Health Care Spending Benchmark Subcommittee

October 2020

Agenda

1. Approve April 2019 Minutes
2. Review of 2018 Health Care Spending in Delaware
3. Discussion of Near-Term Outlook for Spending
4. Calendar Year 2021 Benchmark Calculation
5. Open Discussion
6. Adoption of Calendar Year 2021 Benchmark
7. Public Comment
8. Adjourn

Review of Executive Order 25

- Results from work of the Health Care Delivery and Cost Advisory Group established by Governor Carney under Executive Order 19
- Set initial spending and quality benchmarks for CY 2019 through CY 2023
- Established the DEFAC Health Care Spending Benchmark Subcommittee
- Tasked the Delaware Health Care Commission with setting the quality benchmarks, reporting on performance relative to both benchmarks, and engaging providers and community partners

Purpose of the Subcommittee

- The Subcommittee sets the benchmark
  - Each year through 2023, review and recommend whether the forecasted PGSP growth rate has changed in such a material way that it warrants a change in the spending benchmark
  - After 2023, Subcommittee must evaluate results of PGSP benchmark and PGSP methodology, and recommend any appropriate changes
- Advise the Governor and DEFAC on current and projected trends in health care and the health care industry, as they affect the expenditures and revenues of the State, its citizens, and industries

Subcommittee Timeline

Continuous

Advise on trends in health care and health care industry

Process was put on hold during spring 2020.

March/April

Annual review of the components of PGSP for the following calendar year

May

Report changes, if any, by May 31 to the Governor and the DHCC

July

Announce spending benchmark for following calendar year by July 1

Per E.O. 25, no later than March 2023, and each March thereafter, the DEFAC Subcommittee is to review the full methodology for defining the spending benchmark.

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Health Care Spending and Quality Benchmarks

History of the Health Care Spending Benchmark

- In November 2018, Governor Carney signed Executive Order (EO) 25, which laid out a vision for improving the transparency and public health awareness of health care spending and quality.
- The spending benchmark, effective January 1, 2019, is a target value for the change from the prior year in Statewide per capita health care spending.
  - The benchmark which is equal to the potential gross state product - is based on the long-term outlook for population change, inflation, labor force. A temporary transitional adjustment factor was added for the first three years.
- EO 25 set the spending benchmarks for CYs 2019 – 2023 as follows:
  - CY 2019: 3.80%
  - CY 2020: 3.50%
  - CY 2021: 3.25%
  - CY 2022: 3.00%
  - CY 2023: 3.00%

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Health Care Quality Benchmarks

- The health care quality benchmarks are divided into two categories:
  - **Health status measures**, which quantify certain population-level characteristics of Delaware residents.
    - *Four measures*: Adult obesity, High school students who were physically active, Opioid-related overdose deaths, and Tobacco Use
  - **Health care measures**, which quantify performance on health care processes or outcomes and are assessed at the State, market, insurer and provider levels.
    - *Four measures*: Opioid-related measure (TBD), Emergency department utilization, Persistence of a beta-blocker treatment after a heart attack, and Statin therapy for patients with cardiovascular disease – statin adherence 80%

Preliminary CY 2018 Benchmark Spending Data

Collection of Preliminary CY 2018 Benchmark Spending Data

- Collecting preliminary CY 2018 benchmark spending data enabled DHCC and insurers to gain experience with the data collection process and identify opportunities for process improvement. Data sources:

Market/Spending Component	Data Source	Data Collected
Medicare	CMS and Insurers	FFS and managed care including drug spending and limited pharmacy rebate data (from Insurers only)
Medicaid	DMMA and Insurers	FFS and managed care including pharmacy rebate data
Commercial	Insurers	Medical/service expenditures including pharmacy rebate data
Veterans Health Administration	VA website	Summarized data from the US Department of Veterans Affairs
Net Cost of Private Health Insurance	Insurer or public reports	Summary-level data on revenues and expenses

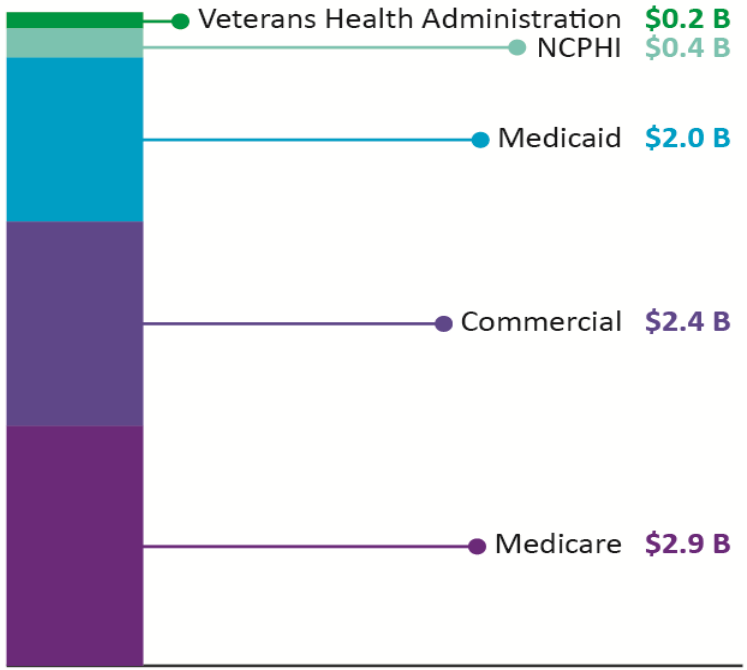
Collection of Preliminary CY 2018 Benchmark Spending Data (cont'd)

- The process was an informative and important exercise for DHCC, insurers and DMMA. Preliminary data may still contain methodological inconsistencies across payers.
- To strengthen future data collection and analysis, DHCC:
  - Revised data collection specifications to improve consistency, for example included code-level definition of primary care spend
  - Re-collected CY 2018 data as part of the CY 2019 data collection process to ensure better year-over-year comparisons
  - Will perform additional analyses, including at the insurer and/or provider level if practical this year.
- Note: Due to methodological differences, these data should not be compared to other sources of Delaware spending. It should also be expected that these data will change once updated CY 2018 data have been analyzed.

Delaware Overall Health Care Spending – CY 2018 Preliminary Data

- Total Health Care Expenditures were approximately $7.8 billion or $8,110 per Delawarean. Values are rounded.
- By market and component:
  - Medicare (FFS and managed care): 36.8% of spending
  - Commercial (fully and self-insured): 31.2% of spending
  - Medicaid (FFS and managed care): 25.1% of spending
  - Net Cost of Private Health Insurance (NCPHI): 4.5% of spending*
  - Veterans Health Administration: 2.5% of spending

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



* Medicare FFS, Medicaid FFS and Veterans Health Administration does not have NCPHI, so expressed as a percentage of THCE, NCPHI is relatively low.

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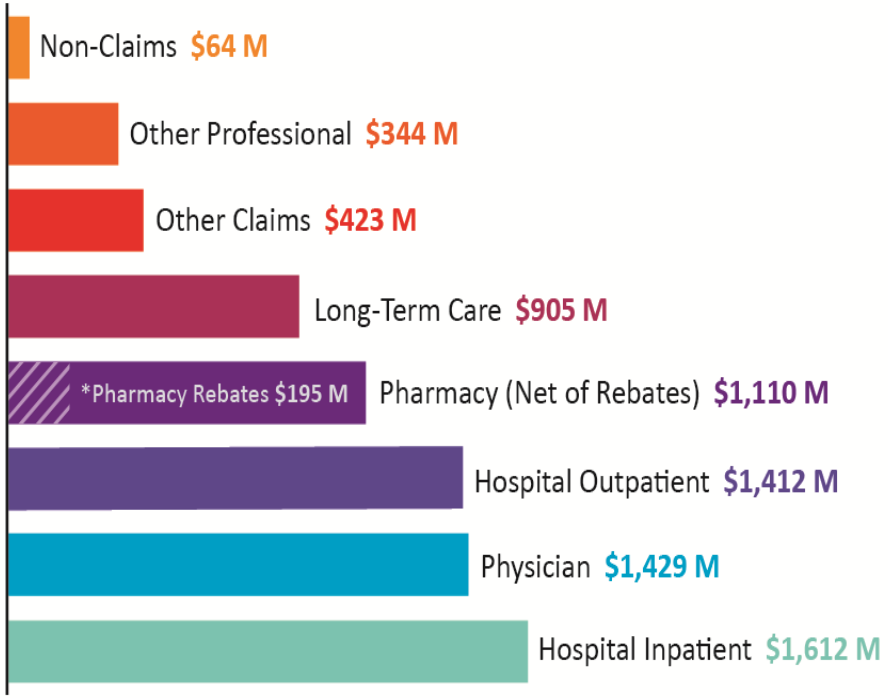
Delaware Spending by Service Category – CY 2018 Preliminary Data

- Total Medical Expense by service category*:
  - Hospital (inpatient and outpatient): 41.4% of spending
  - Physicians (regardless of specialty): 19.6% of spending
  - Pharmacy (net of rebates): 15.2% of spending
- Insurer and Medicaid reported pharmacy rebates were approximately $195 million.
  - Medicare FFS rebates not provided by CMS

Figure 2: Delaware Spending on Medical Services by Service Category



* VA data were not available on a service category basis and are thus excluded. NCPHI is excluded.

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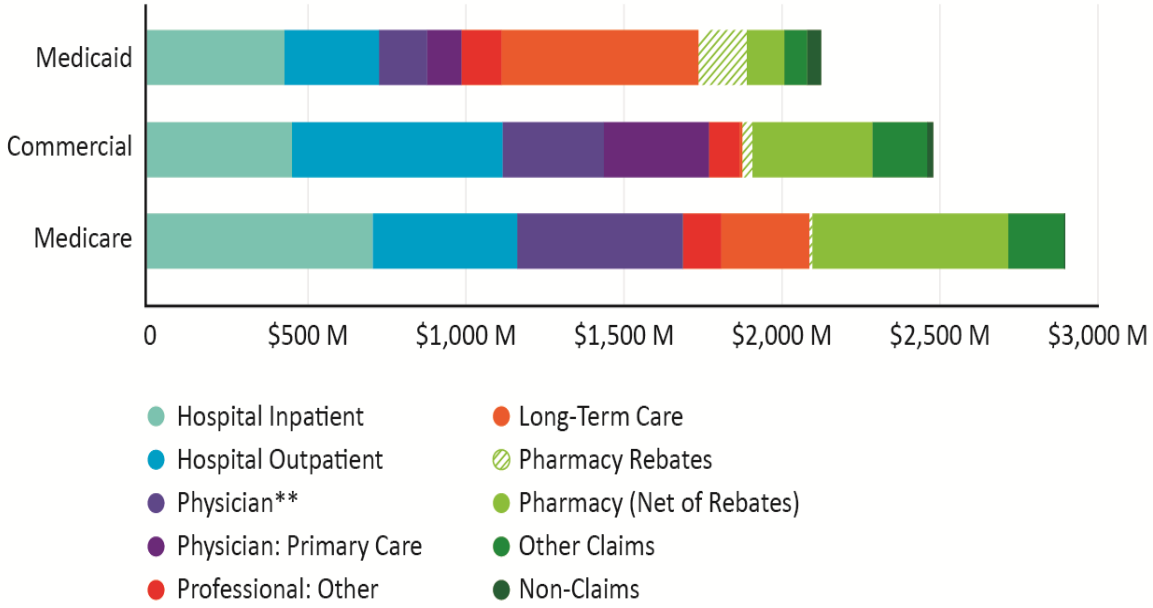
Delaware Spending by Service Category and Market – CY 2018 Preliminary Data

- Hospital spending represented the largest proportion of dollars across market, ranging from 37% - 46% of total spending.
- Population differences across markets impact spending by service category (e.g., more long-term care spending in Medicaid).

Figure 3: Service Category Spending by Market



**For Medicare, "Physician" is inclusive of primary care and specialty care physician spending because CMS did not separately report these two categories of physician spending.

*There are likely methodological differences among insurer reporting that are leading to spending data being under-reported. DHCC updated the TME category definitions to resolve this issue in most recent data submission. NCPHI is excluded.

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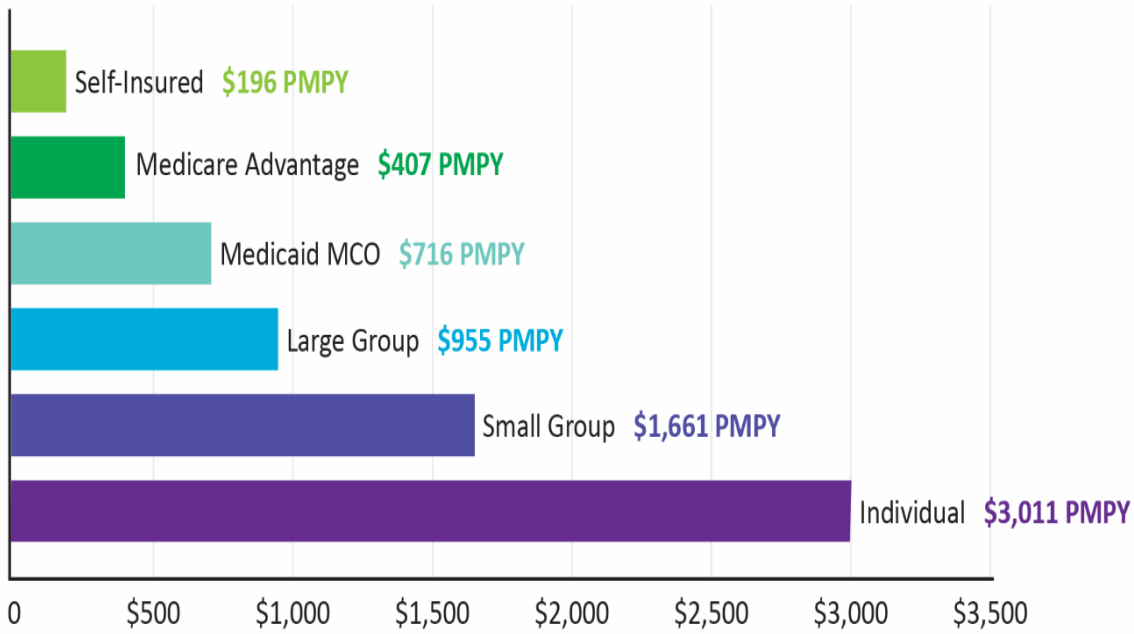
Delaware Spending on the Net Cost of Private Health Insurance (NCPHI)*

- Total NCPHI was approximately $351 million.
- The weighted average per member per year (PMPY) NCPHI amount across markets was $635.
- PMPY differs by market segment, from $3,011 for the commercial individual market to $196 for the self-insured market.

Figure 5: Net Cost of Private Health Insurance



*NCPHI is the cost to DE residents associated with the administration of private health insurance (e.g., insurer overhead, staff salaries, advertising, sales commissions, other administrative costs, premium taxes, profits/losses, etc.). It is the difference between health premiums earned and benefits incurred.

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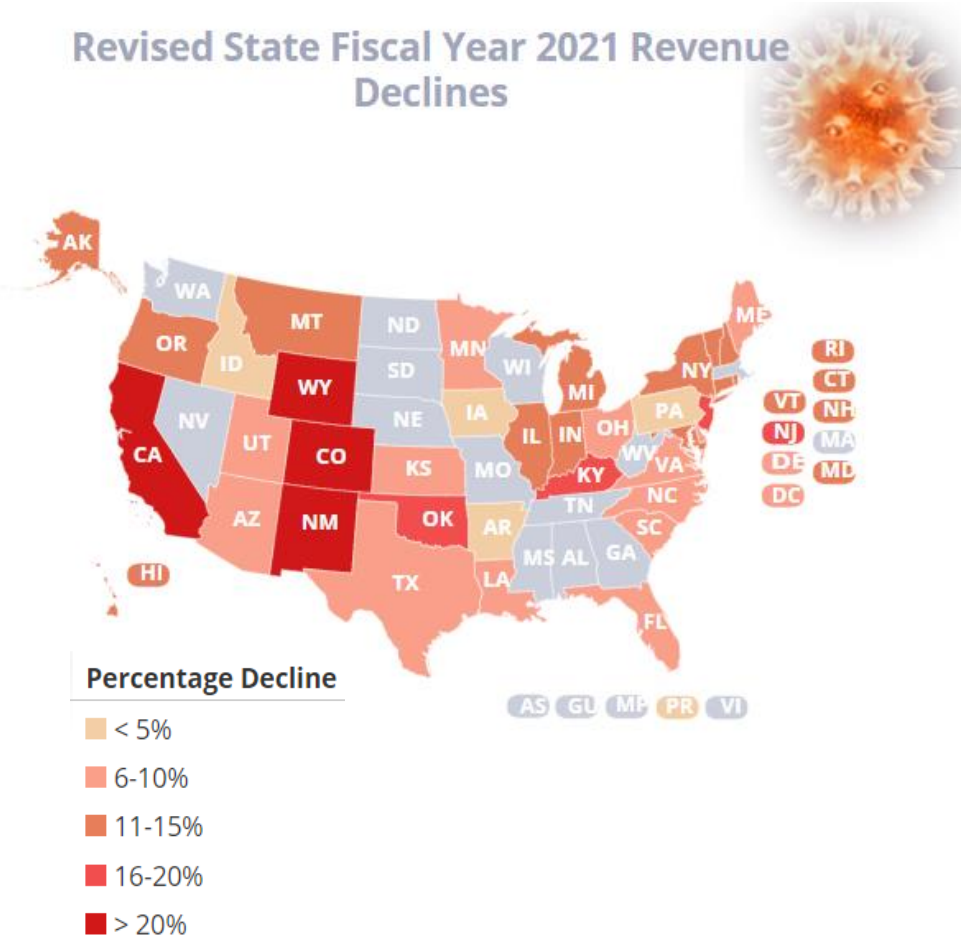
Why the Spending Benchmark is Important, Even During a Pandemic

State Revenues Decline From Pre-COVID Projections

State	% Decline in Revenue Projections to Account For COVID-19 Impact	
	FY 2020	FY 2021
Colorado[1]	5%	20%
Connecticut[2]	2%	13%
Delaware[3]	--	6%
Maryland[4]	5-6%	11-14%
Oregon[5]	--	11%
Pennsylvania[6]	10%	3%
Rhode Island[7]	5%	11%
Vermont[8]	--	11%
Washington[9]	15%	--



Adapted from *National Conference of State Legislatures*, Sep. 2020.[10]

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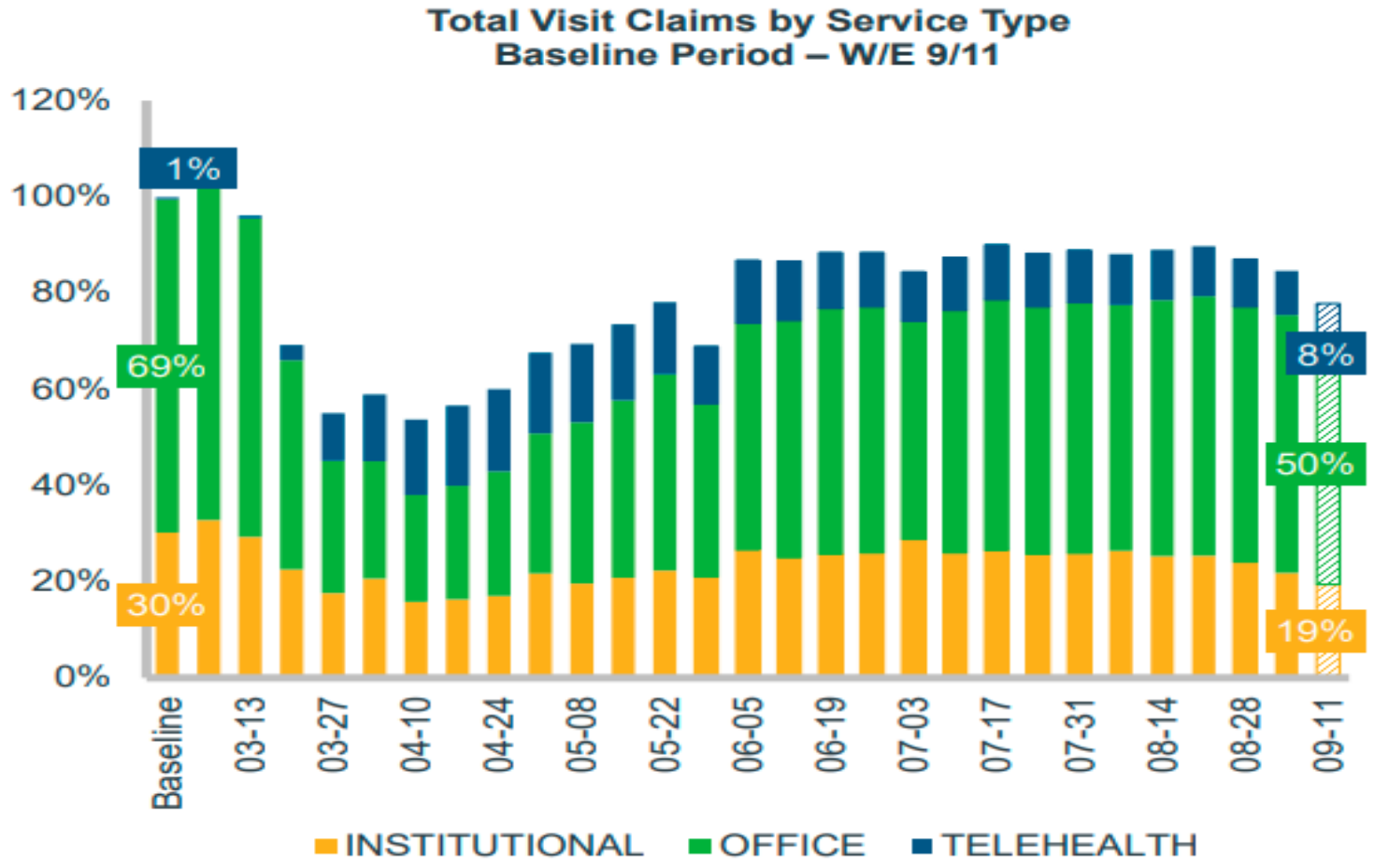
COVID Continues to Impact How and Whether Patients Seek Care



Source: IQVIA: Medical Claims Data Analysis, 2020. Baseline is average claims for period 1/10/2020-2/28/2020

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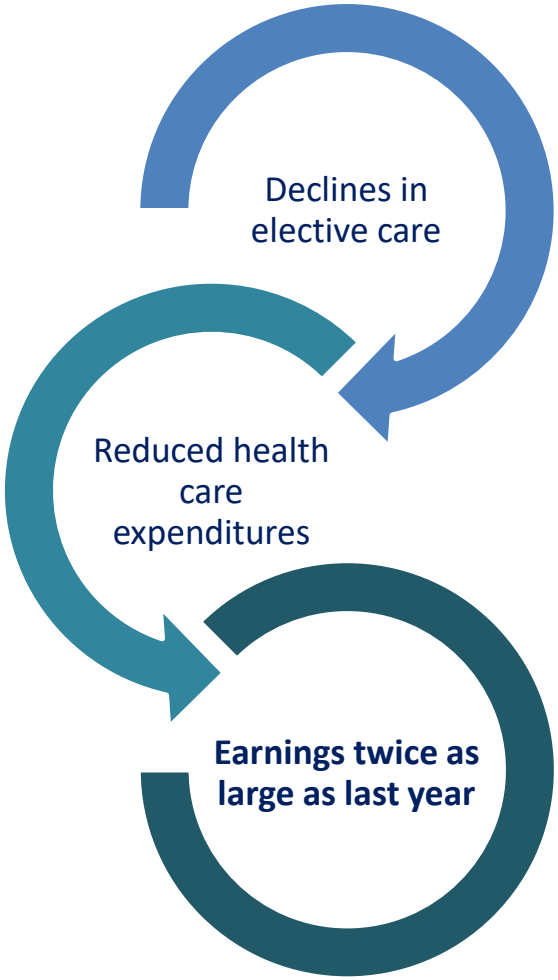
Health Insurers' Increased Earnings



Q2 Net Income		
	2019	2020
United Health Group	$3.4 billion[1]	$6.7 billion[1]
Anthem Inc.	$1.1 billion[1]	$2.3 billion[1]
Humana	$940 million[2]	$1.8 billion[2]

Note: MLR regulations under the ACA require insurers to spend a minimum portion of money collected from premiums (80% for small businesses and individuals; 15% for large employers).[2]

Excess funds must be returned to consumers, but spending reductions from 2020 will not be fully rebated until 2023.[1]

1. Plott et al., *JAMA Forum*, Aug. 2020
2. *The New York Times*, Aug. 2020

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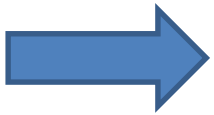
Increased Market Consolidation & Strain on Primary Care Operations Could Lead to Reduced Access

Strain on Primary Care

- Primary care practices are **expected to lose $67,774 in gross revenue per FTE physician** over the course of 2020[1]
- **1 in 5 primary care clinicians** were uncertain about their financial viability 4 weeks out this summer (July 24-27 survey)[2]
- **4 in 5 primary care clinicians** reported practice strain this summer being worse than in March (July 24-27 survey) [2]

Some experts believe that financial strains will lead to **increased market consolidation**[3]



Growing body of research links provider market consolidation with **price increases**[3]

1. Basu et al., *Health Affairs*, June 2020.
2. *Primary Care Collaborative*, July 2020.
3. *Tollen et al., Health Affairs Blog*, Aug. 2020.

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Spending Benchmarks Continue to Keep High and Increasing Costs in Focus

- We won't know for some time what has been the impact of COVID-19 on per capita spending growth. Early evidence is not clear.
- What is clear is that certain providers have been in a financial crisis – particularly primary care providers and rural hospitals. This can lead to market consolidation which can drive prices up.
- Provider market consolidation and insurer profit gain can lead to an overall increase in what state government, employers and consumers pay for health care.
- During economic crises, an increase in health care spending are more problematic than when the economy, wage and income growth are all rising.
- The purpose of a health care spending benchmark is to help constrain health care spending growth by shining a light on it, even during a pandemic.

Other Benchmark States

- Massachusetts has had a spending target set in statute since 2013.
- The oversight agency, the Health Policy Commission, has been given the authority to modify the benchmark from 2018 onward. and annually reviews the benchmark to determine whether it should change.
- In June 2020, the HPC voted to keep the statutorily defined benchmark at 3.1% after discussing the impact of COVID-19 and the likelihood of aberrant spending.
- The HPC intends to report spending against the benchmark along with supplemental analyses of the impact of the pandemic on the state's insurers and providers.
- Massachusetts will not penalize any provider or insurer for exceeding the benchmark due to COVID-19, or other legitimate reasons.
- Rhode Island intends on doing the same.

Assessing Performance Against the Spending Benchmark

Total Health Care Expenditures

- To assess the changes in the amount of health care spending, the Delaware Health Care Commission (DHCC) annually calculates the per capita Total Health Care Expenditures (THCE).

Methodology

THCE (in aggregate) =

Commercial TME + Medicare Advantage TME + Medicare FFS TME + Medicaid/CHIP MCO TME + DMMA FFS TME + VA TME + Insurer NCPHI

TME = Total Medical Expense incurred by Delaware residents for all health care benefits/services by all payers reporting to DHCC; reported net of pharmacy rebates at the state, market and payer level, but not at the provider level

FFS = Fee-for-service

DMMA = Delaware Division of Medicaid & Medical Assistance

NCPHI = Net Cost of Private Health Insurance measures the cost to Delaware residents associated with the administration of private health insurance; defined as the difference between health premiums earned and benefits incurred

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Methodology

THCE (per capita) =

$$\frac{\left(\begin{array}{c}\text{Commercial TME + Medicare Advantage TME +} \\ \text{Medicare FFS TME + Medicaid/CHIP MCO TME +} \\ \text{DMMA FFS TME + VA TME + Insurer NCPHI}\end{array}\right)}{\text{Delaware Population}}$$

The percentage change in the THCE per capita between the measurement CY and the prior CY will be used to assess performance against the Spending Benchmark, applicable to the respective measurement CY.

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Timeline for Measuring and Reporting

- DHCC will publish THCE statistics in the 1st quarter of calendar year following the respective reporting/data year – i.e. CY 2019 performance will be reported in the 1st quarter of CY 2021.
- CY 2018 THCE data has been collected to serve as the initial baseline comparison for CY 2019 results.

THCE Methodology Updates and Next Steps

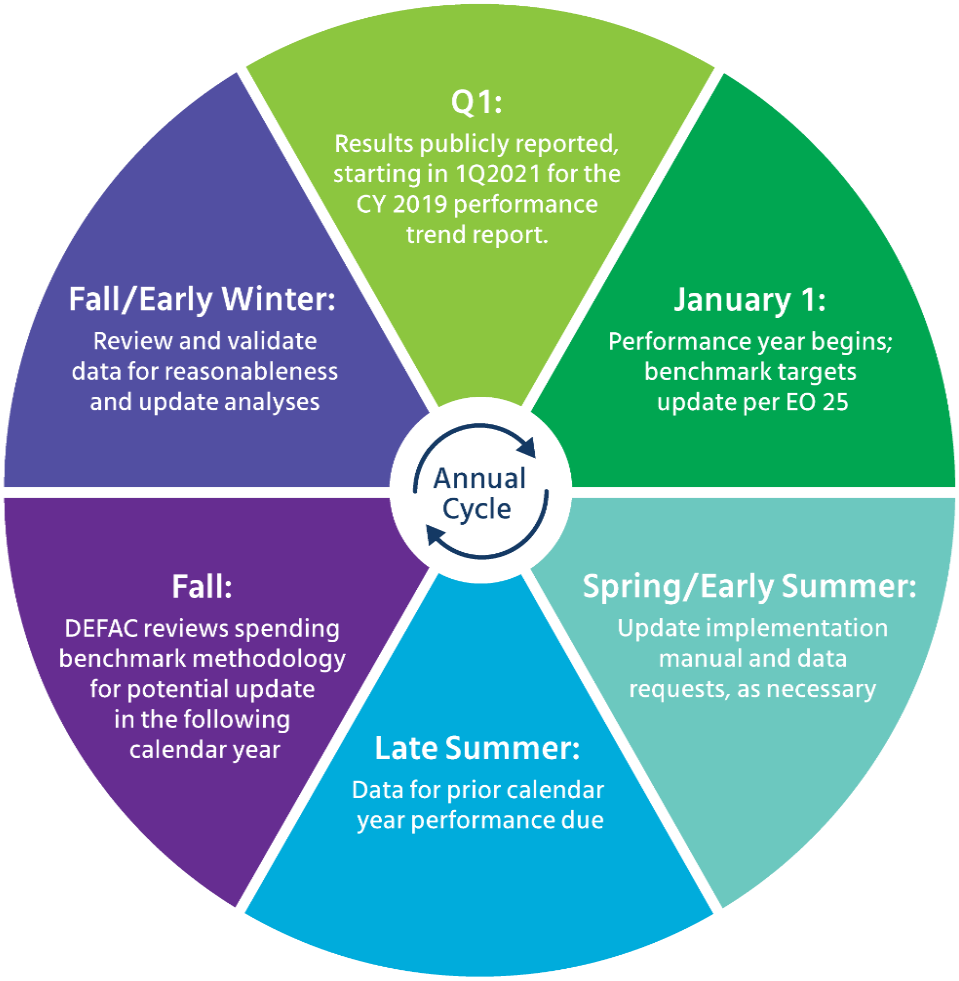
Summary of Changes of Data Specifications

- There were a few minor updates to the methodology for reporting THCE data to clarify and specify the data request and to allow for a finer detailed amount of data to be collected. The changes included:
  - Further specifying what services and providers are considered "primary care" by using a code-level definition
  - Further specifying what non-claims spending is considered "primary care", including primary care capitation payments, care management payments and incentive payments.
  - Improving the specificity with which Medicare and Medicaid dually eligible spending data are reported so the population can be analyzed separately.

- There were no updates to the methodology for calculating the benchmark – PGSP.

Next Steps

- DHCC is still collecting CY 2018 and CY 2019 data and performing data validation.
- In the coming weeks, DHCC will be reaching out to insurers to discuss the validation process and address any potential data inaccuracies.
- The CY 2019 report on the spending and quality benchmarks is targeted for release in Q1 2021.



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Potential Gross State Product (PGSP) Growth

PGSP Methodology

- The sum of:
  - the expected growth in national labor force productivity
  - plus the expected growth in Delaware's civilian labor force
  - plus the expected national inflation
- Minus Delaware's expected population growth
- Plus 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

PGSP Source and Forecast

as set by E.O. 25

Components	Data Source	Forecast	CY 19*	CY 20	CY 21	CY 22	CY 23
Expected growth in national labor force productivity	Congressional Budget Office *Budget and Economic Outlook Report*	Utilize forecasts that project growth for 5 through 10 years in the future		1.4%	1.4%	1.4%	1.4%
+ Expected growth in Delaware's civilian labor force	Delaware Population Consortium Population *Projections by Single Year, Age, Race and Sex*	Calculate growth by averaging the forecasted increase of Years 5 through 10 in the future		0.1%	0.1%	0.1%	0.1%
+ Expected national inflation	Congressional Budget Office *Budget and Economic Outlook Report*	Utilize the personal consumption expenditure growth for 5 through 10 years in the future		2.0%	2.0%	2.0%	2.0%
= Nominal PGSP growth				**3.5%**	**3.5%**	**3.5%**	**3.5%**
– Expected population growth in Delaware	Delaware Population Consortium Population *Projections by Single Year, Age, Race and Sex*	Calculate growth by averaging the forecasted increase of Years 5 through 10 in the future		0.5%	0.5%	0.5%	0.5%
= PGSP growth				**3.0%**	**3.0%**	**3.0%**	**3.0%**
+ Transitional market adjustment				0.5%	0.25%	0.0%	0.0%
= Spending Benchmark as set by E.O. 25			**3.8%**	**3.5%**	**3.25%**	**3.0%**	**3.0%**

* Set at Fiscal Year 2020 Budget Benchmark as of December 2018 (3.8%)

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Expected Growth in National Labor Force Productivity

Projected Average Annual Growth

Data Release	5-10 Years in the Future CY 2025-2030
August 2018	1.4
January 2020	1.4
Change	*0.0*

Source: Congressional Budget Office, Budget and Economic Outlook Report

Expected Growth in Delaware's Civilian Labor Force

Projected Average Annual Growth

Data Release	5-10 Years in the Future CY 2025-2030
October 2017	0.1
October 2019	0.1
Change	*0.0*

Source: Delaware Population Consortium, Population Projections by Single Year, Age, Race and Sex

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Expected National Inflation

PCE Price Index

Projected Average Annual Growth

Data Release	5-10 Years in the Future CY 2025-2030
August 2018	2.0
January 2020	1.9
July 2020	1.9
Change	*-0.1*

Source: Congressional Budget Office, Budget and Economic Outlook Report

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Expected Population Growth in Delaware

Projected Average Annual Growth

Data Release	5-10 Years in the Future CY 2025-2030
October 2017	0.5
October 2019	0.4
Change	*-0.1*

Source: Delaware Population Consortium, Population Projections by Single Year, Age, Race and Sex

Health Care Spending Benchmark
CY 2021

Components	CY 2021 as set by E.O. 25	CY 2021 based on most recent data	Change
Expected growth in national labor force productivity	1.4%	1.4%	-
+ Expected growth in Delaware's civilian labor force	0.1%	0.1%	-
+ Expected national inflation	2.0%	1.9%	-0.1%
= Nominal PGSP growth	**3.5%**	**3.4%**	**-0.1%**
– Expected population growth in Delaware	0.5%	0.4%	-0.1%
= PGSP growth	**3.0%**	**3.0%**	**-**
+ Transitional market adjustment	0.25%	0.25%	-
= Spending Benchmark	**3.25%**	**3.25%**	**-**

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Wrap Up

- Subcommittee Discussion
- Adoption of Calendar Year 2021 Benchmark
- Public Comment
- Adjourn

Adoption of CY 2021 Benchmark

- Subcommittee to vote on recommendation to DEFAC for DEFAC's approval as to whether the forecasted PGSP growth rate has changed in such a material way that it warrants a change in the spending benchmark

Recommendation on Changing the Benchmark

- Delaware should not change its 2021 benchmark in light of COVID-19 for three key reasons:
  1. The PGSP methodology was designed to forecast economic growth of the future (5-10 years) and forecasted measures of the economy are designed to be stable. Despite the economic consequences of COVID-19, the long-term forecasts for the state's economic growth has not changed.
  2. There are no provider or insurer consequences for exceeding the benchmark.
  3. Insurers have already negotiated contracts with providers for CY 2021 and any change in the benchmark would largely be symbolic.

Public Comment

THANK YOU!

For more information about the health care spending benchmark:
https://dhss.delaware.gov/dhcc/global.html

DHCC@delaware.gov

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