STATE OF DELAWARE

Delaware Economic and Financial Advisory Council
Healthcare Spending Benchmark Subcommittee

December 31, 2024

To: Members of the Delaware Economic and Financial Advisory Council (DEFAC)

RE: HB 350 Healthcare Spending Benchmark Methodology Recommendations

Attached, as required by House Substitute 2 to House Bill 350 with House Amendment 1 and Senate Amendment 1, is a report on the recommendations relating to the healthcare spending benchmark methodology approved by the DEFAC Healthcare Spending Benchmark Subcommittee at its December 18, 2024 meeting. The Subcommittee met four times over the past several months to review the spending benchmark methodology and consider incorporating healthcare and macroeconomic trends into the benchmark methodology.

The Subcommittee recommends that DEFAC and the Subcommittee should consider revising the healthcare spending benchmark to be comprised of equal weightings of the 3-year average of all of the following: Delaware personal income growth and Delaware population growth plus the growth in the price index for relevant healthcare Personal Consumption Expenditures (PCE) weighted by total expenditures.

The recommendation also states that the Subcommittee should convene in March 2025 for a report from Department of Health and Social Services and Department of Finance staff on 1) how the Bureau of Economic Analysis compiles and publishes healthcare PCE price index data and whether a readily available objective source can produce a one-year forecast and 2) whether and how to address "per capita" growth to ensure that the spending benchmark methodology is aligned with the methodology for how actual spending growth is or will be reported. Pending satisfaction with such information, the Subcommittee and DEFAC should adopt the revised methodology for the 2026 benchmark and make corresponding adjustments to the 2025 benchmark calculation.

If you have any questions or desire additional information, please contact David Roose, Director of Research and Analysis in the Department of Finance at david.roose@delaware.gov.

Sincerely,

Signed by:
Josette D. Manning, Esquire
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Josette Manning
Chair

K. Dwyer

Kristin Dwyer
Vice Chair

Attachment

STATE OF DELAWARE

Delaware Economic and Financial Advisory Council
Healthcare Spending Benchmark Subcommittee

Report to the Delaware Economic and Financial Advisory Council Regarding the Healthcare Spending Benchmark Methodology

December 31, 2024

Background

House Substitute 2 for House Bill 350 with House Amendment 1 and Senate Amendment 1 of the 152nd General Assembly directed the Delaware Economic and Financial Advisory Council (DEFAC) Healthcare Spending Benchmark Subcommittee (Subcommittee) to review the spending benchmark methodology, as authorized by 16 Del. C. § 9903(k), and consider incorporating healthcare and macroeconomic trends into the benchmark methodology. The Subcommittee is required to submit any recommendations to DEFAC by December 31, 2024.

In response to growing health care costs in Delaware, the General Assembly passed House Joint Resolution 7 in 2017 directing the Department of Health and Social Services (DHSS) to establish a healthcare benchmark focused on improving health outcomes, transparency, and accountability in costs. Governor Carney issued Executive Order 19 in 2018, forming the Health Care Delivery and Cost Advisory Group. The group was tasked with advising DHSS on creating healthcare spending and quality benchmarks. The Advisory Group agreed the benchmark should meet the following criteria:

1) Be a predictable target,
2) Adjust for the effects of inflation,
3) Rely on independent, objective data sources, and
4) Account for significant events.

The Advisory Group also agreed that a prospective economic measure should be the basis for the benchmark. Their work culminated in Executive Order 25, which set the initial spending and quality benchmarks; established the DEFAC Healthcare Spending Benchmark Subcommittee; and tasked the Delaware Health Care Commission with setting the quality benchmarks, reporting on performance relative to both benchmarks, and engaging providers and community partners. The benchmarks and process were later codified by House Bill 442 with House Amendment 1 in 2022.

Delaware's healthcare spending benchmark, codified under 16 Del. C. § 9903(k), utilizes the Potential Gross State Product (PGSP) methodology. PGSP is calculated as the sum of expected growth in U.S. labor force productivity, expected growth in Delaware's civilian labor force, and expected growth in U.S. inflation as measured by Personal Consumption Expenditures (PCE), minus expected growth in Delaware's population. The components are the forecasted growth rates for 5-10 years out into the future. This produces a per capita growth rate used to evaluate total healthcare expenditure data. The initial benchmark for calendar year 2019 was set at 3.8% based on the State's budget benchmark. The subsequent years used the PGSP methodology but included a transitional market adjustment set at 0.5% for calendar year 2020, 0.25% for

calendar year 2021, and 0% for calendar year 2022 and beyond. See figure 1 for the approved benchmarks for calendar year 2019 through calendar year 2025.

Components	CY 19	CY 20	CY 21	CY 22	CY 23	CY 24	CY 25
Expected growth in national labor force productivity		1.4%	1.4%	1.4%	1.4%	1.4%	1.5%
+ Expected growth in Delaware's civilian labor force		0.1%	0.1%	0.1%	0.2%	0.1%	0.3%
+ Expected national inflation		2.0%	1.9%	2.0%	2.0%	2.0%	3.0%
= Nominal PGSP growth		**3.5%**	**3.4%**	**3.5%**	**3.6%**	**3.5%**	**4.8%**
– Expected population growth in Delaware		0.5%	0.4%	0.5%	0.5%	0.5%	0.6%
+ Transitional Market Adj.		0.5%	0.25%	0.0%	0.0%	n/a	n/a
= PGSP growth/Spending Benchmark	**3.8%**	**3.5%**	**3.25%**	**3.0%**	**3.1%**	**3.0%**	**4.2%**

Figure 1 Healthcare spending benchmarks approved by the Subcommittee

The Subcommittee met four times over the fall of 2024 to fulfill the requirements of House Bill 350: October 2, October 24, November 18, and December 18. Meetings were held in a hybrid format with both in-person and virtual attendance options for members and the public. At the end of each meeting, a time was reserved for public comment. Staff support was provided by the Department of Finance (DOF) and DHSS.

Healthcare and Macroeconomic Trends Considered

Subcommittee members raised several concerns about the current PGSP methodology. Many questioned whether PGSP adequately reflects the unique cost drivers of healthcare, such as pharmaceuticals and advanced medical technologies. A disconnect was noted between the benchmark and actual cost inflation experienced in the healthcare sector, particularly in pharmaceuticals and labor costs. Additionally, members expressed concern that the financial consequences outlined in House Bill 350 unfairly target hospitals, which do not control all cost drivers. This prompted calls for the State to consider expanding accountability to other stakeholders, including insurance companies and pharmaceutical manufacturers. However, this was deemed outside the scope of the Subcommittee's charge. Some members highlighted that the methodology suffers from a lack of clarity and coherence, describing it as overly complex and disconnected from prevailing national healthcare cost trends and affordability metrics. They proposed simplifying the benchmark calculation to make it more intuitive and aligning it more closely with national and consumer-centric economic indicators. Furthermore, while the PGSP approach prioritizes stability by using forecasted long-term growth rates, members noted it does not accommodate recent near-term healthcare cost surges. Broader economic trends, such as inflation and wage growth, were also emphasized.

The Subcommittee discussed several macroeconomic and healthcare trends that could inform revisions to the benchmark methodology. Rising costs in pharmaceuticals, behavioral health services, and advanced medical technologies were highlighted as significant contributors to total expenditure growth. Labor costs driven by workforce shortages and supply chain challenges were also identified as primary drivers of spending. Delaware's aging population (6th highest median age in the nation[1]) adds to these pressures, as older residents typically require more healthcare services. While the future growth rate of the 65+ population may slow, their healthcare needs will remain substantial and continue to impact overall expenditure trends.

[1] Source: US Census; 2020 Census Demographic and Housing Characteristics File

Affordability emerged as a critical concern, with members advocating for the inclusion of household income growth and affordability metrics in the benchmark to better reflect consumer realities. Other states' methodologies, which incorporate measures of household income, were considered for their potential applicability in Delaware. Michael Bailit, of Bailit Health consulting firm, provided an overview of the eight states that currently have healthcare spending benchmarks, their macroeconomic adjustments, and the policies in four states holding entities accountable.

The significant disparity between national healthcare cost growth projections and Delaware's current benchmark rates underscores potential inadequacies in the State's methodology. This divergence prompted critical discussions within the Subcommittee, emphasizing the need for a more adaptable and representative approach to ensure the benchmark's effectiveness. Brian Frazee, President and CEO of the Delaware Healthcare Association, presented two alternative methodologies for calculating the benchmark. He argued that the current approach is confusing and arbitrary, failing to account for key cost drivers such as Delaware's older and sicker population and pharmacy expenses. The first alternative suggested using national consultants' average projections for healthcare cost growth, while the second proposed maintaining the PGSP structure but replacing its inflation component with the CMS National Healthcare Expenditure growth rate. Both alternatives would result in significantly higher benchmarks than the approved current rate of 4.2% for calendar year 2025.

The Subcommittee looked to the structure of the State's budget benchmark to inform updates to the healthcare spending benchmark methodology. The budget benchmark, which is intended to provide policy makers with an independent and objective economic metric for sustainable budget growth, is comprised of an equally-weighted, three-year average of the growth rates of Delaware total personal income and the sum of Delaware population and inflation as measured by the Implicit Price Deflator for State and Local Government Purchases (S&L Price Deflator). Whereas the S&L Price Deflator measures the average change over time in the prices paid for a market basket of goods and services that reflects the purchases made by state and local governments, this would not be an applicable measure of inflation for the healthcare sector.

DOF proposed the potential use of a customized healthcare PCE price index as a more relevant measure of healthcare inflation. This index would combine price indices compiled by the U.S. Bureau of Economic Analysis (BEA) for pharmaceuticals/medical supplies, physician services, paramedical services, and hospital services, weighted by the share of combined expenditures. DOF discussed the differences between using Delaware total personal income growth and using Delaware median household income growth and highlighted the fact that median household income growth is a substantially more volatile measure. Subcommittee members continued the discussion as to which measure of income is a better determination of wealth. Subcommittee members requested more information before determining which income measure to include in the benchmark. DOF staff also demonstrated that using three- or five-year averages for each component could reduce volatility in the overall benchmark and produced calculations of such a proposed benchmark methodology using data as far back as 1970. This demonstrated that the new proposed methodology was able to dynamically respond to changing economic conditions during different periods and economic cycles. See figure 2 for a comparison of the proposed benchmark methodology and the current methodology for benchmark years 2019 through 2025. However, DOF staff did acknowledge that more research needed to be done with regards to what the healthcare PCE data captures and what adjustments are necessary to make this proposed benchmark methodology a per capita figure.

Benchmark Year	Single Year	3-Year Average	5-Year Average	Current Methodology
2019	3.7%	3.3%	3.0%	3.8%
2020	4.5%	3.6%	3.5%	3.5%
2021	2.7%	3.6%	3.4%	3.25%
2022	3.7%	3.6%	3.4%	3.0%
2023	6.0%	4.1%	4.1%	3.1%
2024	6.3%	5.3%	4.6%	3.0%
2025	4.7%	5.6%	4.7%	4.2%

Figure 2 Benchmark calculations under the proposed methodology compared to the current methodology

Like the original methodology, the proposed methodology fulfills the original intent of the healthcare spending benchmark, which is that healthcare spending growth should not outpace objective measures of growth of the State's economy. What this new methodology does is provide a different view on the economic growth of the State. It uses historical data instead of the long-term forecast of 5-10 years out into the future, which members agreed was a drawback of the current methodology. It also contains a healthcare-specific measure of inflation from an objective source. Growth in Delaware total personal income is incorporated to emphasize consumer affordability as well as ability to pay. As shown in the historical data, this new methodology will be more volatile. This may make it harder for healthcare systems to predict what the benchmark will be for future year planning. On the other hand, it will address the desire of healthcare systems that the benchmark be more responsive to changing economic conditions. Subcommittee members agreed that although additional research is needed, the new proposal effectively integrates the healthcare and macroeconomic trends that were lacking in the original methodology.

Recommendations

At the Subcommittee's December 18 meeting, the members unanimously voted to recommend that DEFAC and the Subcommittee should consider revising the healthcare spending benchmark to be comprised of equal weightings of the 3-year average of all of the following:

a) Delaware personal income growth, and
b) Delaware population growth plus the growth in the price index for relevant healthcare Personal Consumption Expenditures weighted by total expenditures.

The recommendation also states that the Subcommittee should convene in March 2025 for a report from DHSS and DOF staff on

1) how the BEA compiles and publishes healthcare PCE price index data and whether a readily available objective source can produce a one-year forecast and
2) whether and how to address "per capita" growth to ensure that the spending benchmark methodology is aligned with the methodology for how actual spending growth is or will be reported.

Pending satisfaction with such information, the Subcommittee and DEFAC should adopt the revised methodology for the 2026 benchmark and make corresponding adjustments to the 2025 benchmark calculation.

Appendix

DEFAC Healthcare Spending Benchmark Subcommittee Members

Josette Manning, Chair
Secretary, Department of Health and Social Services

Kristin Dwyer, Vice Chair
Delaware State Program Manager - External Affairs, Nemours

Rick Geisenberger
Secretary, Department of Finance

Michael Houghton
DEFAC Chair

Neeraj Batta
Vice President, Batta Environmental

Gary Siegelman
Chief Medical Officer, Bayhealth

David Tam
President and CEO, Beebe Healthcare

Rebecca Ford
Corporate Director - Population Health Finance & Business Planning, ChristianaCare

Additional Materials

Presentations, minutes, and other documents from the DEFAC Healthcare Spending Benchmark Subcommittee meetings: https://dhss.delaware.gov/dhcc/defachcbspcomm.html

House Joint Resolution 7, signed September 7, 2017, directed DHSS to establish a healthcare benchmark: https://legis.delaware.gov/BillDetail?LegislationId=26153

Executive Order 19, signed February 21, 2018, formed the Health Care Delivery and Cost Advisory Group: https://governor.delaware.gov/executive-orders/eo19/

Executive Order 25, signed November 20, 2018, set the initial spending and quality benchmarks: https://governor.delaware.gov/executive-orders/eo25/

House Bill 442 with House Amendment 1, signed August 19, 2022, codified the healthcare spending and quality benchmarks: https://legis.delaware.gov/BillDetail?LegislationId=109583

House Substitute 2 for House Bill 350 with House Amendment 1 and Senate Amendment 1, signed June 13, 2024, directed the Subcommittee to review the spending benchmark methodology: https://legis.delaware.gov/BillDetail?LegislationId=141253