

TRENDS IMPACTING DELAWARE'S HEALTH



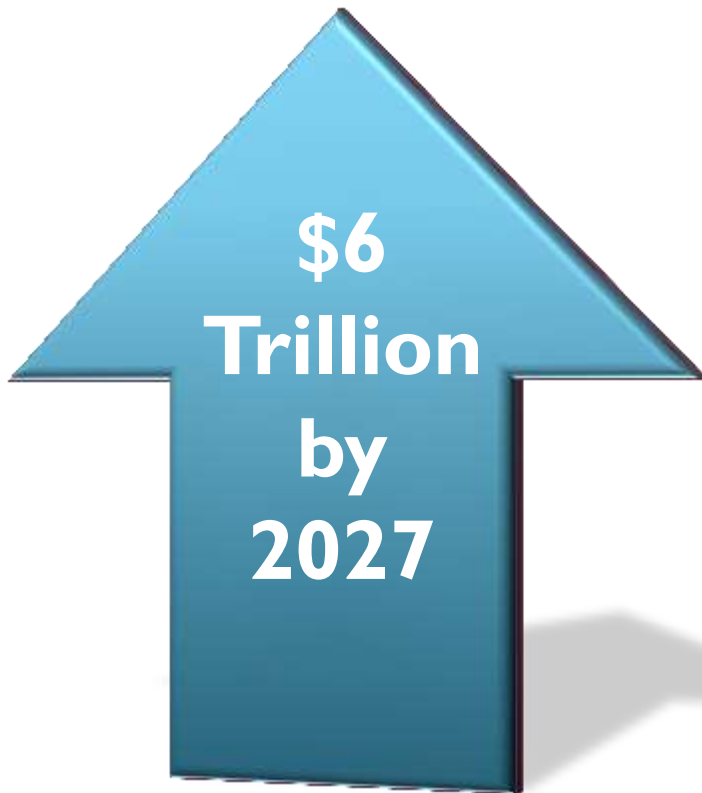
KARA ODOM WALKER, MD, MPH, MSHS
CABINET SECRETARY, DHSS

DEFAC Health Care Spending Benchmark Subcommittee
April 22, 2019
Buena Vista

NATIONAL HEALTH CARE TRENDS



HEALTH CARE SPENDING



**\$6
Trillion
by
2027**

- Under current law, national health spending is projected to grow at an **average rate of 5.5% per year** for 2018-27 and to reach nearly \$6.0 trillion by 2027.
- Health spending is projected to grow **0.8 percentage point faster than Gross Domestic Product (GDP)** per year over the 2018-27 period; as a result, the **health share of GDP** is expected to rise from 17.0% in 2017 to **19.4% by 2027**.



U.S. ECONOMIC, DEMOGRAPHIC FACTORS

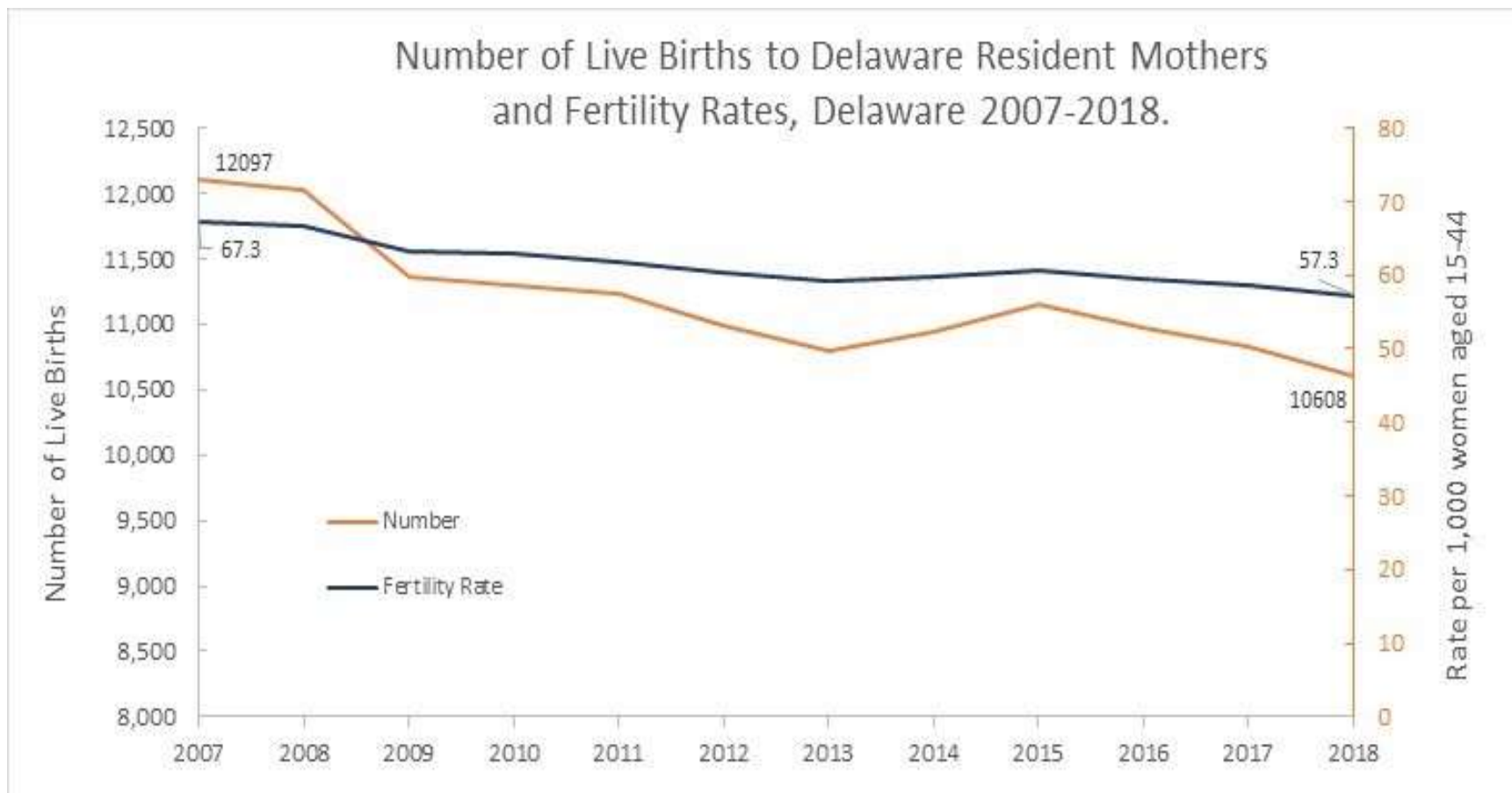
- Prices for health care goods and services are projected to grow somewhat faster over 2018-27 (2.5 percent compared to 1.1 percent for 2014-17).
- As a result of comparatively higher projected enrollment growth, average annual spending growth in Medicare (7.4 percent) is expected to exceed that of Medicaid (5.5 percent) and private health insurance (4.8 percent).
- The Medicare enrollment impacts are the key reason the share of health care spending sponsored by federal, state, and local governments is expected to increase by 2 percentage points over the projection period, reaching 47 percent by 2027.
- The insured share of the population is expected to remain stable at around 90 percent throughout 2018-27.



DELAWARE DEMOGRAPHIC TRENDS



MEANWHILE, BIRTH RATE DECLINING

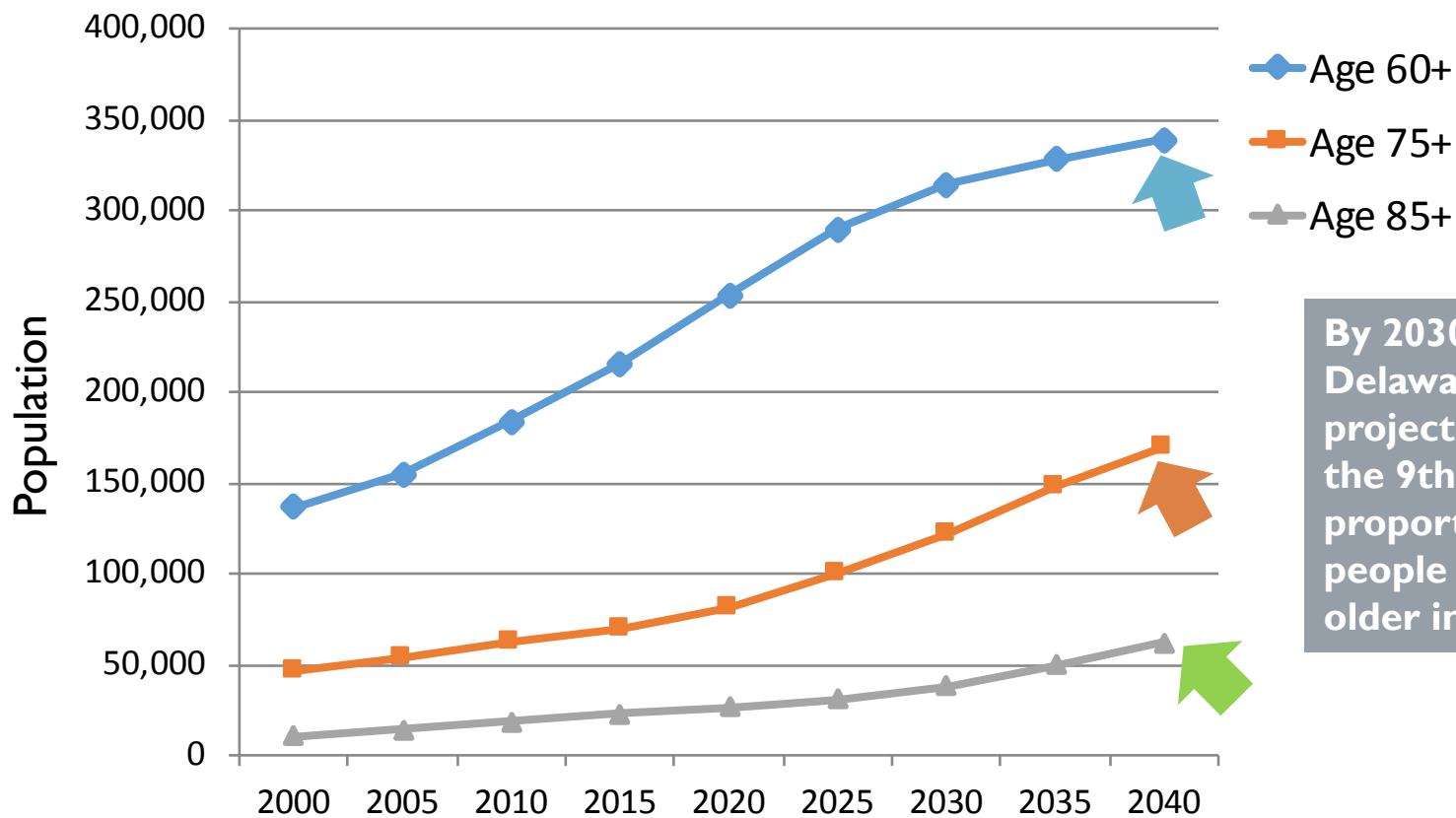


Source: Division of Public Health, Delaware Health Statistics Center.

*2018 numbers are preliminary



FAST-GROWING AGING POPULATION



By 2030, Delaware is projected to have the 9th-highest proportion of people age 65 and older in the U.S.



FAST-GROWING AGING POPULATION

- About 1 in 5 people is over age 60 years.
- By 2025, those older than 60 will be one-fourth of state's population.
- The “oldest older” population – those individuals older than 85, and most in need of critical care services are growing.
- From 2020 to 2040, we expect that part of the population to double.

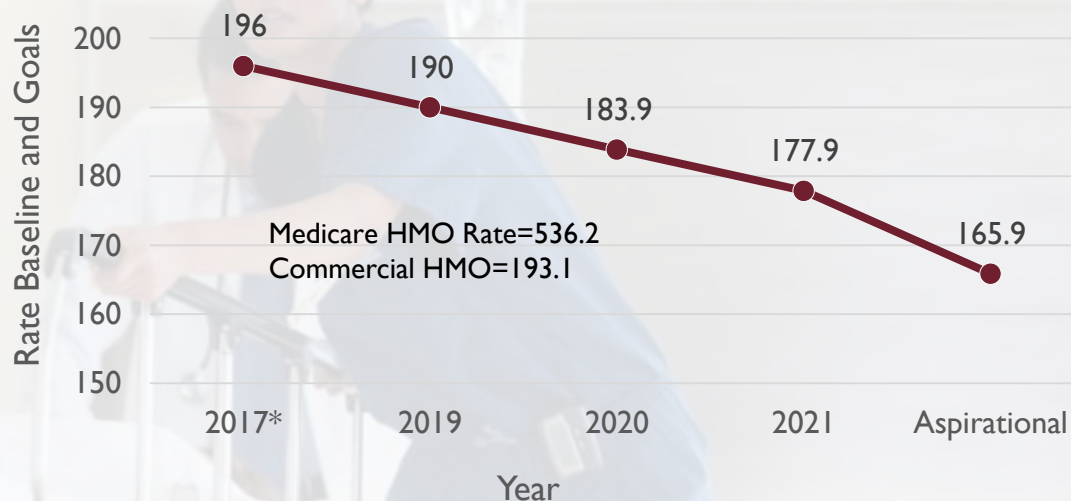


QUALITY BENCHMARK IN THE STATE/NATION AND THEIR ECONOMIC IMPACT



QUALITY BENCHMARK FOR EMERGENCY DEPARTMENT UTILIZATION RATE

Emergency Department Utilization Rate per 1,000 Commercial Patients Baseline and Goals



*Adapted from NCQA Quality Compass

**Delaware's baseline was derived from the weighted average performance of Aetna, Cigna, Highmark, and UnitedHealthcare. Weights were HEDIS 2018 enrollment by plan.

QUALITY BENCHMARK FOR OPIOID-RELATED OVERDOSE DEATHS

308

overdose deaths in 2016

345

overdose deaths in 2017
(double the deaths
recorded 5 years earlier)

419

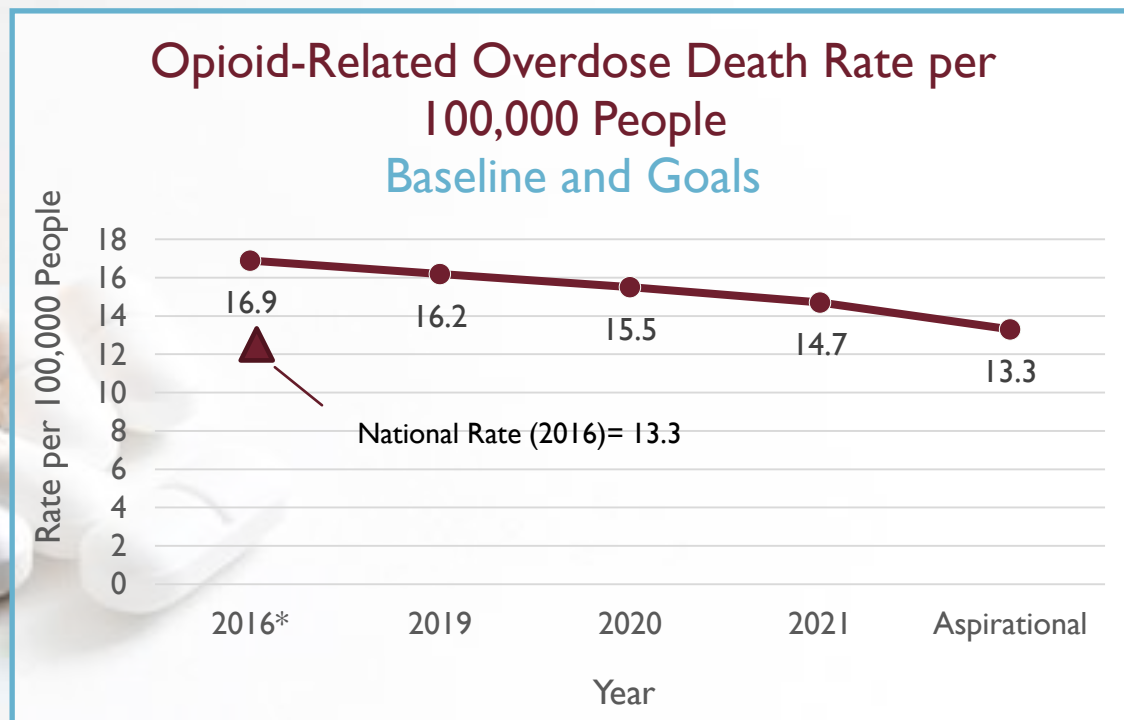
suspected overdose
deaths in 2018
(preliminary figure
from Division of
Forensic Science)

Record Total Number
of Deaths in Delaware

SUSPECTED OVERDOSES



QUALITY BENCHMARK FOR OPIOID-RELATED OVERDOSE DEATHS



*WONDER, DCD



QUALITY BENCHMARK FOR CONCURRENT USE OF OPIOIDS AND BENZODIAZEPINES

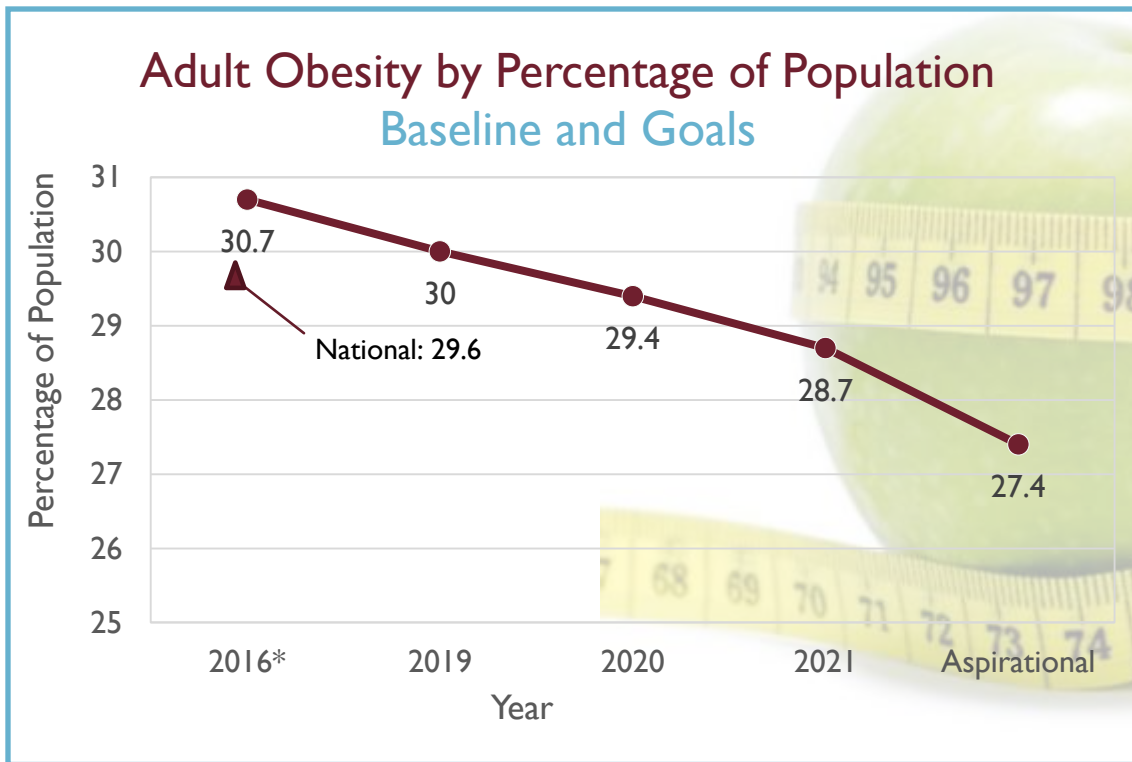


Benchmark Values:

Residents per 1,000 with overlapping prescriptions to be determined for 2020 and 2021 and for the aspirational benchmark after insurer data are obtained by the State during 2019.



QUALITY BENCHMARK FOR ADULT OBESITY



*Behavioral Risk Factor Surveillance System, CDC



CURRENT OBESITY RATES AMONG ADULTS



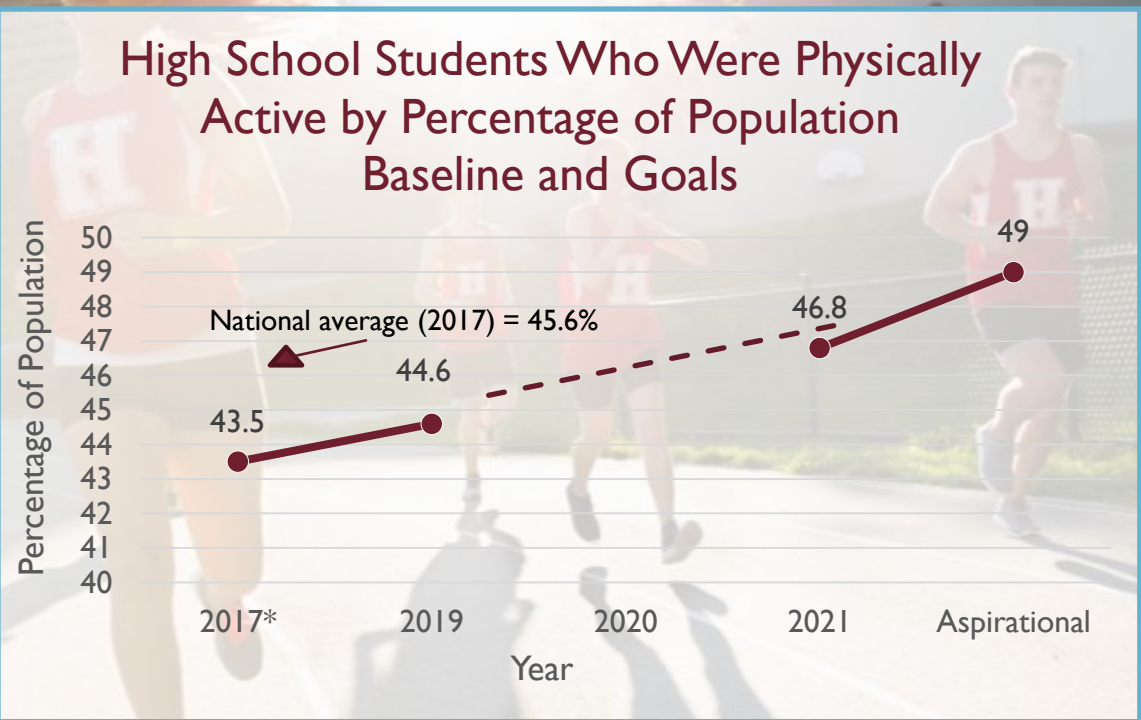
National average (2017) =29.6

† Obese is defined as body mass index (BMI) ≥ 30.0 ; BMI was calculated from self-reported weight and height (weight [kg]³/height [m]²). Respondents reporting weight < 50 pounds or ≥ 650 pounds; height < 3 feet or ≥ 8 feet; or BMI < 12 or ≥ 100 were excluded. Pregnant respondents were also excluded.

Data Source: Behavioral Risk Factor Surveillance System (BRFSS)



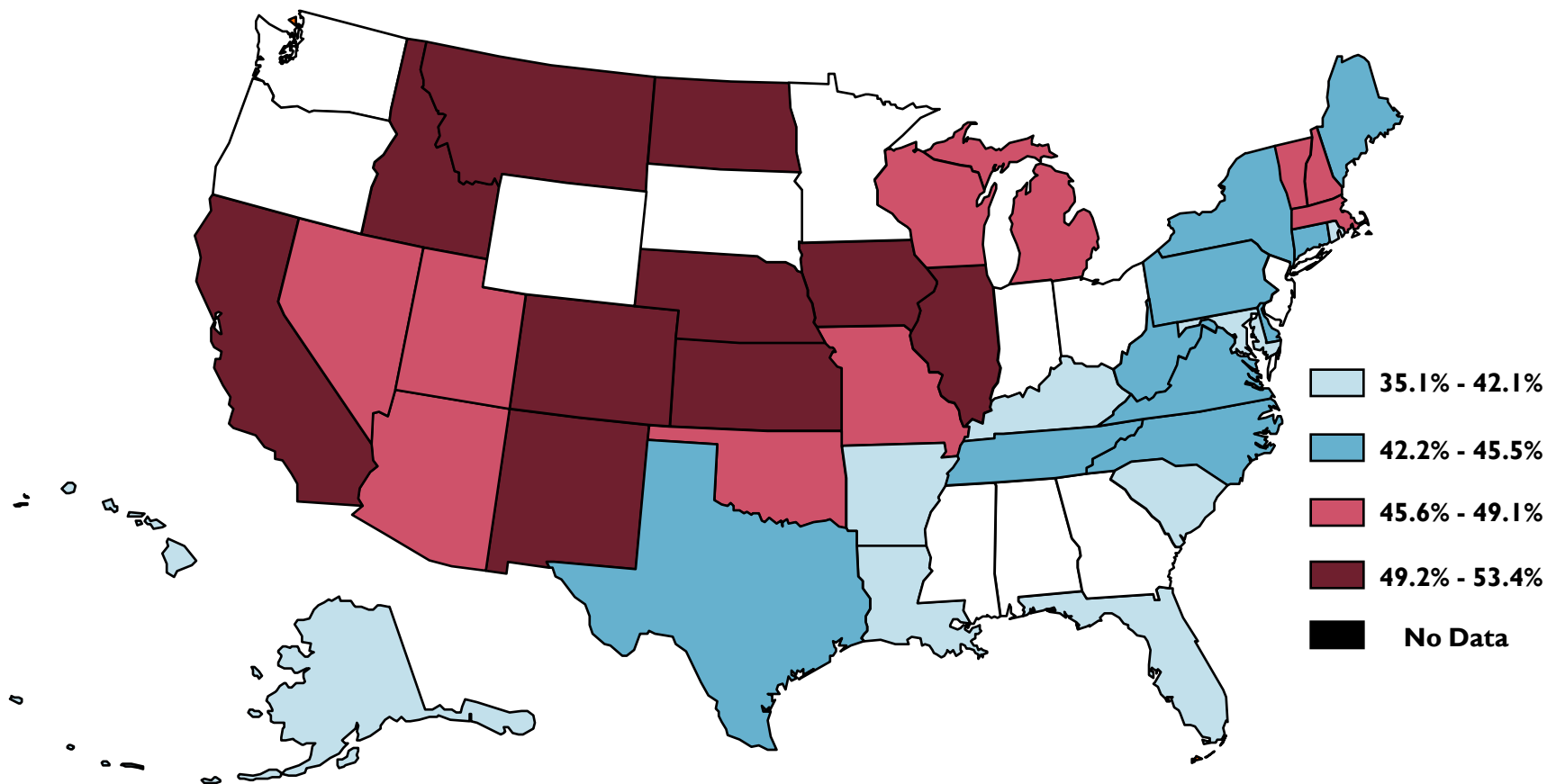
QUALITY BENCHMARK FOR HIGH SCHOOL STUDENTS WHO WERE PHYSICALLY ACTIVE



*Youth Risk Behavior Survey, CDC

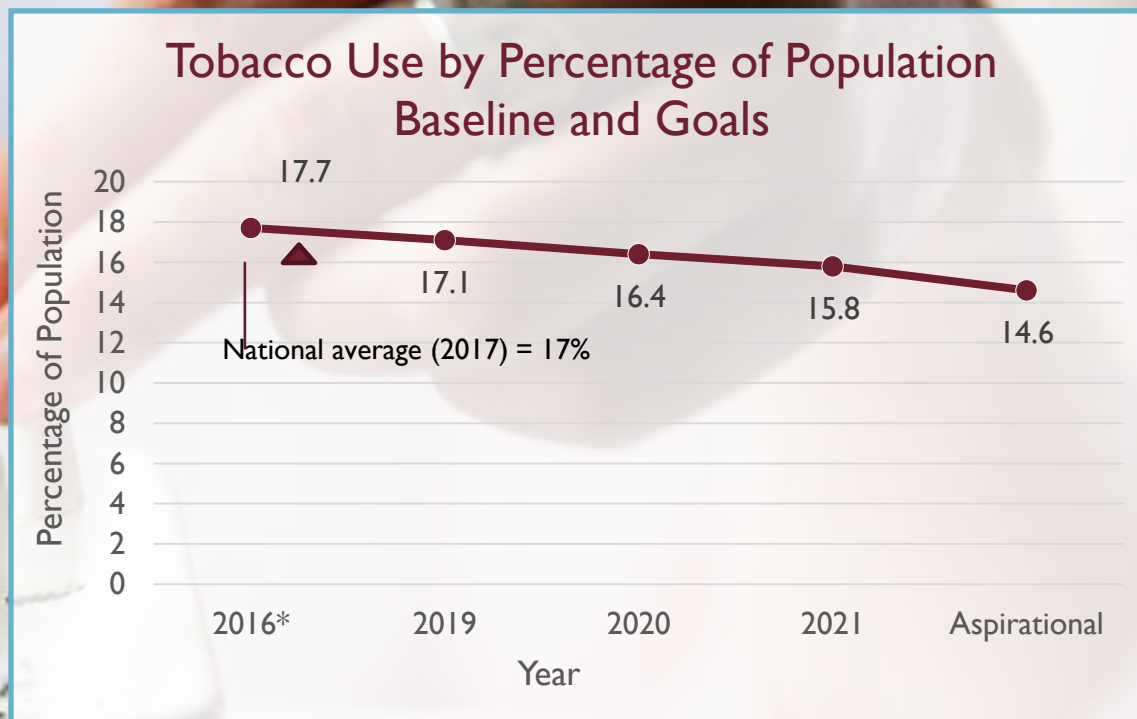
**There is no benchmark for 2020 because there will be no data available to measure performance. The survey serving as the data source is administered by the federal government every other year.

Percentage of High School Students Who Were Physically Active at Least 60 Minutes Per Day on 5 or More Days*



In any kind of physical activity that increased their heart rate and made them breathe hard some of the time during the 7 days before the survey

QUALITY BENCHMARK FOR TOBACCO USE



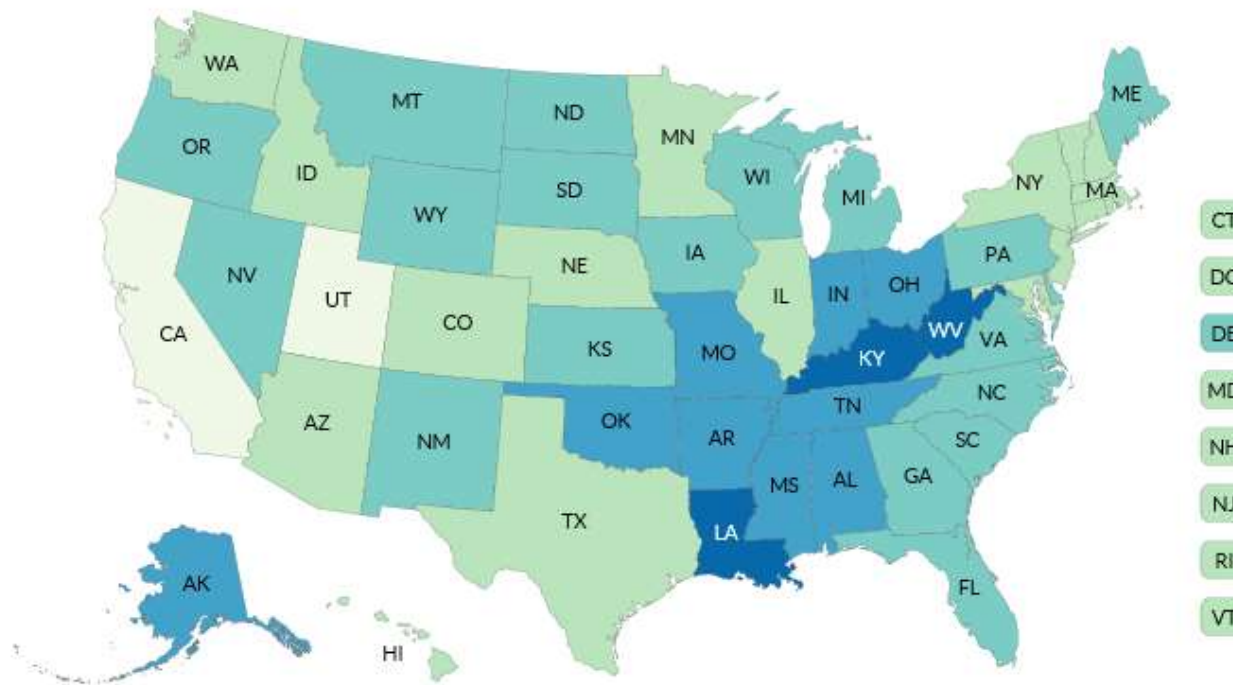
*Behavioral Risk Factor Surveillance System, CDC

CURRENT CIGARETTE USE AMONG ADULTS

Current Cigarette Use Among Adults (Behavior Risk Factor Surveillance System) 2017

About This Map

- 8.9% - <12.4%
- 12.4% - <15.9%
- 15.9% - <19.4%
- 19.4% - <22.9%
- 22.9% - 26.4%

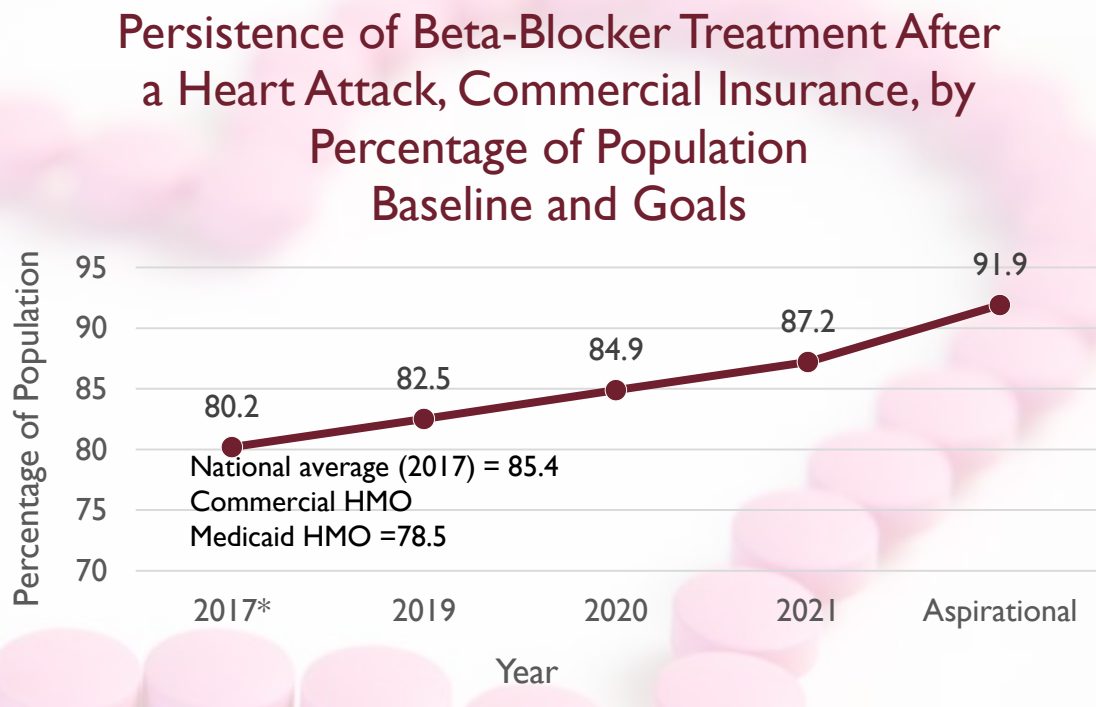


Territories

GU PR



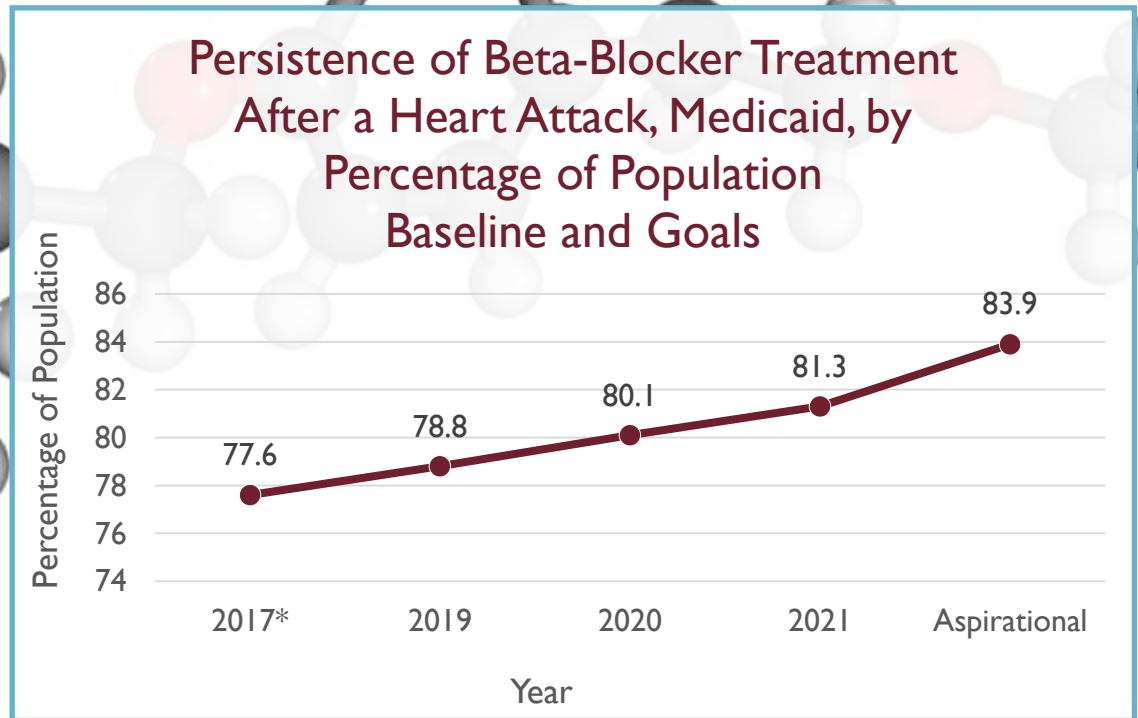
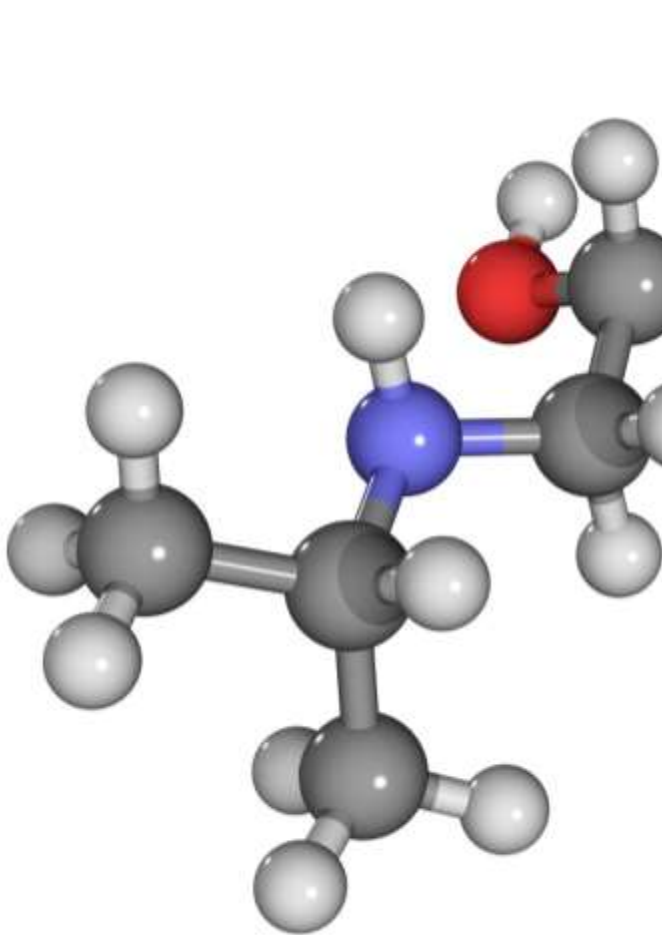
QUALITY BENCHMARK FOR PERSISTENCE OF BETA-BLOCKER TREATMENT AFTER A HEART ATTACK — COMMERCIAL INSURANCE



*NCQA Quality Compass

**Delaware's baseline is Highmark's baseline rate, as Highmark was the only plan with commercial data available in NCQA's Quality Compass for HEDIS 2018.

QUALITY BENCHMARK FOR PERSISTENCE OF BETA-BLOCKER TREATMENT AFTER A HEART ATTACK — MEDICAID

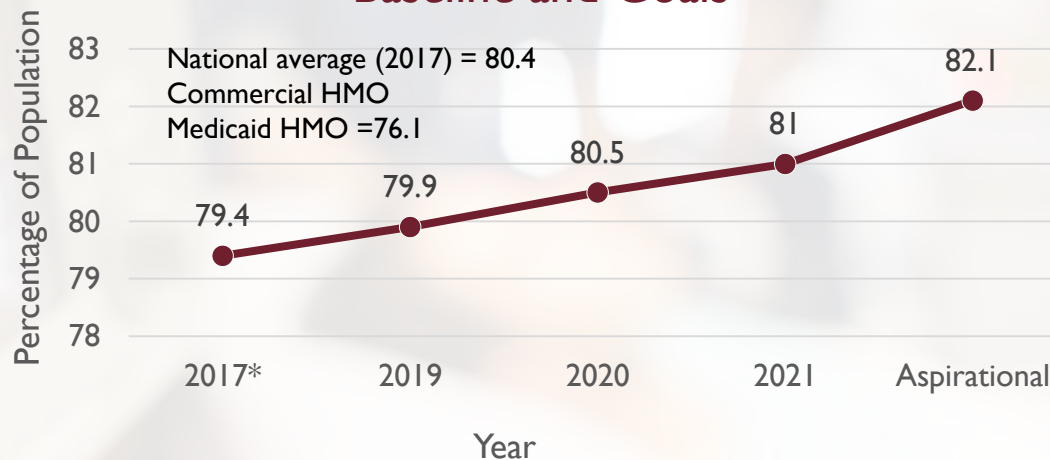


*NCQA Quality Compass

**Delaware's baseline is Highmark's baseline rate, as Highmark was the only plan with Medicaid data available in NCQA's Quality Compass for HEDIS 2018.

QUALITY BENCHMARK FOR STATIN THERAPY FOR PATIENTS WITH CARDIOVASCULAR DISEASE — COMMERCIAL INSURANCE

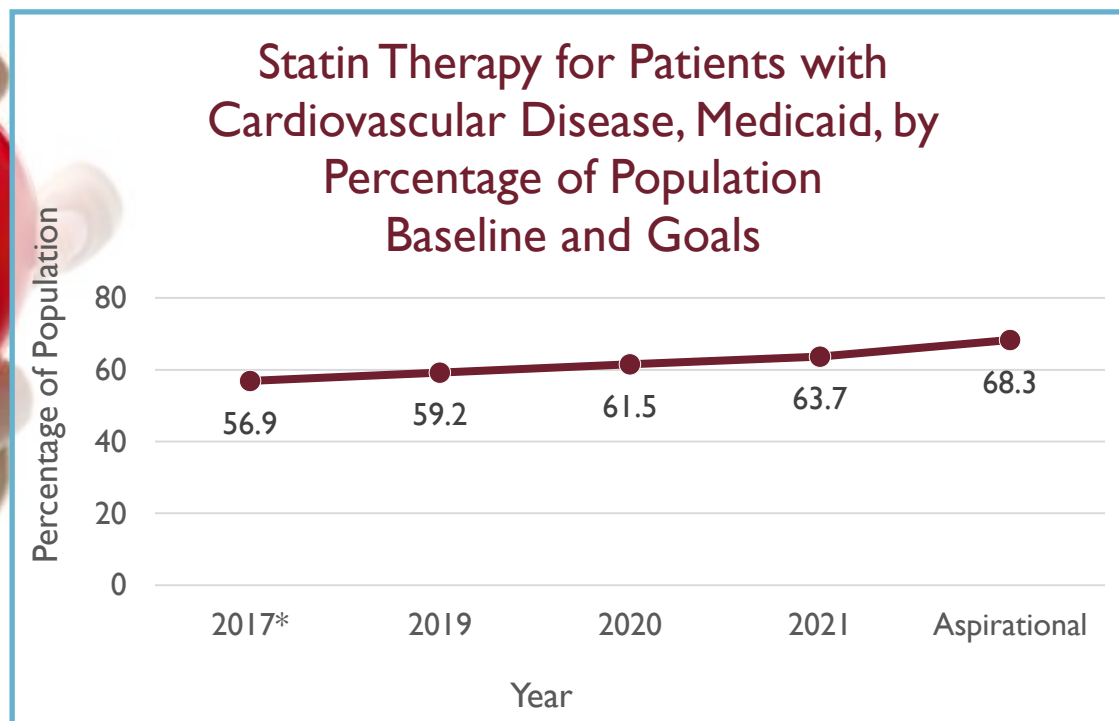
Statin Therapy for Patients with
Cardiovascular Disease, Commercial
Insurance, by Percentage of Population
Baseline and Goals



*NCQA Quality Compass

**Delaware's baseline was derived from the weighted average performance of Aetna, Cigna, Highmark, and UnitedHealthcare. Weights were HEDIS 2018 enrollment by plan.

QUALITY BENCHMARK FOR STATIN THERAPY FOR PATIENTS WITH CARDIOVASCULAR DISEASE — MEDICAID



*NCQA Quality Compass

**Delaware's baseline is Highmark's baseline rate, as Highmark was the only plan with Medicaid data available in NCQA's Quality Compass for HEDIS 2018.



HEALTH CARE BENCHMARKS: WHAT'S NEXT?

- **By May 31st of each year:** DEFAC will report to the Governor and the Health Care Commission on any changes to the spending benchmark approved by DEFAC.
- **4th quarter of each year:** HCC will report on the performance relative to the spending and quality benchmarks.
- **Ongoing:** HCC will engage providers and community partners in discussion – with the State and each other – about how to reduce variation in cost and quality, and to help the State perform well relative to each benchmark.



LINKING STATE EMPLOYEE BENEFITS COMMITTEE AND THE BENCHMARK

With statewide growth trends and quality targets in place, the State Employee Benefits Committee (SEBC) can use these targets as guidelines to develop specific growth trends and quality targets

- Embedded in contracts
- Updated strategic planning targets
- Prioritize benefits design around primary care, emergency department utilization, opioid use, cardiovascular disease prevention
- Consider tobacco cessation, obesity management and cholesterol targets for specific state employees



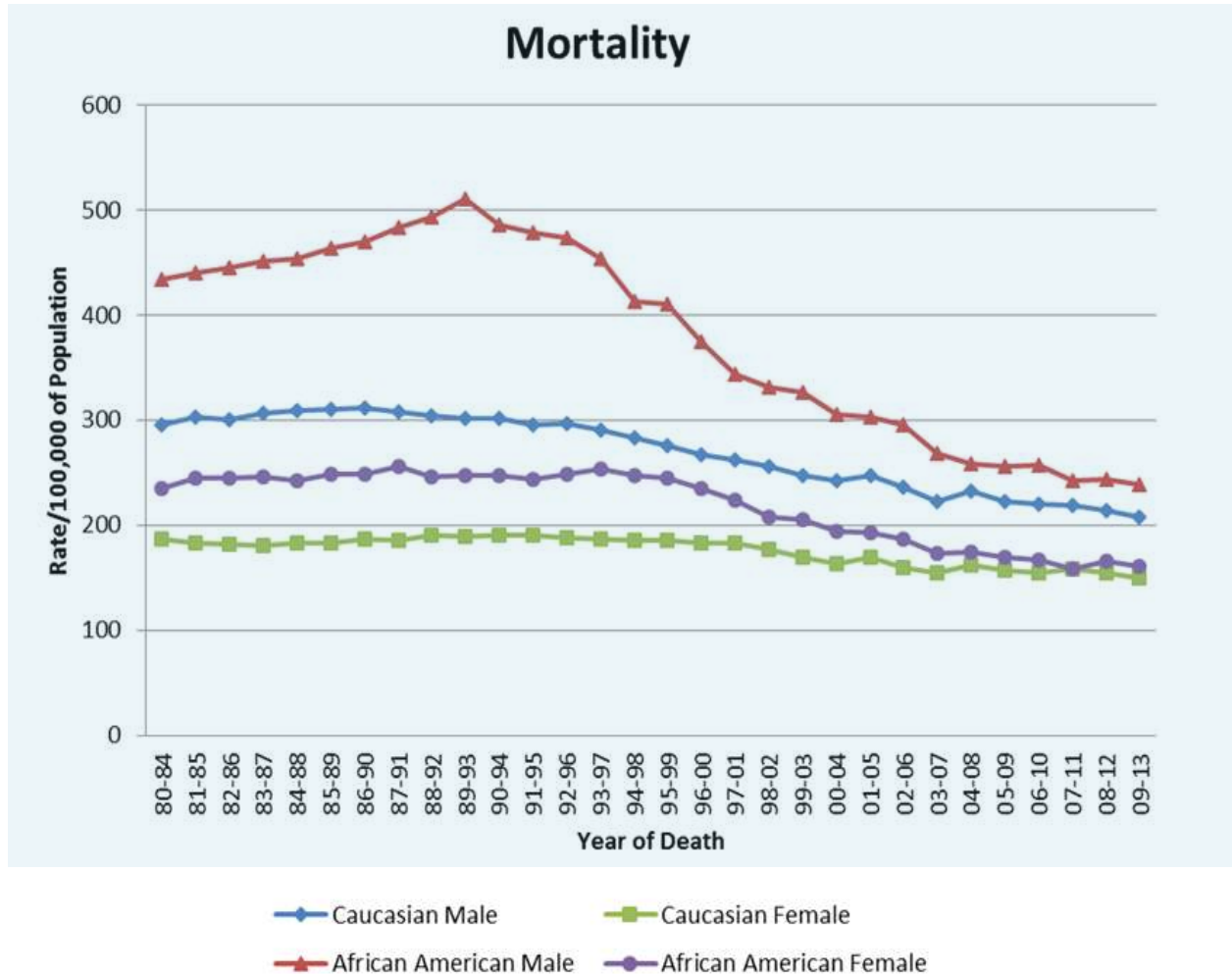
HEALTH TRENDS



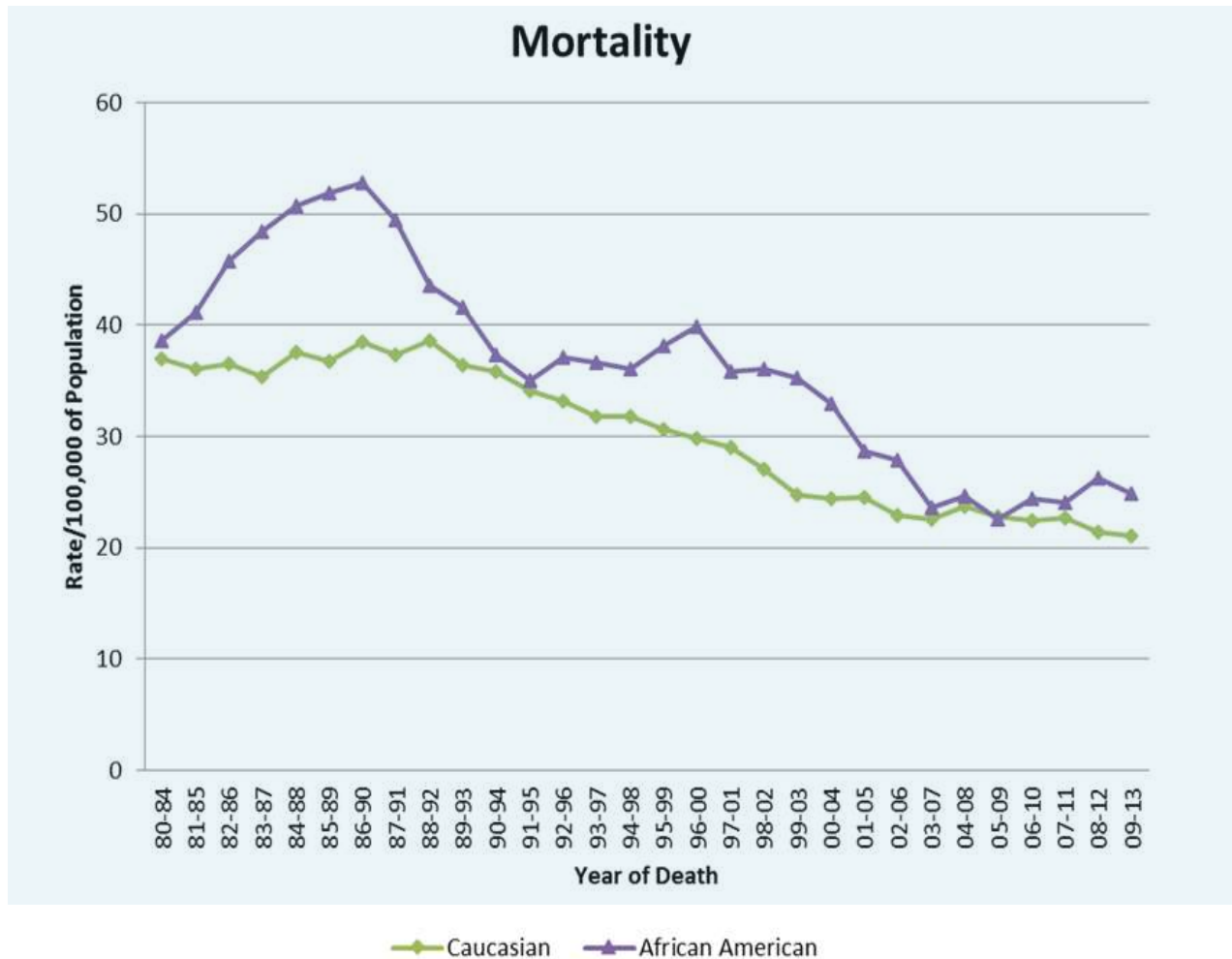
CANCER



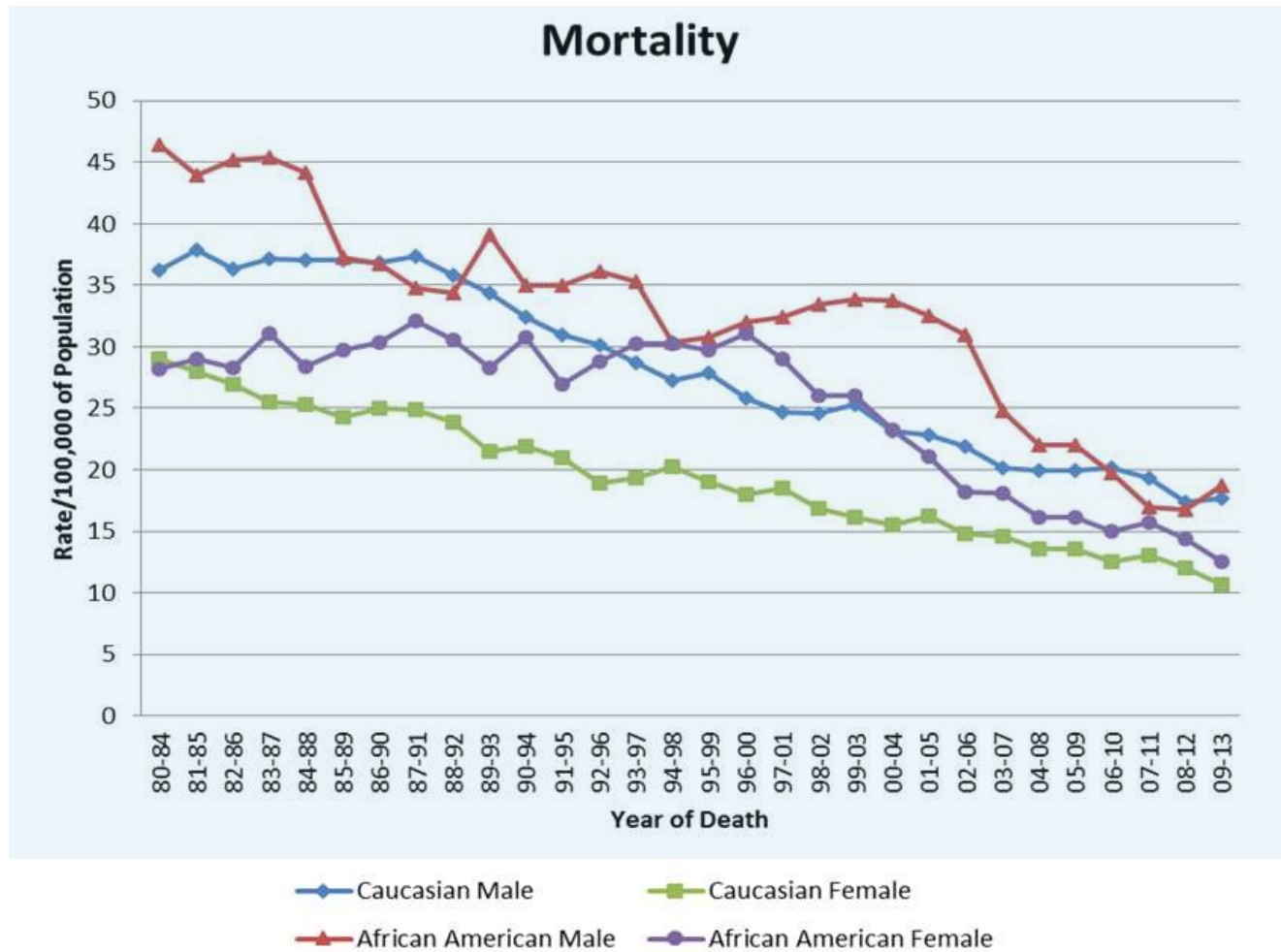
Cancer Mortality by Race, Delaware, 1980-1984 to 2009-2013



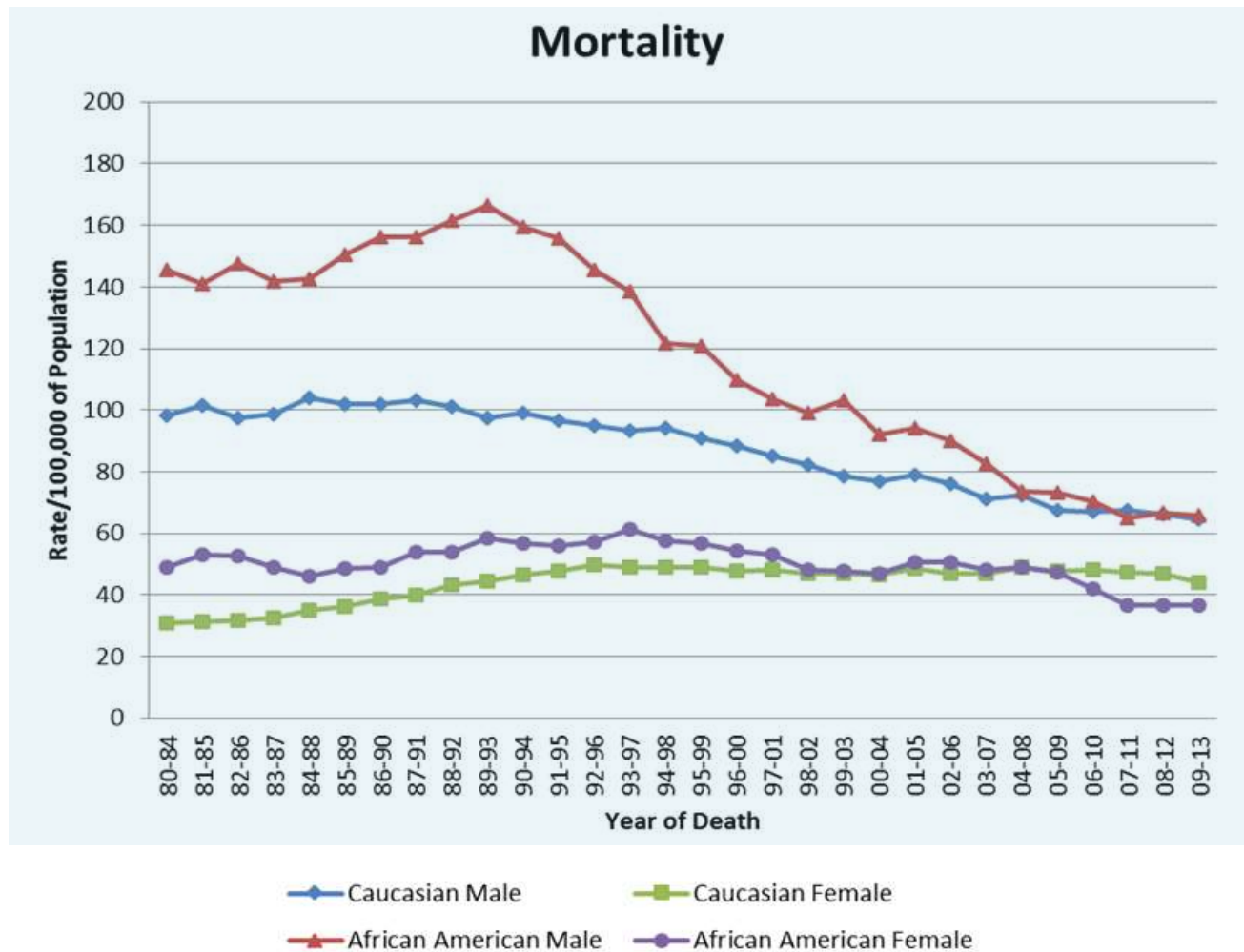
Breast Cancer Mortality by Race, Delaware, 1980-1984 to 2009-2013



Colorectal Cancer Mortality Rate by Race, Delaware, 1980-1984 to 2009-2013



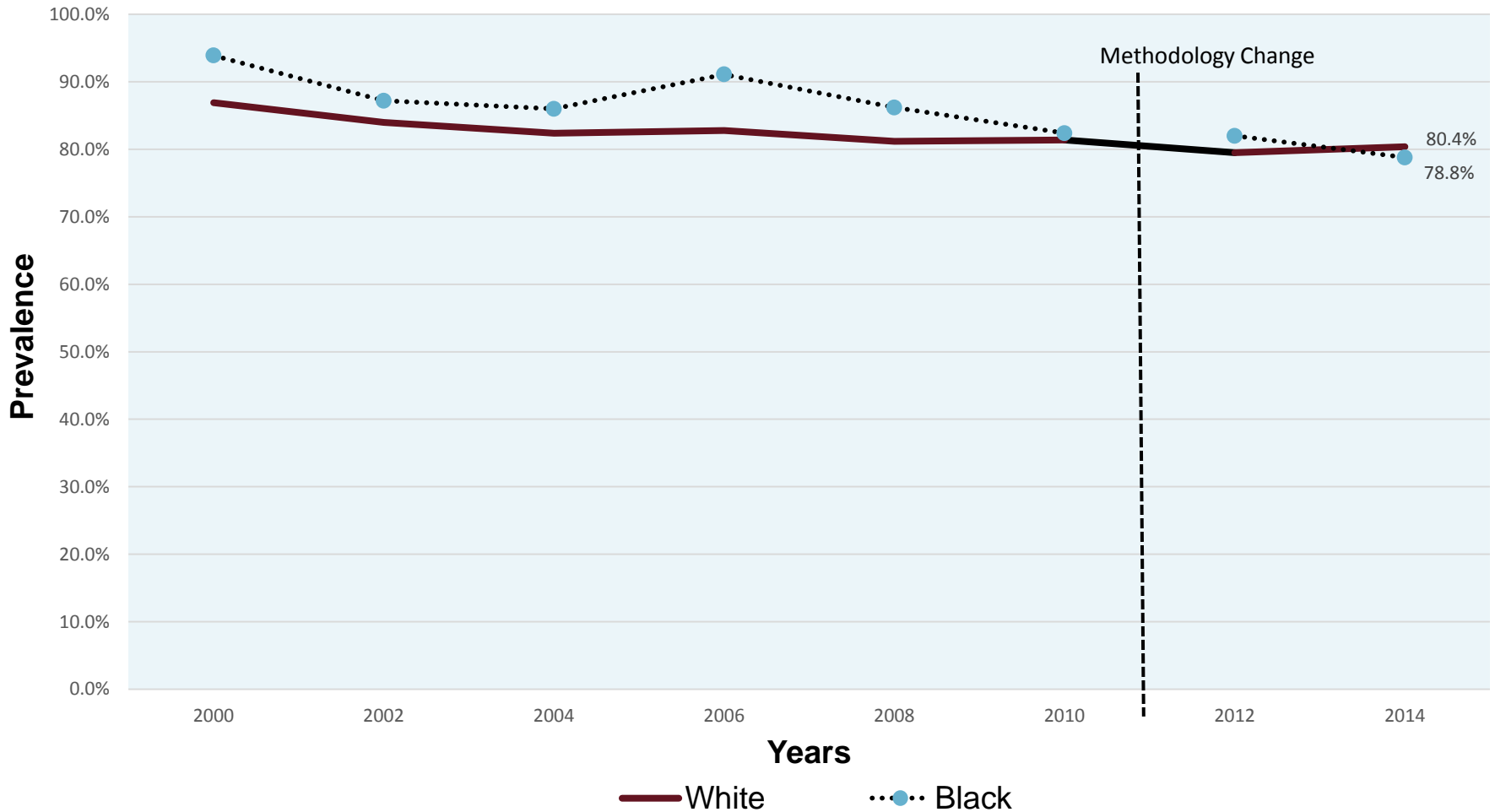
Lung Cancer Mortality by Race, Delaware, 1980-1984 to 2009-2013



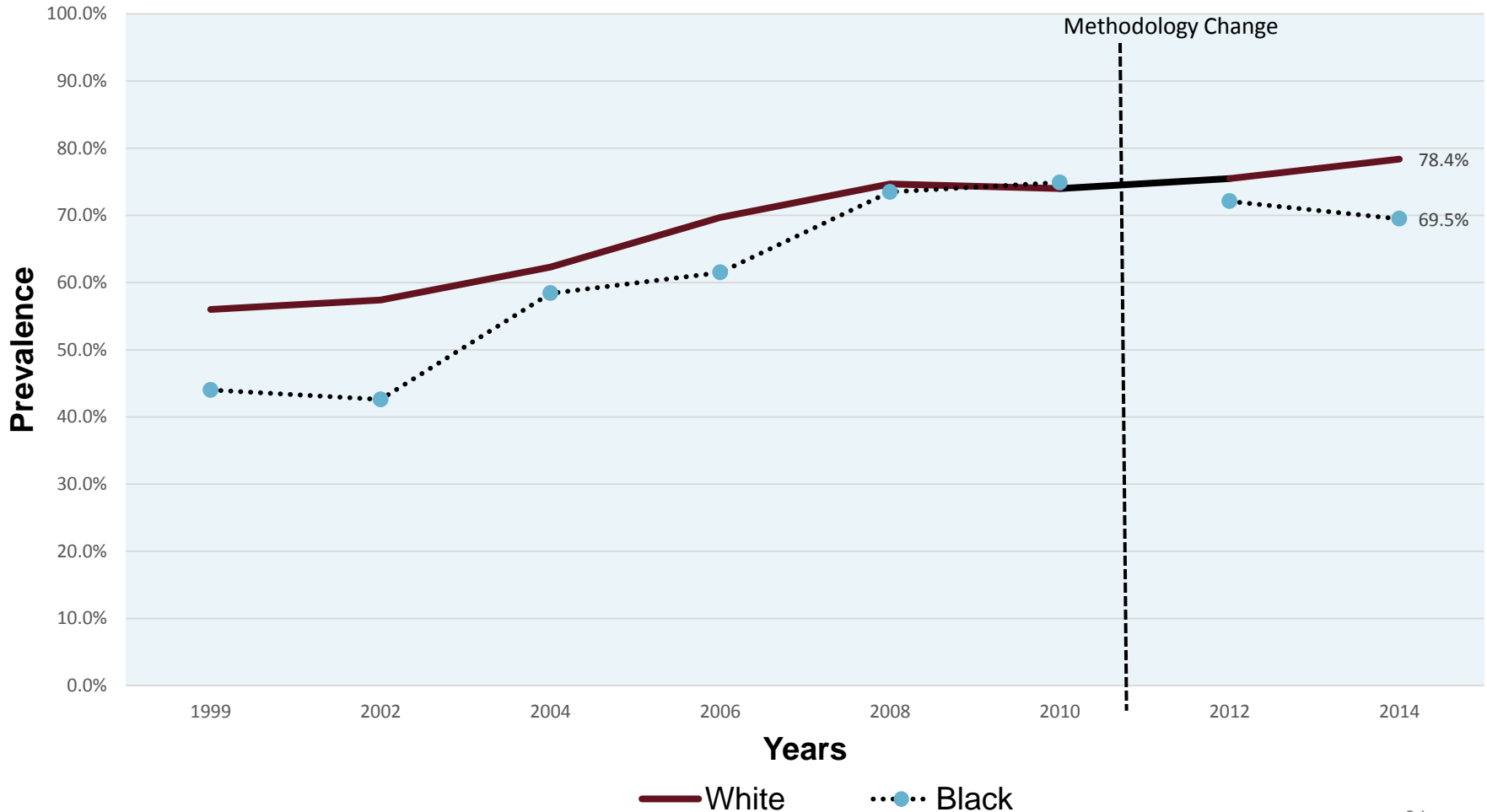
CANCER SCREENING



Prevalence of Delaware Women Age 40 and Older Who Have Received a Mammogram Within the Past Two Years, 2000-2014



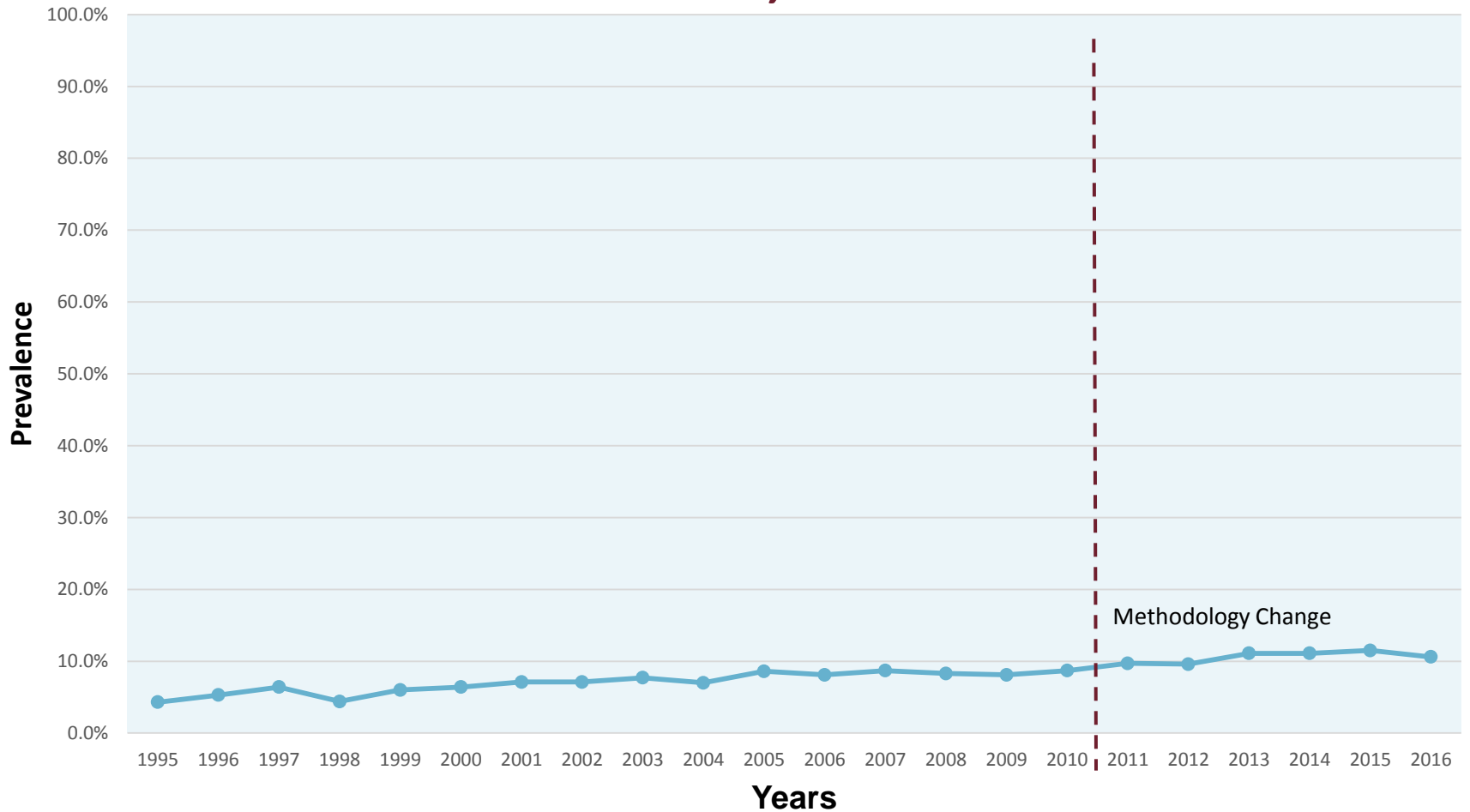
Prevalence of Delaware Adults by Race Who Have Ever Received a Sigmoidoscopy or Colonoscopy, 1999-2014



TYPE 2 DIABETES



Prevalence of Delaware Adults Diagnosed with Diabetes, 1995-2016



Source: Delaware Health & Social Services, Division of Public Health, Behavioral Risk Factor Survey (BRFS), 1995-2016

THE COSTS OF DIABETES IN DELAWARE

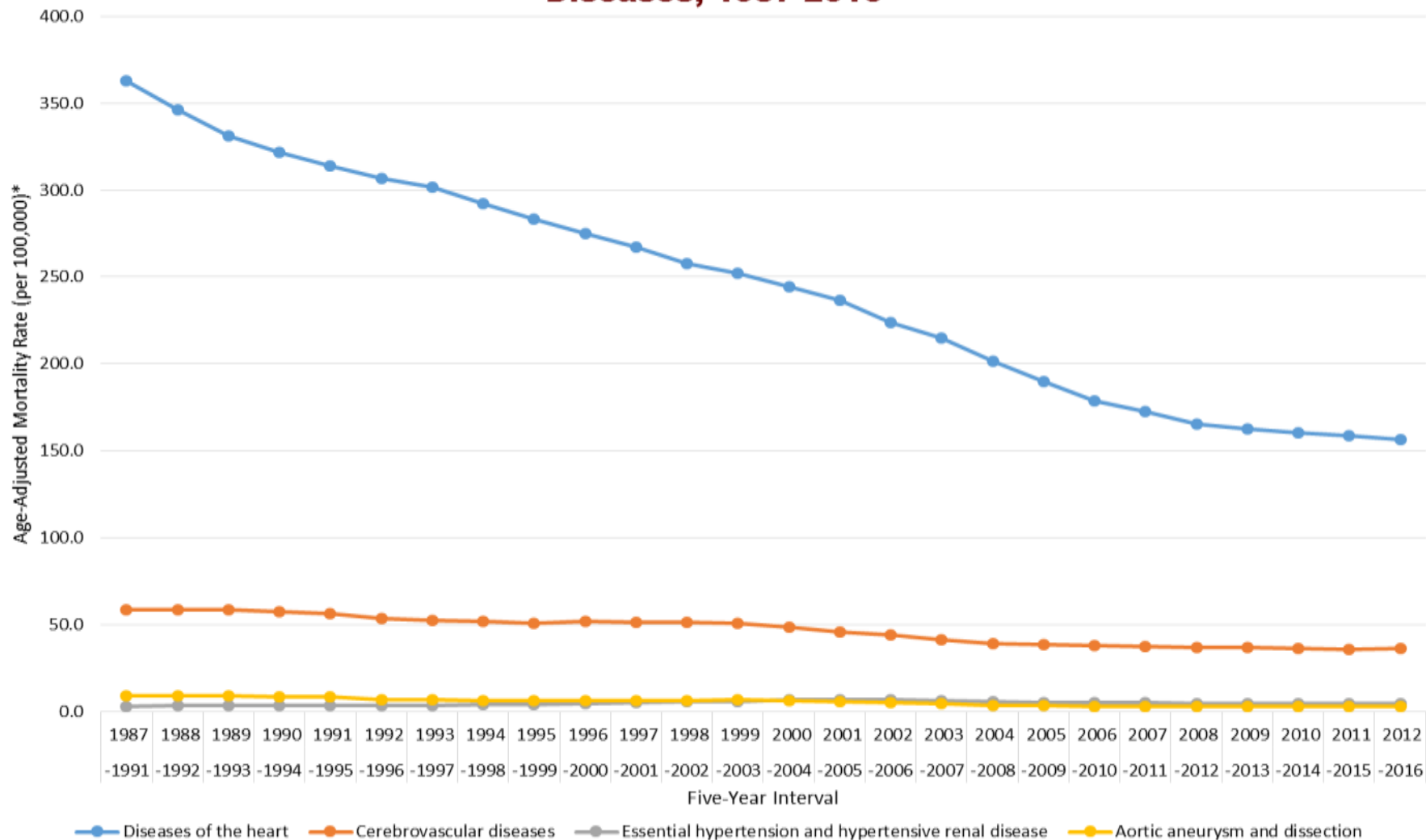
- The American Diabetes Association estimated the total cost of diabetes in Delaware at \$980 million in 2017.
 - \$700 million in estimated medical costs.
 - \$280 million in estimated indirect costs.



CARDIOVASCULAR DISEASE



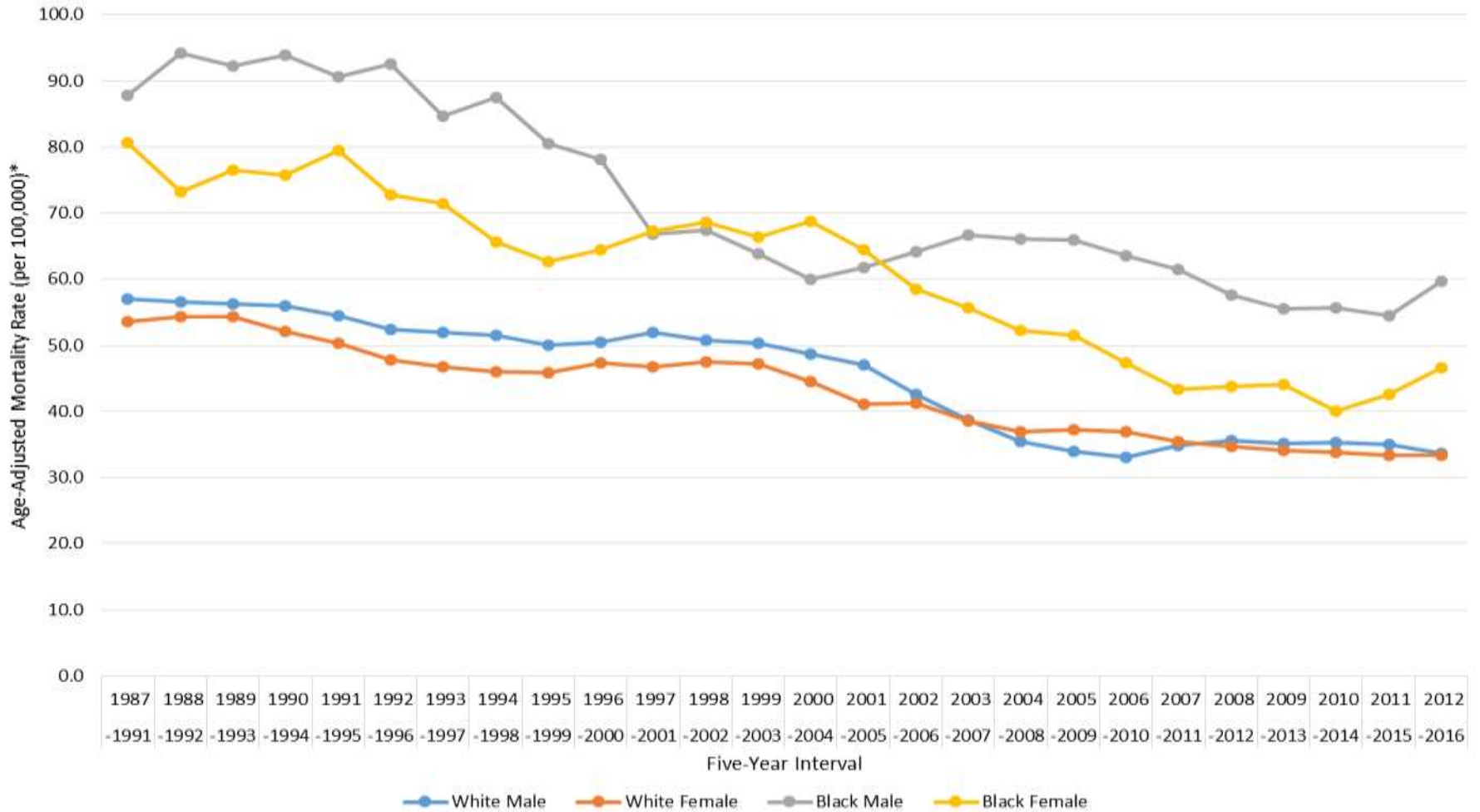
Five-Year Age-Adjusted Mortality Rates for Selected Cardiovascular Diseases, 1987-2016



*Rates per 100,000, adjusted to U.S. 2000 population.

Source: Delaware Department of Health and Social Services, Division of Public Health, Delaware Health Statistics Center

Five-Year Age-Adjusted Mortality Rates for Cerebrovascular Diseases, by Race-Sex, 1987-2016



*Rates per 100,000, adjusted to U.S. 2000 population.

Source: Delaware Department of Health and Social Services, Division of Public Health, Delaware Health Statistics Center

COST OF CARDIOVASCULAR DISEASE IN 2018

According to the American Heart Association:

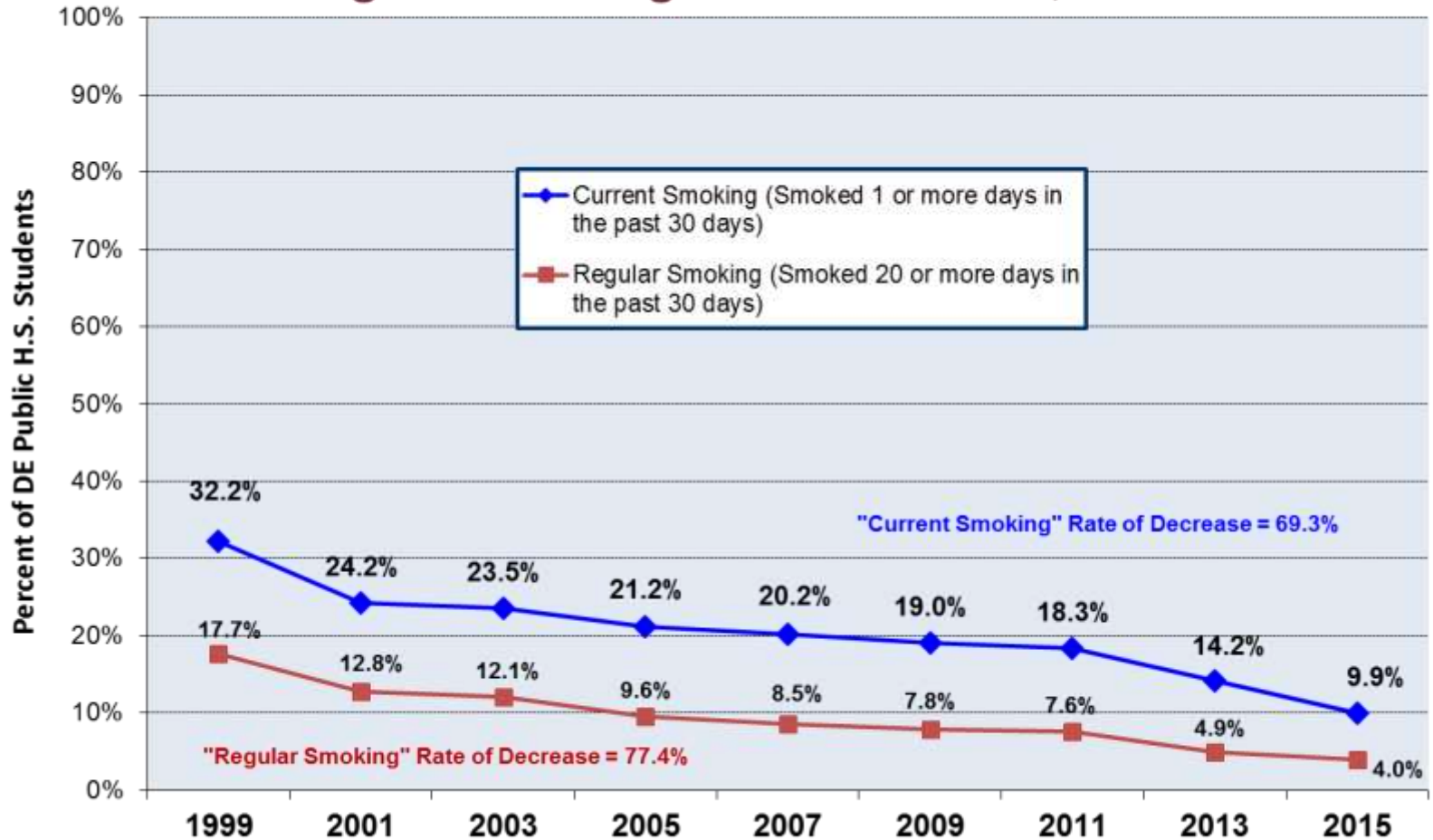
- Total direct medical costs of cardiovascular disease are projected to increase to \$749 billion in 2035.
 - Projections show that by 2035, the total direct costs of high blood pressure could increase to an estimated \$220.9 billion.
- In 2018, direct and indirect costs of total cardiovascular diseases and stroke are estimated to total more than \$329.7 billion; that includes both health expenditures and lost productivity.
 - The estimated direct and indirect cost of heart disease in 2013 to 2014 (average annual) was \$204.8 billion.
 - Heart attacks (\$12.1 billion) and coronary heart disease (\$9.0 billion) were 2 of the 10 most expensive conditions treated in U.S. hospitals in 2013.



TOBACCO USE



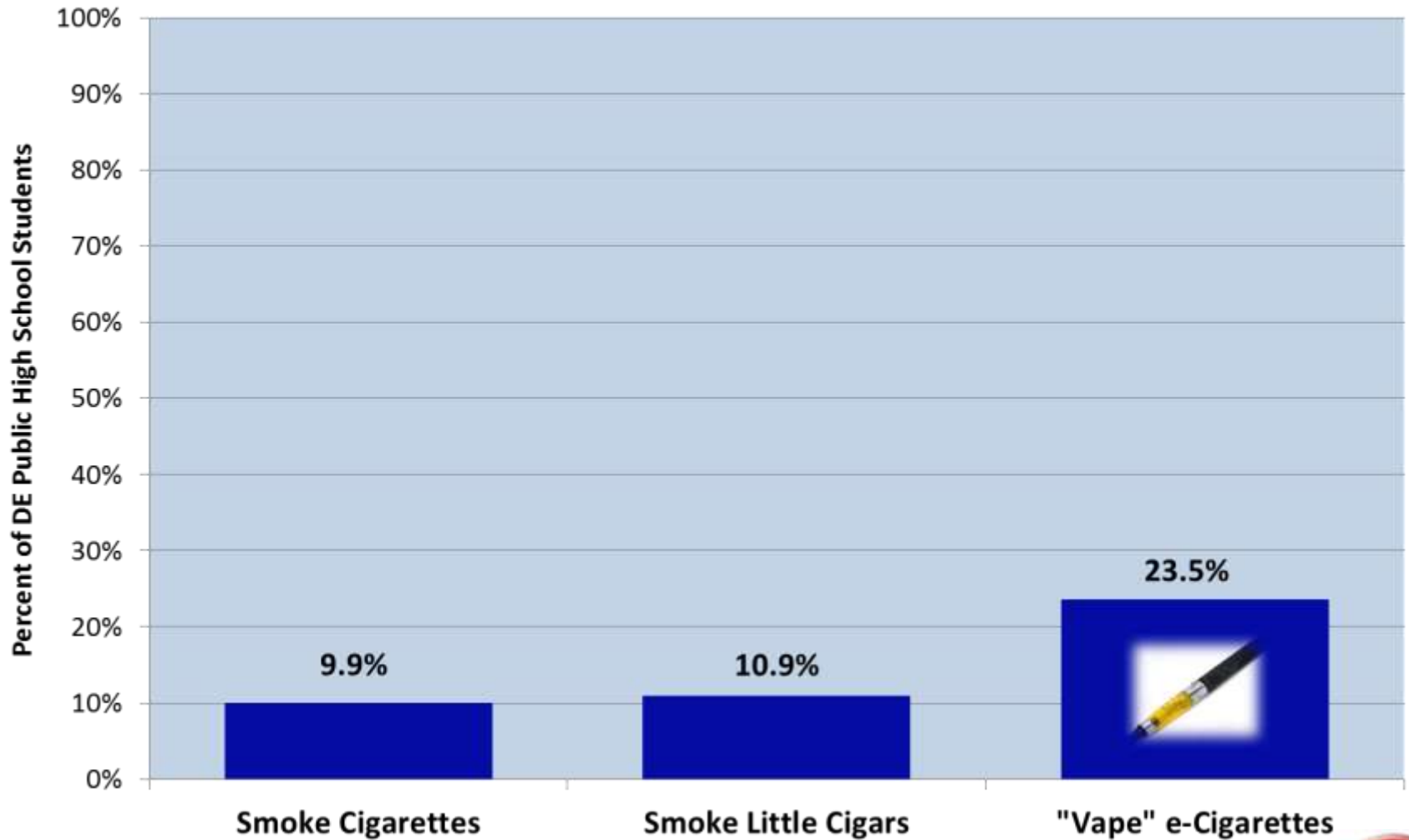
Prevalence of Current Cigarette Smoking Among Delaware High School Students, 1999-2015



Sources: CDC/DOE/DPH, Youth Risk Behavior Survey (YRBS), 1999-2015



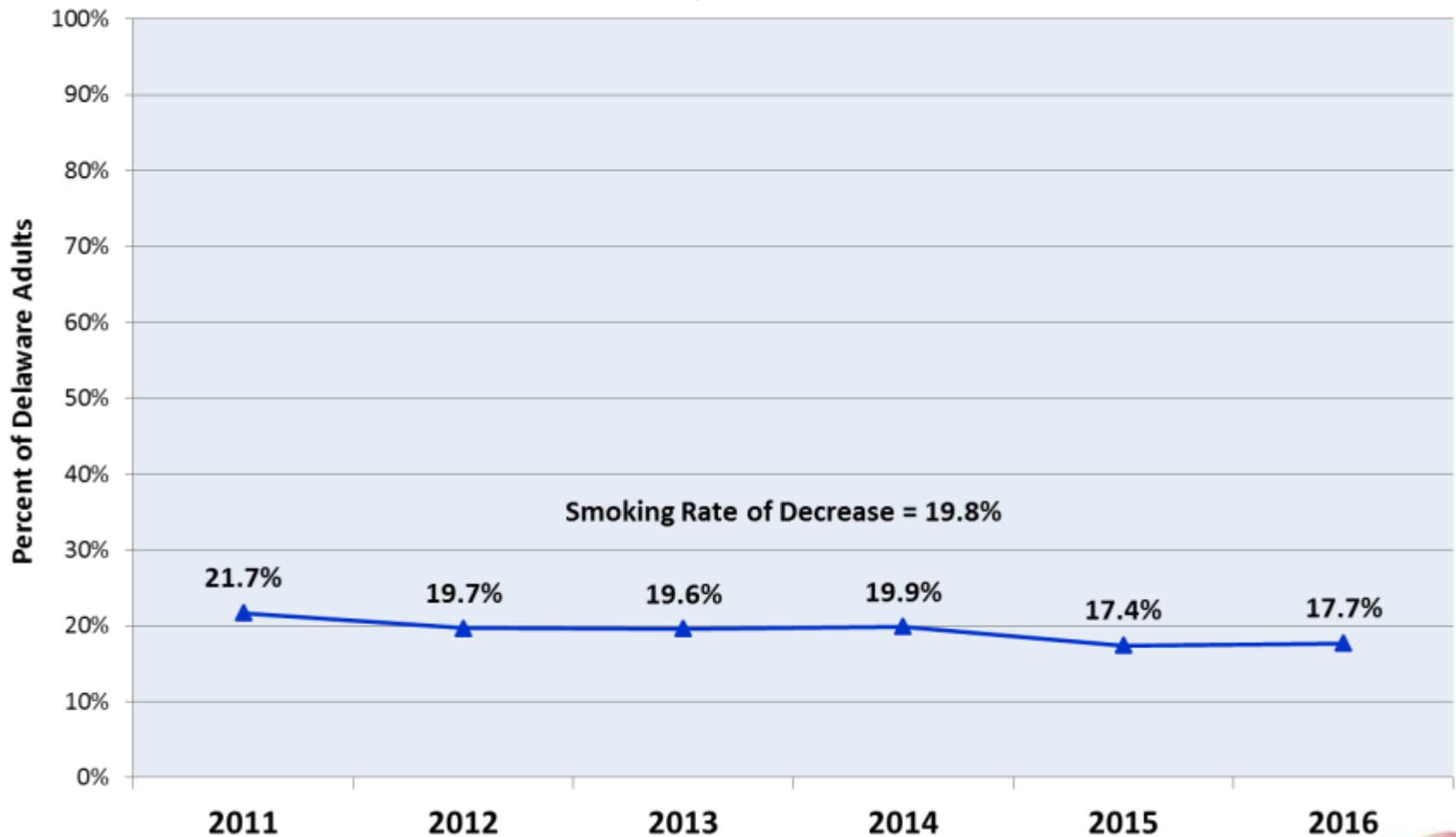
Current Cigarette Smoking Prevalence vs. Current Use of Other Products, Delaware High School Students, 2015



Source: DHSS, Division of Public Health, Youth Risk Behavior Survey (YRBS), 2015.



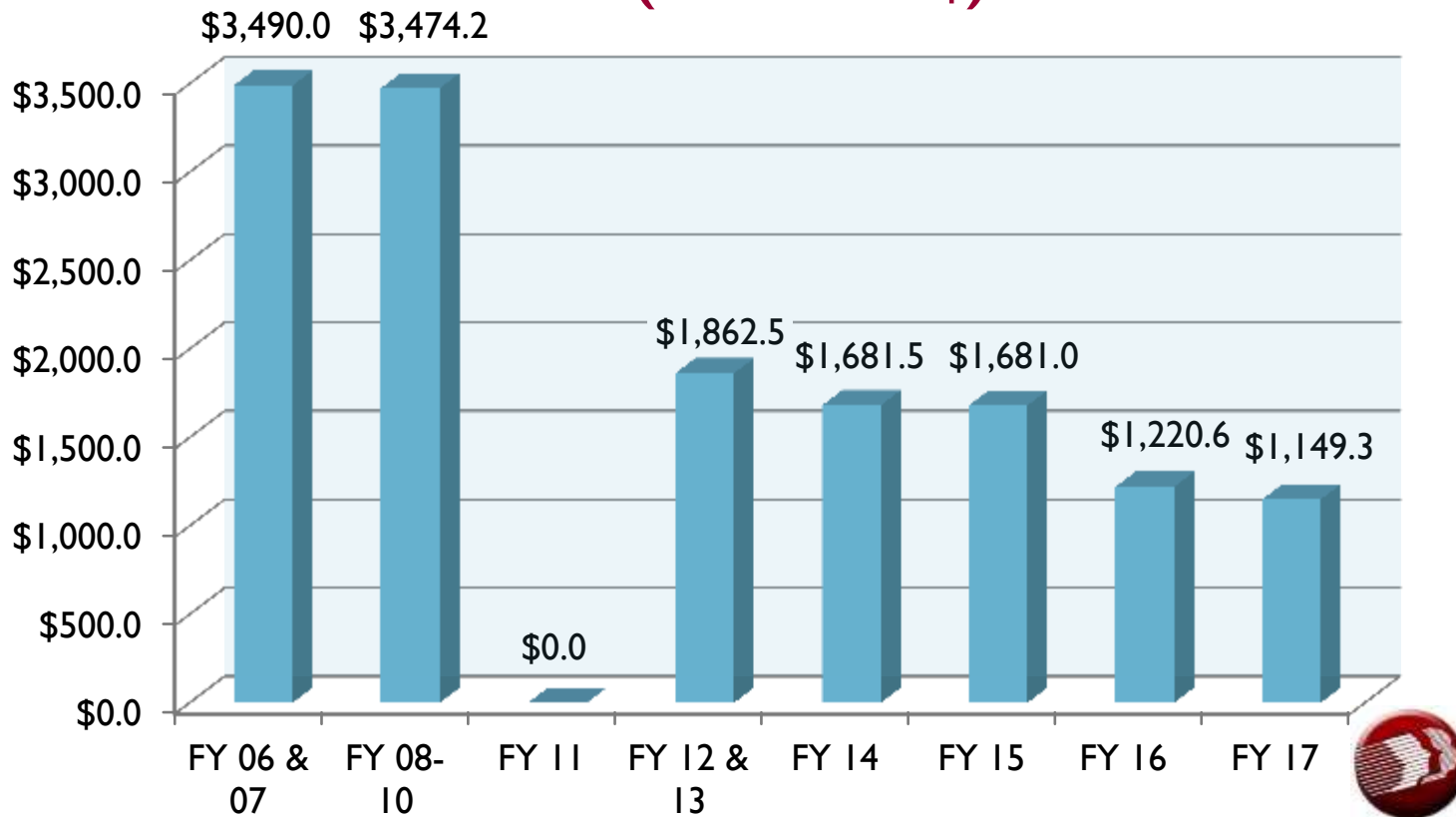
Delaware Adult Cigarette Smoking Prevalence, 2011-2016



Source: Delaware Health & Social Services, Division of Public Health, Behavioral Risk Factor Survey (BRFS), 2011-2015.
New baseline in 2011, due to change in methodology to multi-mode survey and new weights.



Division of Public Health Tobacco Settlement Funding from the Delaware Health Fund for Community-Based Organizations (Thousands \$)



Does Not Include Personnel Costs

THE COSTS OF TOBACCO USE IN DELAWARE

- 1,400 Delawareans die each year from tobacco use.
- 17,000 children now <18 years old will die prematurely from smoking.
- \$532 million in annual health care costs directly caused by smoking.
 - \$95.6 million are Medicaid costs.
- \$391.2 million in annual smoking-caused productivity losses.

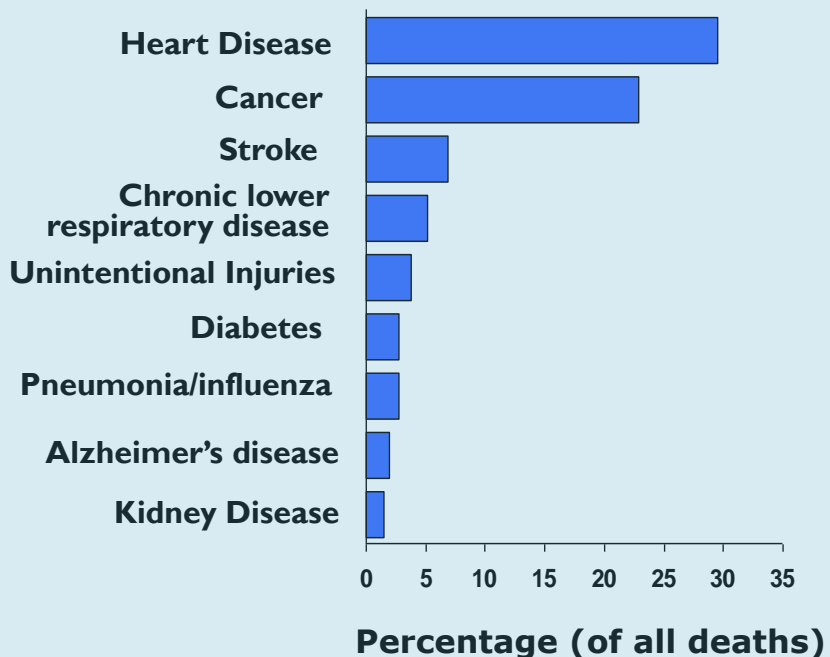


CHRONIC DISEASES AND RELATED RISK IN THE U.S.

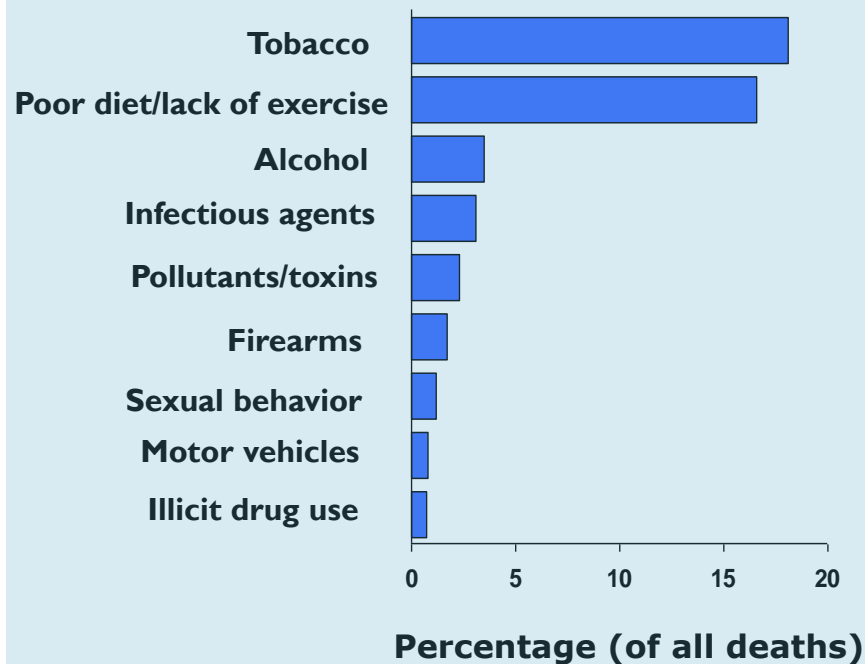


Chronic Diseases and Related Risk Factors in the United States

Leading Causes of Death*



Actual Causes of Death†



* National Center for Health Statistics. Mortality Report. Hyattsville, MD: US Department of Health and Human Services; 2002

† Adapted from McGinnis Foege, updated by Mokdad et. al.



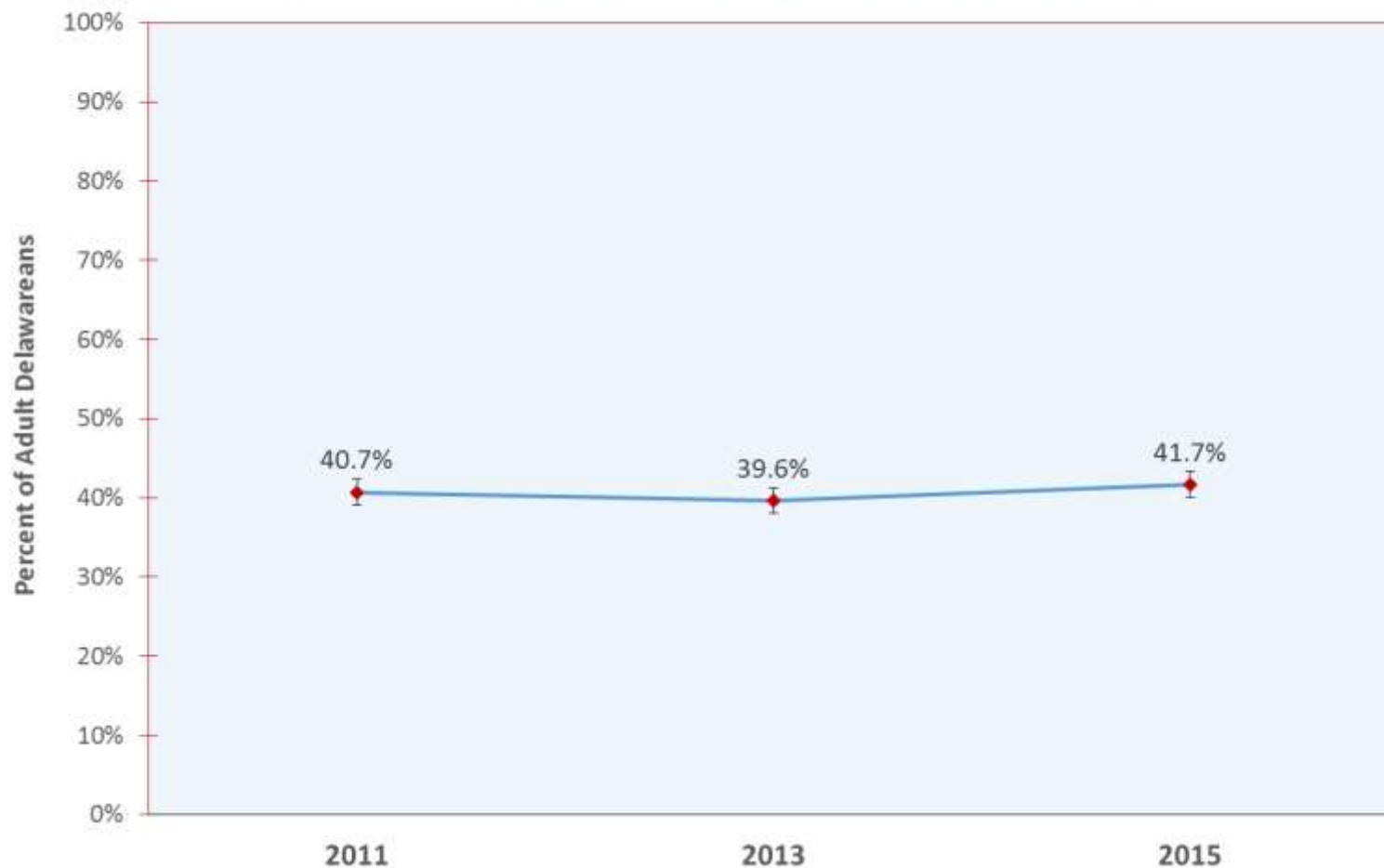
OBESITY/OVERWEIGHT

- **Obesity:** 20.8% of obese Delaware adults have diabetes, compared to 3% of normal weight Delaware adults.
- **Overweight:** 8.4% of overweight Delaware adults have diabetes, compared to 3% of normal weight Delaware adults.

Source: Delaware Health and Social Services, Division of Public Health, Delaware Behavioral Risk Factor Survey, 2016.



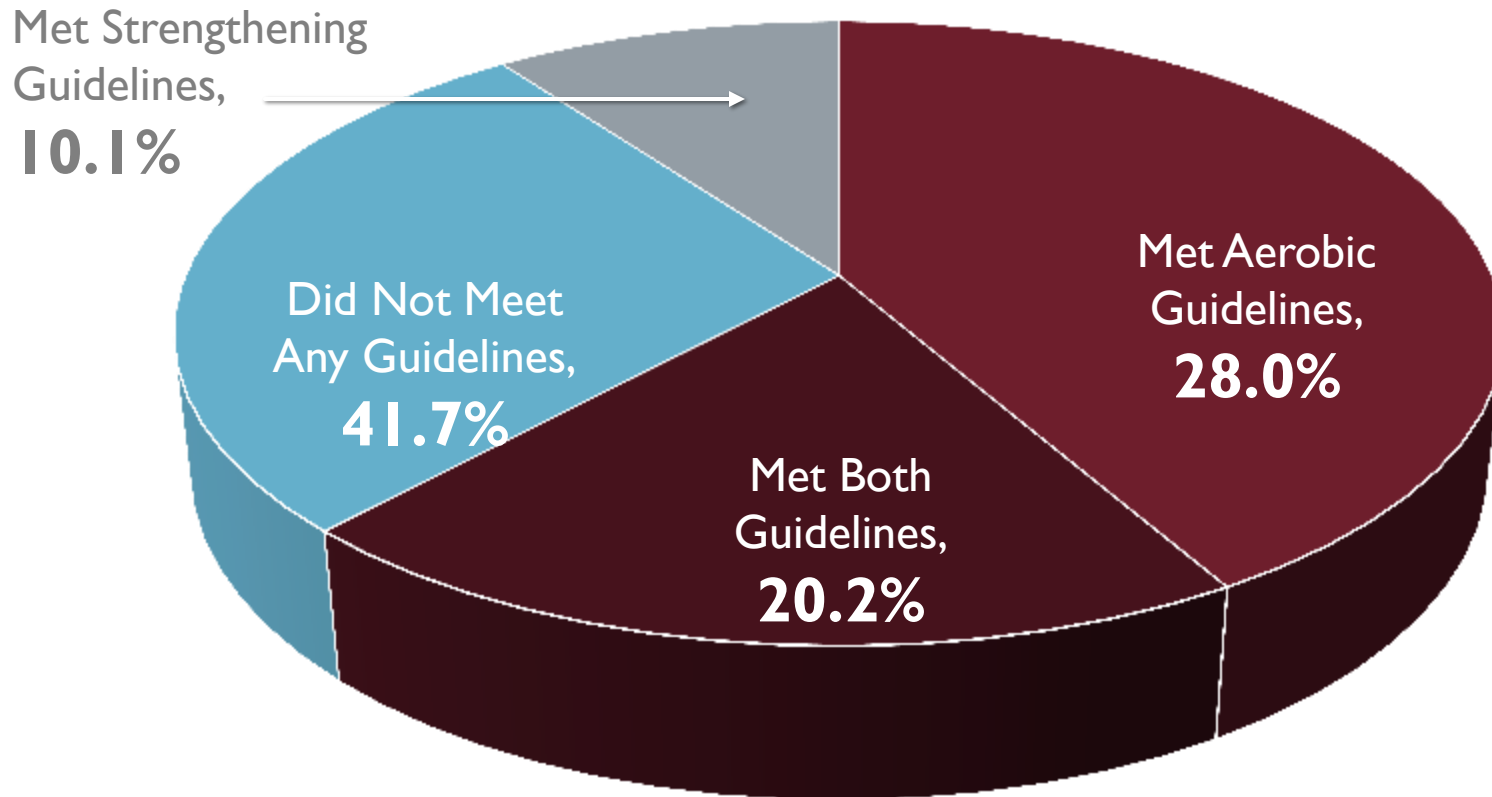
Delaware Adults Who Did NOT Meet CDC Physical Activity Guidelines, 2011-2015



Source: Delaware Health & Social Services, Division of Public Health, Behavioral Risk Factor Survey (BRFS), 2011-2015.



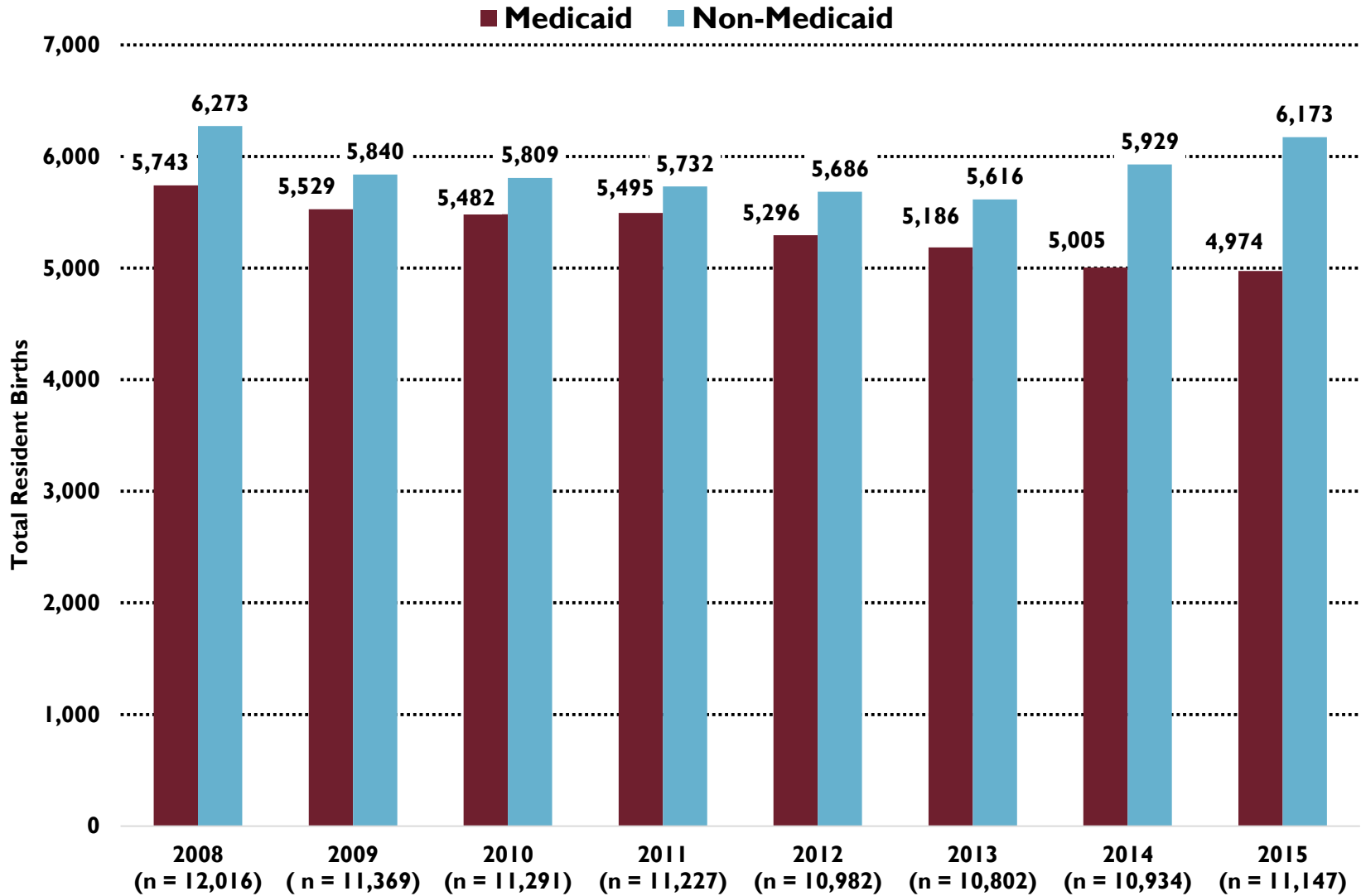
Percent of Delaware Adults Who Met CDC Guidelines for Physical Activity, 2015



BIRTHS, TEEN BIRTHS, UNINTENDED PREGNANCY, INFANT MORTALITY

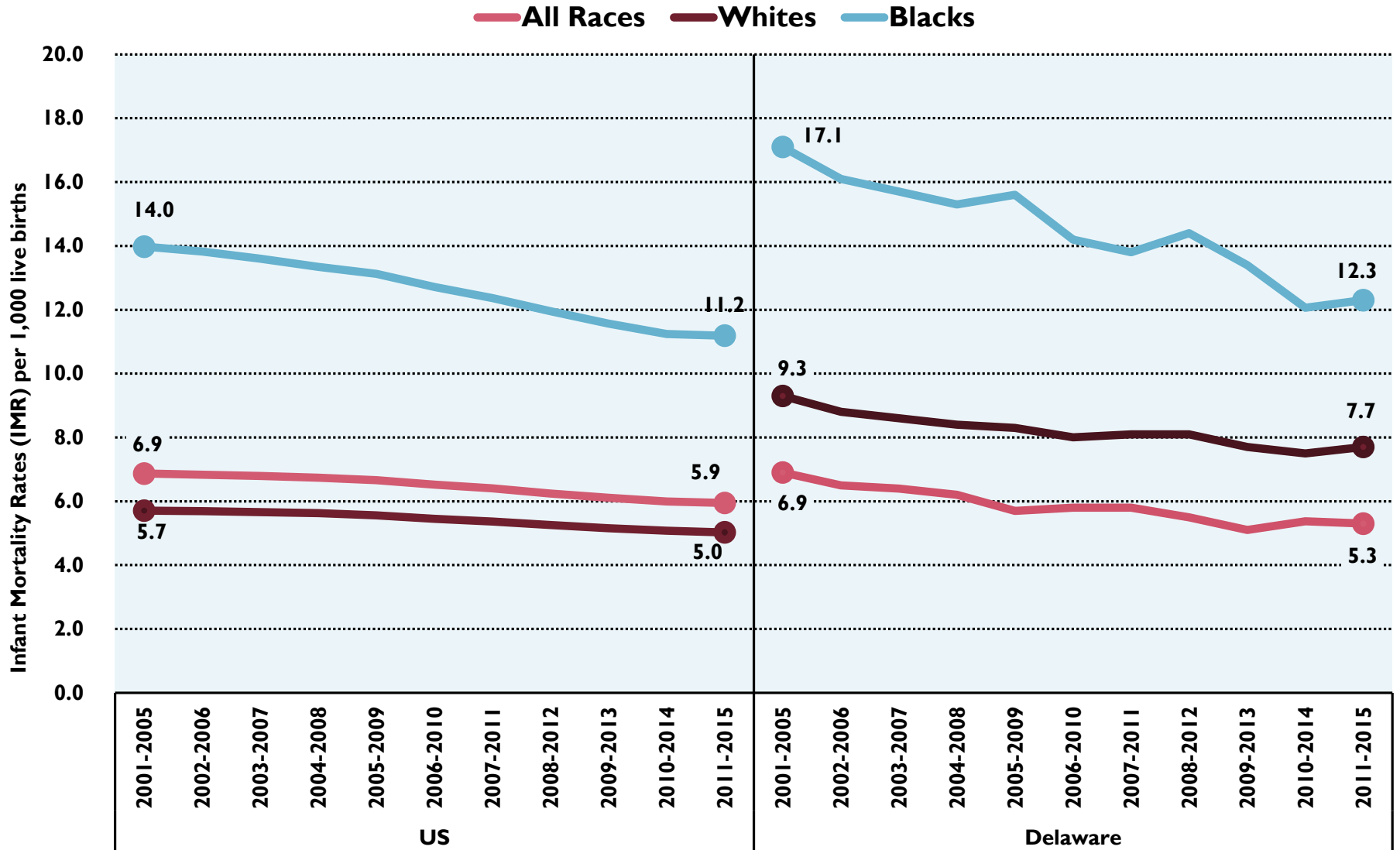


Delaware Resident Births by Payer, 2008-2015



Source: Delaware Health and Social Services, Division of Public Health, Vital Statistics Data, 2001-2015.

Five-Year Infant Mortality Rates, 2001-2015

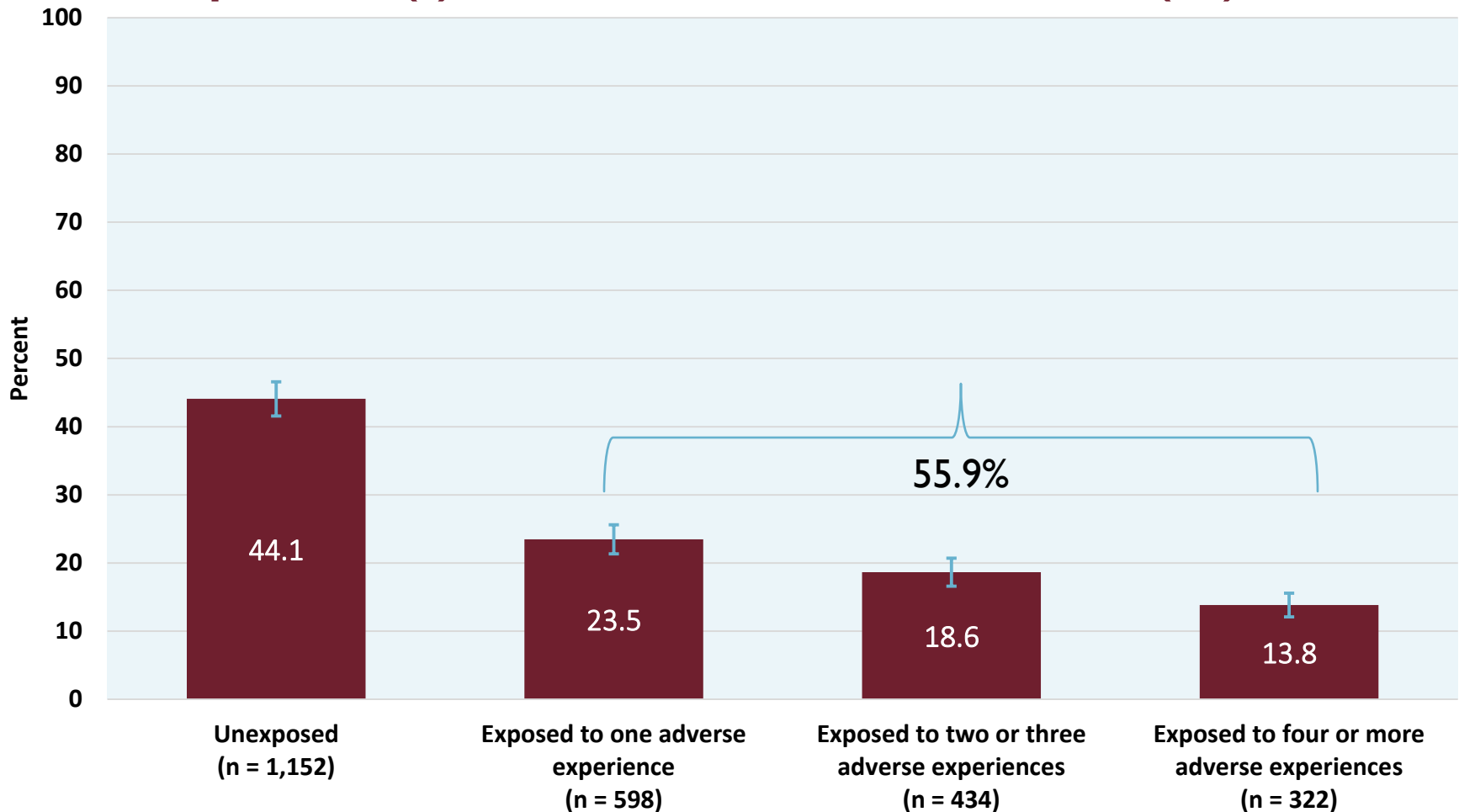


Source: Delaware Health and Social Services, Division of Public Health, Vital Statistics Data, 2001-2015. (See INFANT4 vital statistics)

ADVERSE CHILDHOOD EXPERIENCES (ACES)



Percentage of Delaware Adults 18 and Older Who Reported One or More Adverse Childhood Experience(s), with 95% Confidence Intervals (CI), 2015

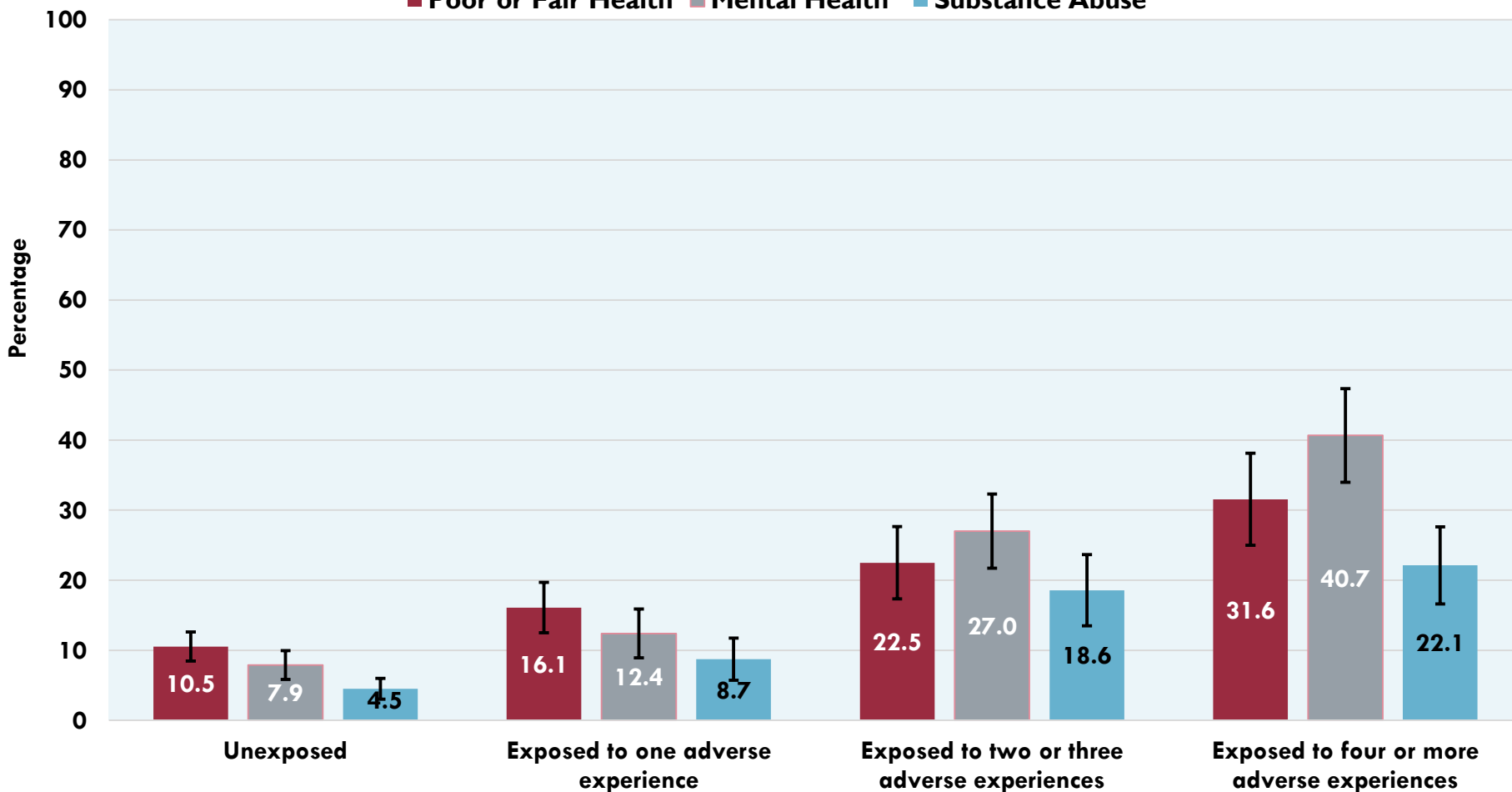


Source: Delaware Household Survey (DeHHS), 2015 data.

*ACE score is a summary measure, and ranges from 0 (unexposed) to 10 (exposed to all categories)

Percentage of Delaware Adults 18 and Older Who Reported One or More Adverse Childhood Experience(s) and Health Status, 2015

■ Poor or Fair Health ■ Mental Health ■ Substance Abuse

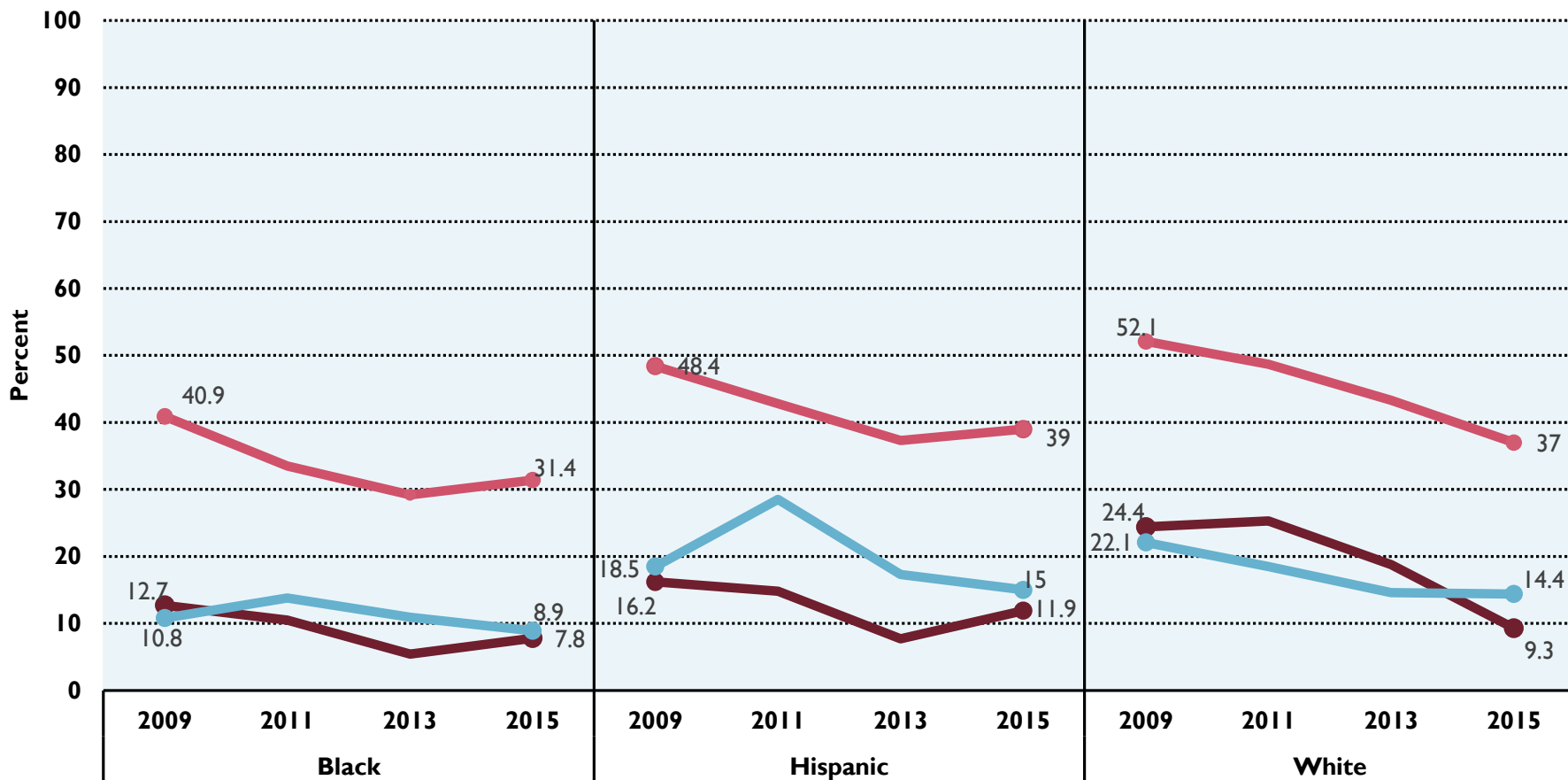


Source: Delaware Household Survey (DeHHS), 2015 data.

*ACE score is a summary measure, and ranges from 0 (unexposed) to 10 (exposed to all categories)

Percentage of Female High School Students in Delaware Who Reported Smoking Cigarettes, Drinking Alcohol at Least Once in the Past 30 Days, and/or Offered Illicit Drugs in the Past 12 Months

— Currently Smoke — Currently Drink — Illicit Drugs



THE COSTS OF SUBSTANCE USE IN DELAWARE

- 1,400 Delawareans die each year from tobacco use.
- 17,000 children now <18 years old will die prematurely from smoking.
- \$532 million in annual health care costs directly caused by smoking.
 - \$95.6 million are Medicaid costs.
- \$391.2 million in annual smoking-caused productivity losses.





THANK YOU