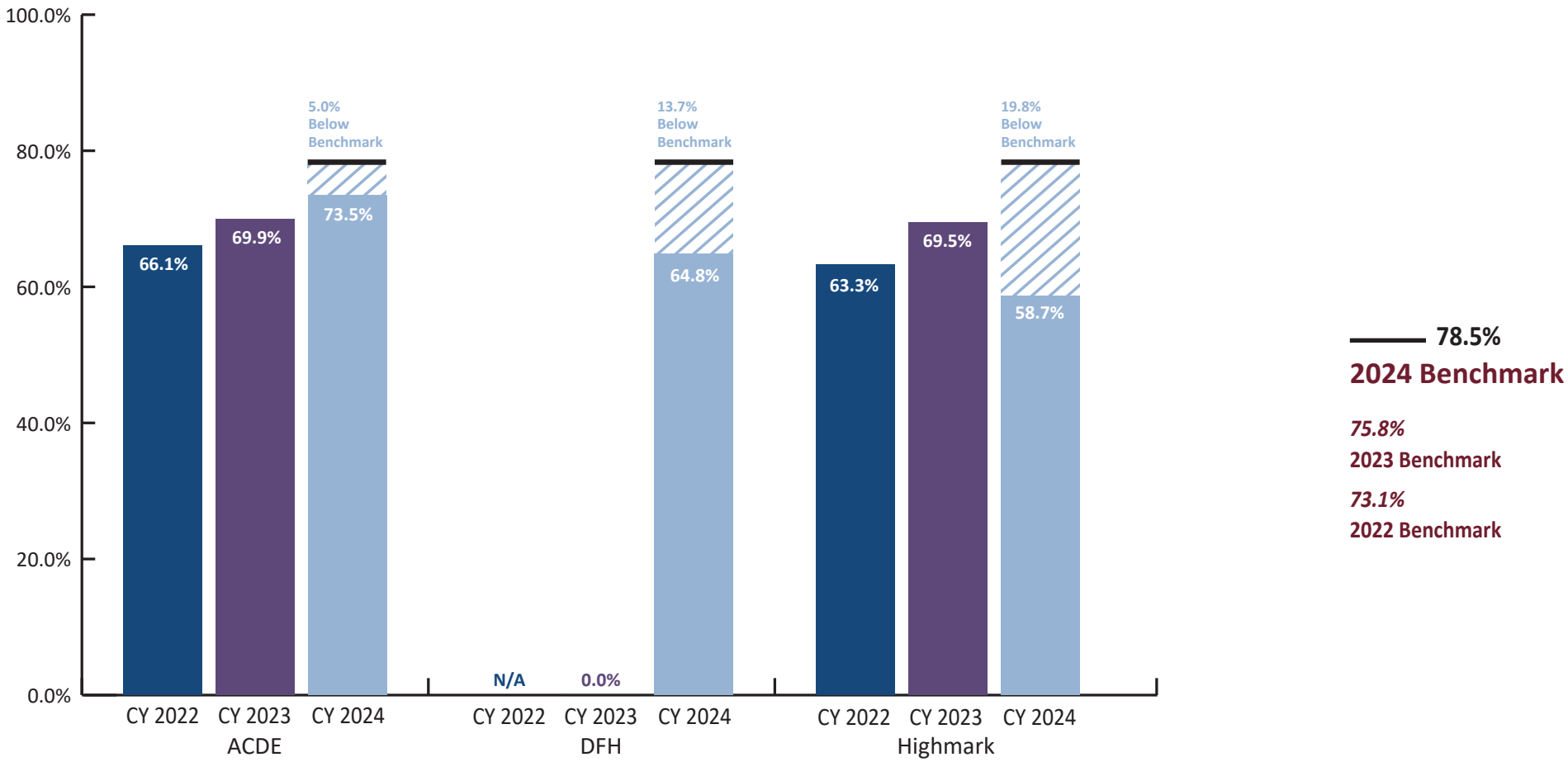


Statin Therapy

A higher result is better for this measure.

Aetna, ACDE, and UHC performed better than the CY 2024 benchmark.

Figure 6-14: Statin Therapy for Patients with Cardiovascular Disease Quality Measure - Actual Results versus Benchmark

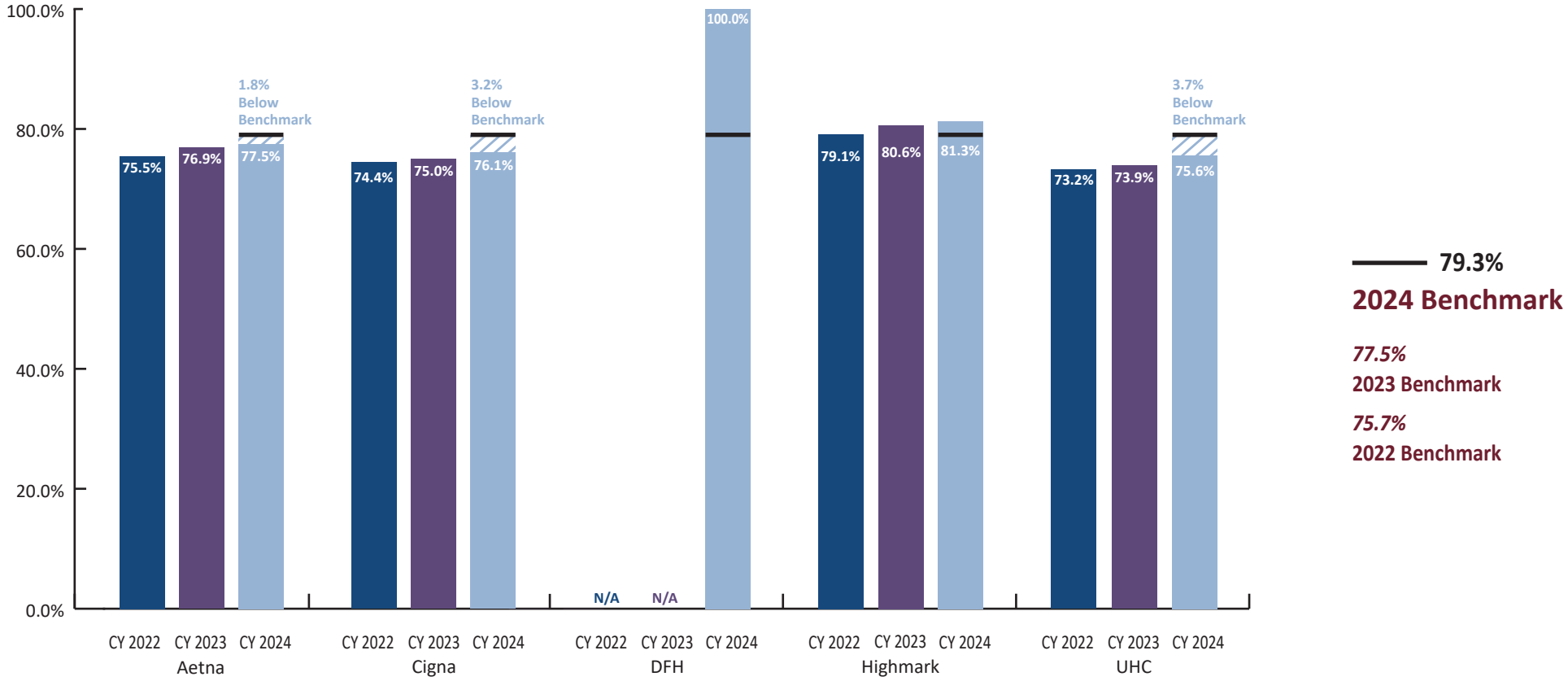


Statin Therapy

A higher result is better for this measure.

No Medicaid insurer met the CY 2024 Benchmark.

Figure 6-15 A: Breast Cancer Screening Quality Measure - Actual Results versus Benchmark

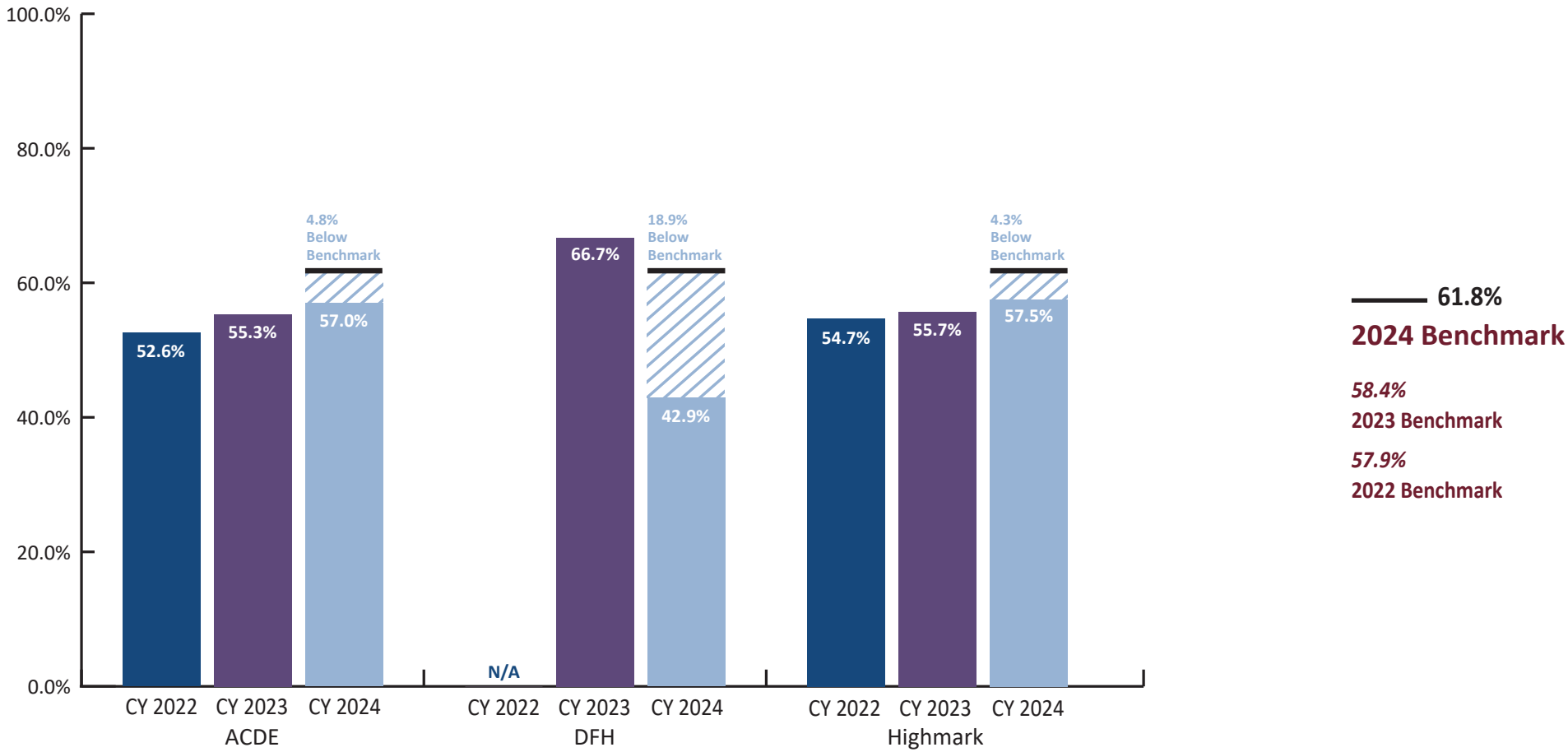


Breast Cancer Screening

A higher result is better for this measure.

Both DFH and Highmark Commercial insurers performed better than the CY 2024 benchmark.

Figure 6-15 B: **Breast Cancer Screening Quality Measure - Actual Results versus Benchmark**

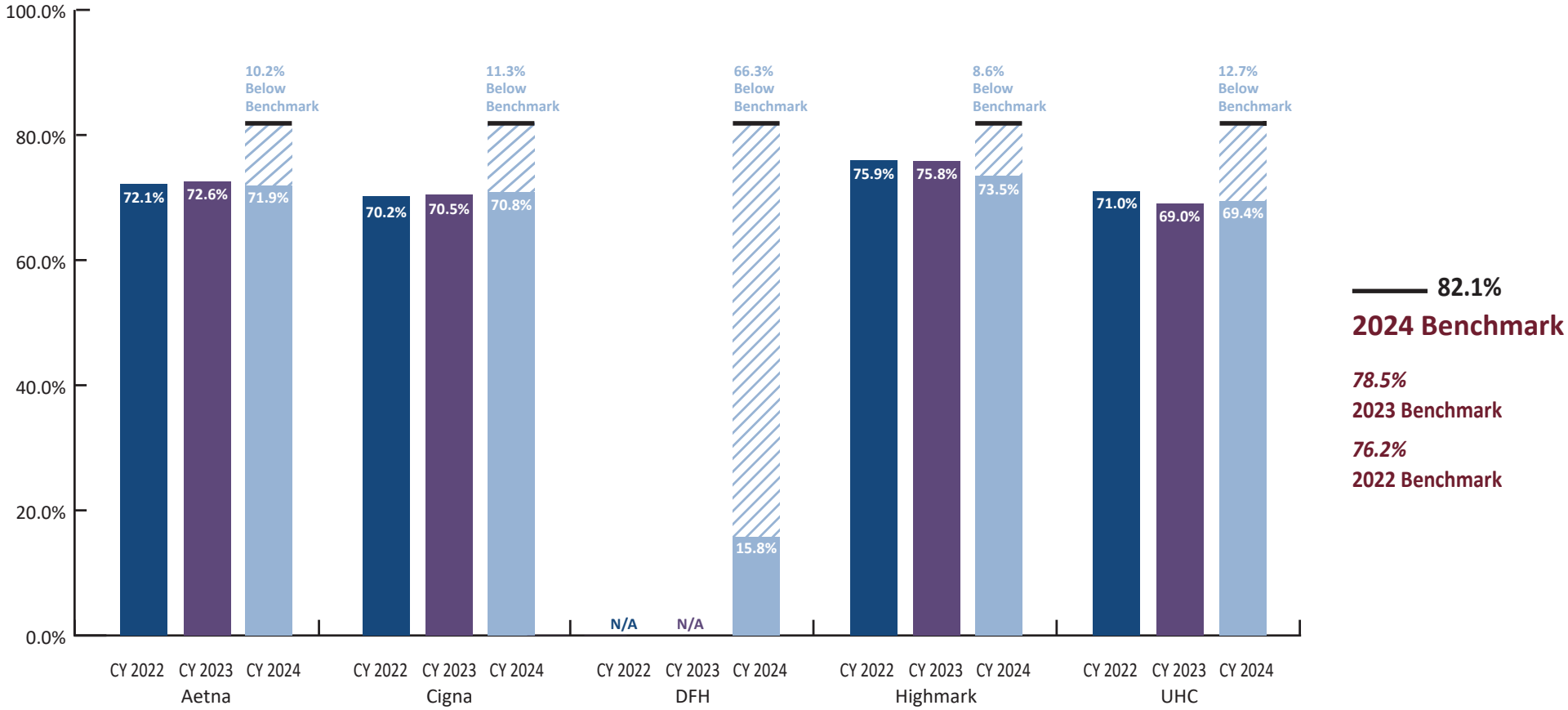


Breast Cancer Screening

A higher result is better for this measure.

No Medicaid managed care insurer met the CY 2024 benchmark.

Figure 6-16 A: Cervical Cancer Screening Quality Measure - Actual Results versus Benchmark



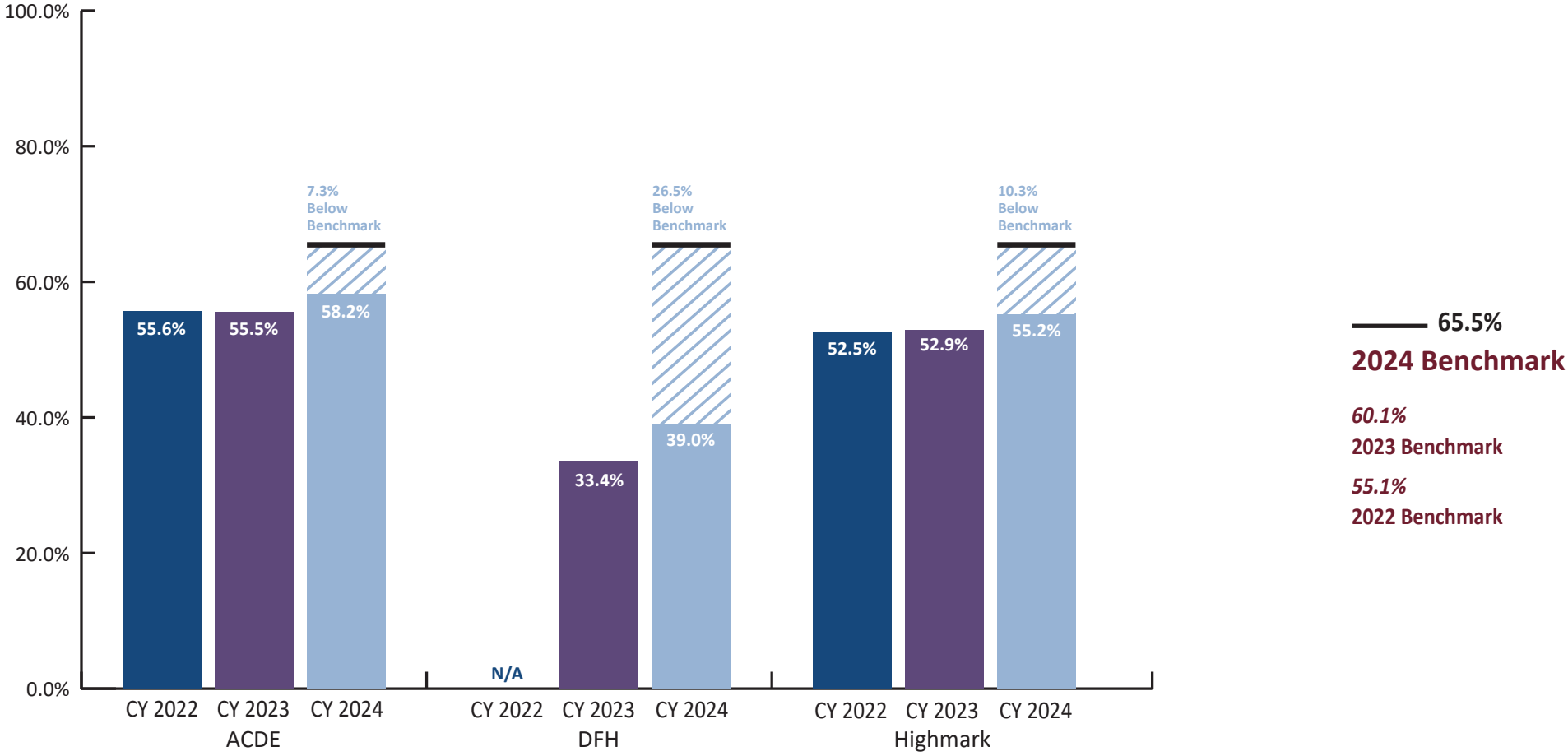
Cervical Cancer Screening

A higher result is better for this measure.

No Commercial Insurer met the CY 2024 benchmark.

Note: The state result is a combination of administrative and hybrid methodologies.

Figure 6-16 B: Cervical Cancer Screening Quality Measure - Actual Results versus Benchmark



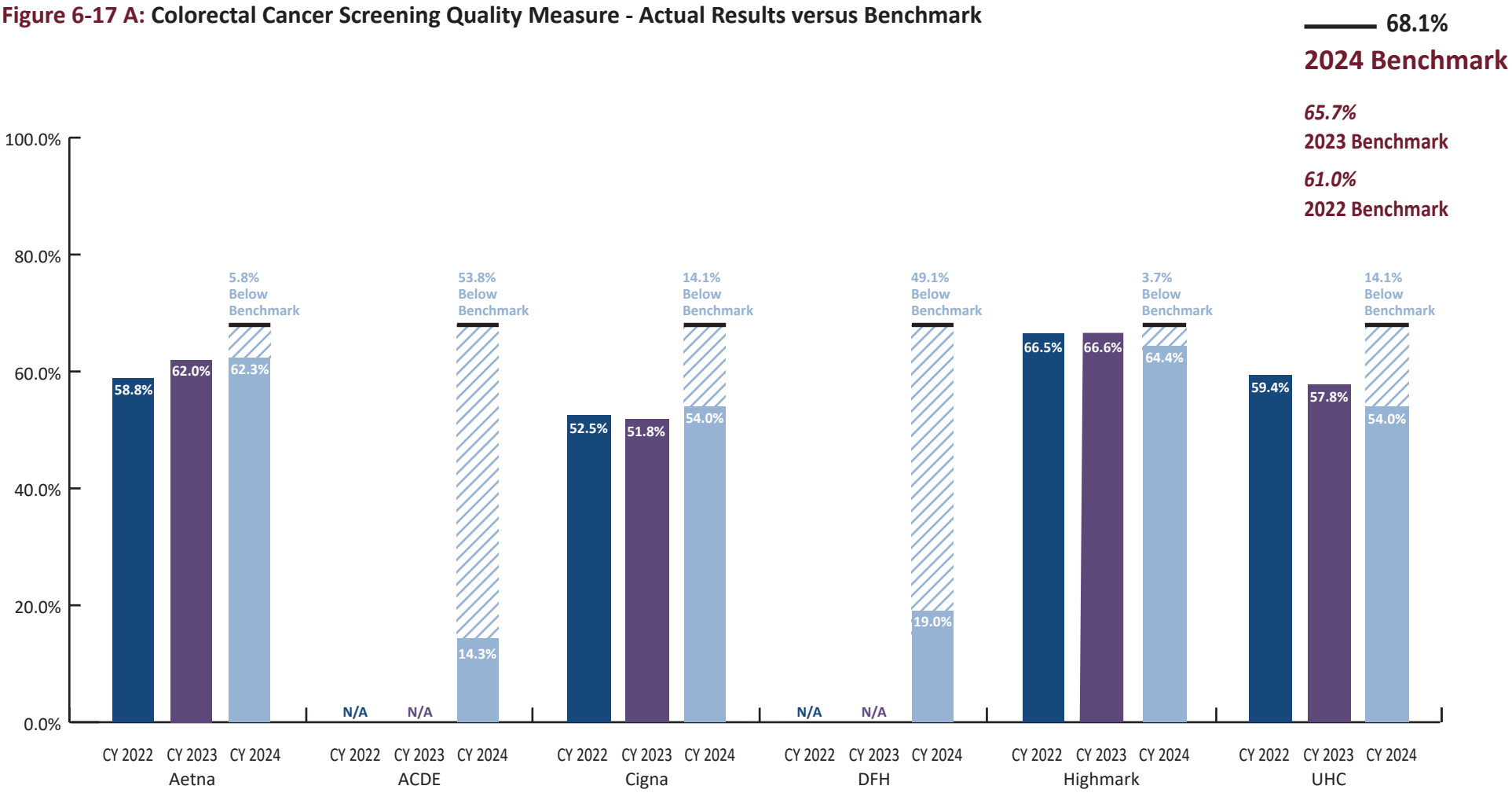
Cervical Cancer Screening

A higher result is better for this measure.

No Medicaid managed care insurer met the CY 2024 benchmark.

Note: The state result is a combination of administrative and hybrid methodologies.

Figure 6-17 A: Colorectal Cancer Screening Quality Measure - Actual Results versus Benchmark



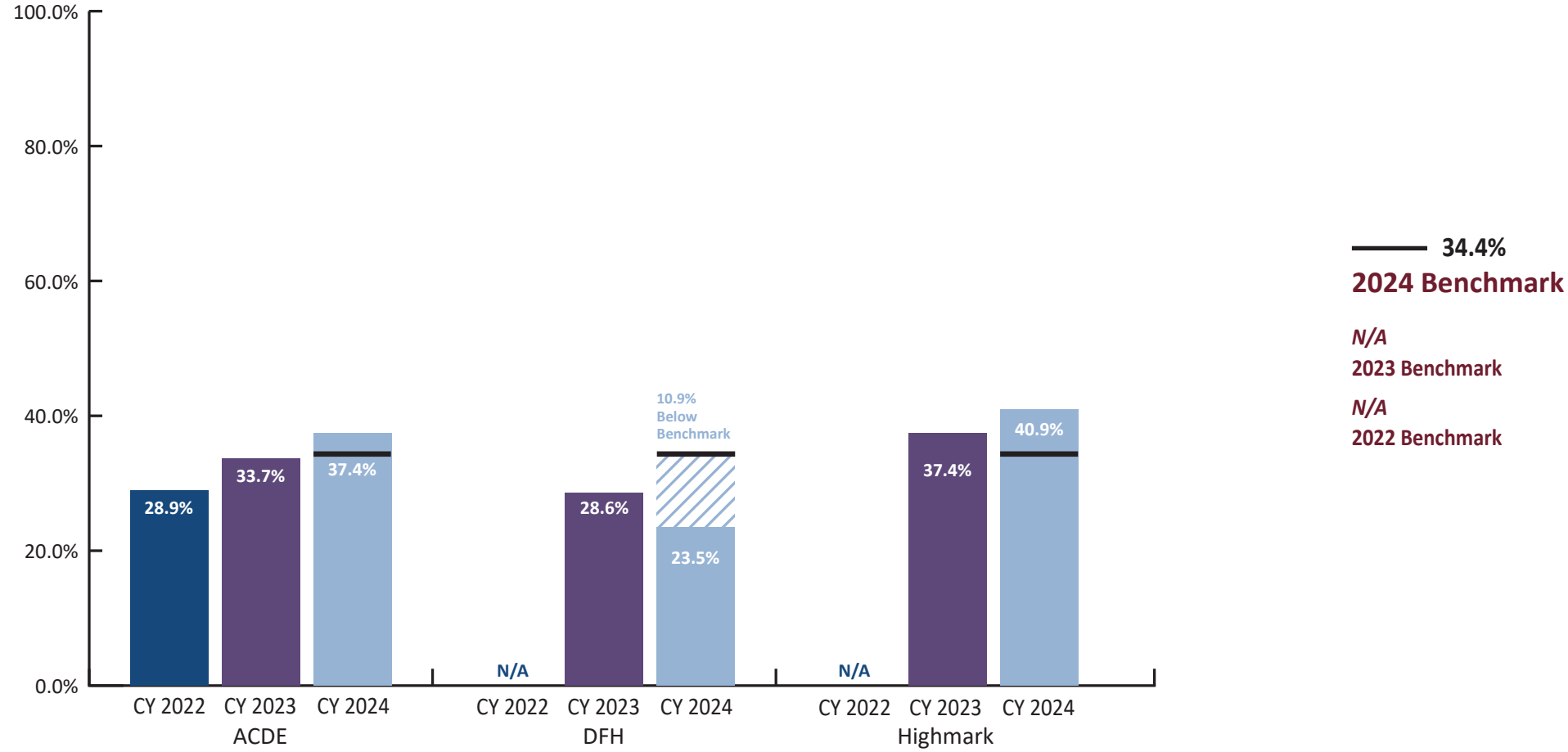
Colorectal Cancer Screening

A higher result is better for this measure.

No Commercial insurer met the CY 2024 benchmark.

Note: This quality measure was only applicable to the Commercial Market in CY 2022 and 2023. The state result is a combination of administrative and hybrid methodologies.

Figure 6-17 B: Colorectal Cancer Screening Quality Measure - Actual Results versus Benchmark



Colorectal Cancer Screening

A higher result is better for this measure.

CY 2024 is the first year a benchmark was set for the Medicaid population. Both ACDE and Highmark performed better than the benchmark.

Note: CY 2022 and CY 2023 Medicaid results are for informational purposes only. The state result is a combination of administrative and hybrid methodologies.

7. Thank You

The DHSS 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.

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.

Department of Health and Social Services (DHSS): The State agency responsible for overseeing and administration of the benchmark data collection and reporting processes. The DHSS 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 DHSS.

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 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 DHSS 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 DHSS.

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