



# DELAWARE HEALTH AND SOCIAL SERVICES

Office of the Secretary

## A Note to Delaware's Health Care Stakeholders



The State of Delaware is continuing along our "Road to Value" for our entire health care system. While we are still addressing the health care, humanitarian and fiscal crisis created by COVID-19, our essential purpose in driving change to make health care better for all Delawareans through our "Road to Value" remains vitally important. We need to support our health care system to rebound from the global pandemic with value-based goals so it can be stronger going forward. Now, more than ever, our vision to improve transparency and public awareness of spending and quality in our State through the adoption of spending and quality benchmarks will assist in these efforts.

In 2018, the Department of Health and Social Services, the Delaware Health Care Commission and the Delaware Economic and Financial Advisory Council worked together to establish the spending and quality benchmarks. I want to personally thank the insurers that reported initial calendar year 2018 baseline data during 2019, giving them and the Department experience in collecting and reporting data, which is essential to the benchmarks and improving the process moving forward.

The enclosed baseline spending briefing document provides a preliminary snapshot of the experience in health care spending that occurred in our State based on the data reported so far. Even with this preliminary baseline data, this document represents a key step forward in our transparency efforts. We all look forward to learning what the benchmarks will tell us about the trend in spending on health care in our State and to adding to our knowledge about health care quality as we continue to collect additional data over the next several years.

Working together, we can support the goal of making sure Delawareans can access and afford quality health care. The benchmarks are a means to continue the conversation about how to improve cost and quality for the individuals we serve as patients and members in our communities.

Sincerely,

**Kara Odom Walker, MD, MPH, MSHS**  
*Cabinet Secretary*

# Delaware Health Care Spending Benchmark

## Results of Preliminary Calendar Year 2018 Baseline Spending Analysis

June 4, 2020

### Introduction

In November 2018, Governor John Carney signed Executive Order 25, which laid out a vision for improving the transparency and public awareness of health care spending and quality in Delaware through the adoption of spending and quality benchmarks. The benchmarks were effective January 1, 2019. In order to calculate performance against the 2019 spending benchmark, the Delaware Health Care Commission (DHCC) collected initial calendar year (CY) 2018 data. The data herein represent the findings regarding CY 2018 health care spending on behalf of Delaware residents.

While DHCC collected data at the State, market (i.e., Medicare, Medicaid<sup>1</sup>, commercial), insurer and provider level, this preliminary CY 2018 spending data analysis presents that data at the State and market levels only. In future years, when more years' worth of data are available, further analyses and reporting will be performed, including at the insurer and/or provider level if practical.

In addition, as these data are collected for the first time, DHCC anticipates there may be some methodological inconsistencies in data submission across payers. DHCC will seek to correct those inconsistencies with strengthened specifications and will recollect CY 2018 data using updated specifications. It is expected that the CY 2018 spending totals will change because of the forthcoming revised specifications. Therefore, the information presented in this preliminary briefing document is not the definitive outlook on the overall spending in the Delaware health care

Note: Until CY 2019 data are collected, there is no appropriate comparator for these data. Other publicly available per-capita estimates or total spending calculations for Delaware were not performed using the same methodology, and therefore, are not comparable. In subsequent years after more data are collected using the same methodology, DHCC will have a better understanding of the trend in spending over time, which is what the spending benchmark is seeking to measure.

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<sup>1</sup> Unless otherwise specified, within this context references to "Medicaid" include Delaware's Title XXI CHIP program.

system. DHCC intends to include the updated CY 2018 baseline data in the first annual benchmark trend report to be released early next year. At that time, performance against the quality benchmarks will also be released.

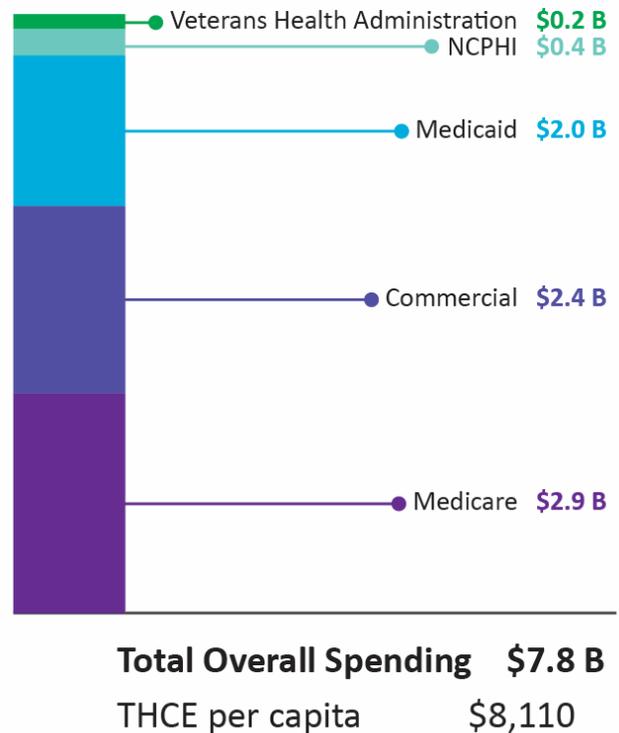
## Delaware Overall Health Care Spending

Based on all the preliminary data collected, Delaware’s Total Health Care Expenditure (THCE) in CY 2018 was approximately \$7.8 billion or an average of \$8,110 per Delawarean<sup>2</sup> as shown in Figure 1<sup>3</sup>.

THCE is a measurement of payer-reported spending on behalf of Delaware residents for all health care services, including non-claims-based payments made to providers (e.g., performance incentives, care management). THCE is reported net of payer-reported pharmacy rebates and spending is not adjusted for the health status of the population.

- The Medicare market (inclusive of fee-for-service and managed care) represents 36.8% of spending in the State, the largest proportion of all markets.<sup>4</sup>
- Commercial market (inclusive of fully and self-insured spending) represents 31.2% of all spending.
- Medicaid market (inclusive of fee-for-service and managed care) represents 25.1% of all spending.
- Veterans Health Administration expenditures represents 2.5% of all spending.

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



<sup>2</sup> CMS has previously reported per capita spending in Delaware to be \$10,254 (2014) using data from the National Health Expenditure projections, which is an estimate of spending using non-payer submitted data. Delaware collected data directly from payers using a different methodology than CMS. Therefore, this baseline spending estimate should only be compared to benchmark spending data collected in future years using the same methodology. It is incorrect to conclude that Delaware reduced spending from 2014 to 2018 using CMS data as a comparator due to differences in data sources and methodologies.

<sup>3</sup> Total reported spending was \$7,844,213,453. Values in Figure 1 are rounded.

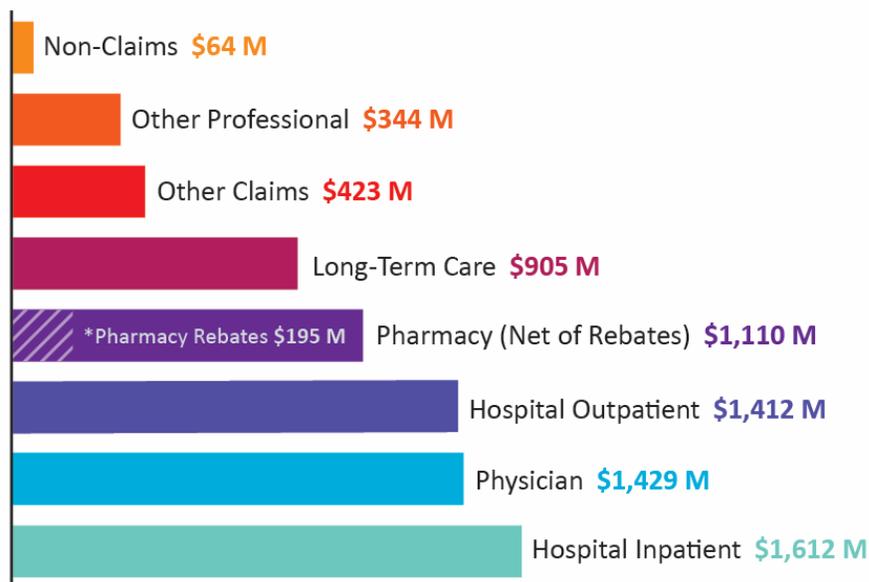
<sup>4</sup> UnitedHealthcare declined the State’s request that it submit data on its Medicare Advantage population, which represents 20% of the Medicare Advantage market. Therefore, all Medicare market and Medicare Advantage data in this briefing document are understated.

THCE also includes the Net Cost of Private Health Insurance (NCPHI), which measures the cost of administering private insurance (inclusive of Medicare managed care and Medicaid managed care) and represents 4.5% of spending in Delaware<sup>5</sup>.

## Delaware Total Medical Expense (TME) by Service Category

Payers reported claims-based and non-claims-based payments by thirteen service categories<sup>6</sup> using general definitions provided in DHCC’s Benchmark Implementation Manual. As shown below in Figure 2, hospital spending (inpatient and outpatient) represented 41.4% of all reported spending in CY 2018. Spending on professional claims to physicians (regardless of specialty) represented 19.6% and pharmacy, net of rebates, represented 15.2% of all spending in Delaware. Private payers and the Division of Medicaid and Medical Assistance (DMMA) received a total of approximately \$195 million in rebates for Delaware business from pharmaceutical manufacturers. The Centers for Medicare & Medicaid Services (CMS) did not report the value of its Medicare fee-for-service pharmaceutical rebates. Data from the Veterans Health Administration was not available on a service category basis and is thus excluded from Figure 2 and Figure 3. TME excludes NCPHI.

**Figure 2: Delaware Spending on Medical Services**  
by Service Category

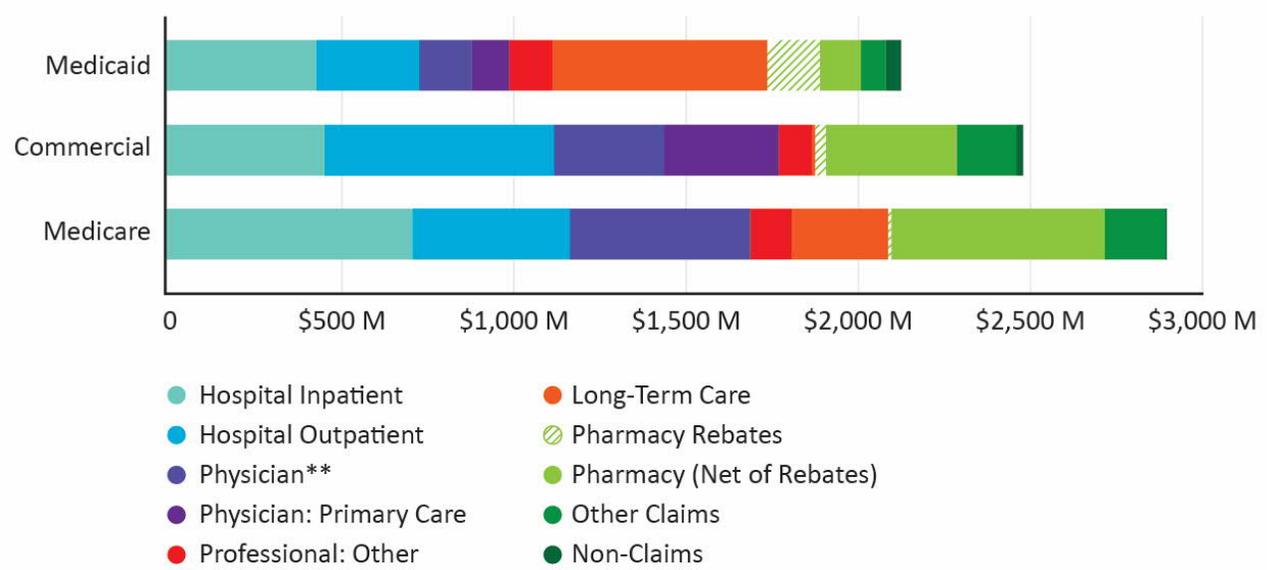


<sup>5</sup> NCPHI is not applicable to Medicare fee-for-service, Medicaid fee-for-service or Veterans Health Administration, which is why as a percentage of THCE, NCPHI is relatively low.

<sup>6</sup> (1) hospital inpatient; (2) hospital outpatient; (3) physician: primary care; (4) physician: specialty care; (5) professional: other; (6) long-term care; (7) pharmacy; (8) other claims; (9) non-claims: incentive programs; (10) non-claims: capitation and risk settlement; (11) non-claims: care management; (12) non-claims: recovery; (13) non-claims: other. Values in Figures 2 and 3 are rounded.

The mix of service category spending differed by market. Across each of the three markets, hospital spending (inclusive of inpatient and outpatient) represented the largest proportion of dollars, ranging between approximately 37% and 46% of total market spending. As noted previously, there are likely methodological differences among insurer reporting that are leading to some spending data being under-reported. With updated data specifications, this will likely be resolved in subsequent data submissions.

**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.

In Figure 4 below, DHCC measured the percent of total claims and non-claims spending (net of rebates) reported for primary care physicians vs. non-primary-care physicians in the Medicaid and commercial markets.<sup>7</sup>

**Figure 4: Percent of TME by Physician Category by Market**

Physician Category	Medicaid Market <sup>8</sup>	Commercial Market
Primary Care	5.5%	13.5%
Non-Primary Care	7.7%	13.1%

<sup>7</sup> CMS did not report primary care physicians as a subcategory of Medicare fee-for-service physician spending.

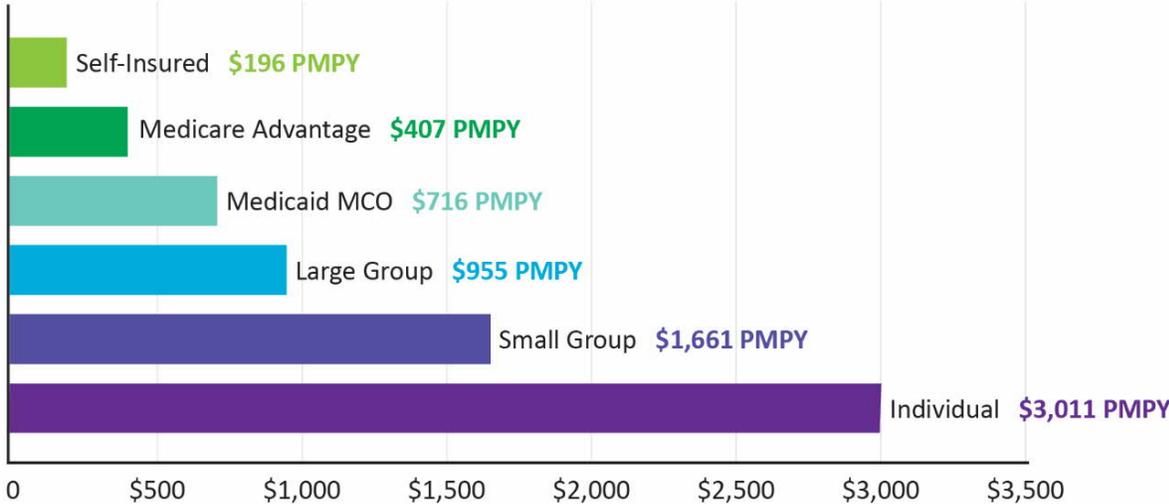
<sup>8</sup> The Medicaid Market has significant spending on Long-Term Care services that makes comparisons to the Commercial Market difficult.

Given research-based estimates of spending on primary care physicians in commercially insured populations are around 8%, DHCC will be clarifying the Implementation Manual for future reporting periods to help improve insurer consistency in reporting of primary care professional spending.<sup>9</sup> It is possible that these percentages are not comparable to research estimates since each data contributor interpreted the data reporting instructions differently and may have included different types of spending in the physician service categories or defined primary care physician differently. DHCC is intending to use a code-level service definition for “Primary Care” via collaboration with the Department of Insurance and Freedman in future benchmark data submissions to improve consistencies across payers.

### Delaware Spending on the Net Cost of Private Health Insurance

The Net Cost of Private Health Insurance (NCPHI) measures the costs to Delaware residents associated with the administration of private health insurance as shown below in Figure 5. 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 losses.

**Figure 5:** Net Cost of Private Health Insurance



The figure above depicts the average per member per year (PMPY) NCPHI by market segment. The PMPY average ranges by market segment from \$3,011 for the commercial individual market to \$196 for the self-insured market with an overall weighted average of \$635. The

<sup>9</sup> Reiff, J and Biniek J. “Primary care spending in the commercially insured population.” Health Care Cost Institute. [https://healthcostinstitute.org/images/pdfs/Academy\\_Health\\_Poster\\_05102019.pdf](https://healthcostinstitute.org/images/pdfs/Academy_Health_Poster_05102019.pdf)

average was computed within each market segment by payer that had complete data using publicly available financial reporting forms. Due to data limitations, estimations were made for payers that did not fully report information on publicly available financial reporting forms. Further, the overall costs of NCPHI, which are calculated to be approximately \$351 million, represent the total estimate for members of reporting insurers, and not for all insurers in the State. For more information on the methodology of NCPHI, please see Appendix A.

## Next Steps

This initial CY 2018 baseline data collection served as an important step in the State's implementation of the spending benchmark. It also provided insurers and DHCC an opportunity to test its data specification methodology and identify areas in which it could improve or clarify the specifications. It is the first step in the annual cycle to review the benchmark, collect data, analyze data and publish performance.



In the coming weeks, DHCC will also issue a data filing request and announcement of webinars to support insurers as they prepare for this year's data collection process. At that time, DHCC will publish an updated Benchmark Implementation Manual. As part of the next round of benchmark data collection, insurers will be asked to resubmit CY 2018 data incorporating any methodological updates to ensure better year-over-year trend comparisons. Therefore, in some manner, the DHCC expects the next set of CY 2018 data will differ from this initial set. Delaware health care system performance against the CY 2019 spending benchmark (i.e., 3.8% growth) will be released early next year.

## Glossary of Key Terms

For a complete list of key terms, please see the [Delaware Health Care Spending and Quality Benchmarks Implementation Manual](#).

- 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. NCPHI is reported as a component of THCE at the State, market and insurer levels. NCPHI will not be reported at the provider level.
- Total Health Care Expenditures (THCE): The total medical expense incurred by Delaware residents for all health care benefits/services by all payers reporting to the DHCC plus insurers' NCPHI.
- Total Health Care Expenditures Per Capita: Total health care expenditures (as defined above) divided by Delaware's total state population. The annual change in THCE per capita is compared to the Spending Benchmark at the State, market and insurer levels. THCE will not be reported at the large provider level.<sup>10</sup>
- Total Medical Expense (TME): The total medical expense incurred by Delaware residents for all health care benefits/services by all payers reporting to the DHCC. Payers report TME by insurance category code (e.g., Commercial – Full Claims, Medicare & Medicare Managed care, etc.) and at the provider level whenever possible. TME is reported net of pharmacy rebates. TME excludes Medigap members and claims. TME also excludes NCPHI.

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<sup>10</sup> NCPHI, a component of THCE, is not reportable at the large provider level; therefore, THCE is not reported at the large provider level.

## Appendix A. Methodology

DHCC collected data from Aetna, AmeriHealth Caritas, Cigna, Highmark Blue Cross Blue Shield Delaware, UnitedHealthcare, CMS, DMMA and the Veterans Health Administration using the specifications outlined in the June 6, 2019 [Delaware Health Spending and Quality Benchmarks Implementation Manual](#) (version 1.2).

DHCC validated the data using a two-part methodology that consisted of (1) a basic data check to ensure all expected data were submitted and there were no obvious errors, and (2) a more robust validation to ensure that the data reported were reasonable, and therefore, likely accurate. This analysis involved comparison of total medical expense data received to external data sources, including to insurer commercial filings for rate review, DMMA financial reports and CMS statistics. These data checks were intended to provide a reasonable level of confidence in the data, but did not constitute an audit of the data. In some cases, external data sources were limited and hence DHCC relied upon the attestation that data submitters included in their submission as a basis for the reasonableness of the data provided. As a result of the checks performed, a number of issues with insurer-submitted data were identified and resolved with insurers. If material deficiencies are subsequently found in this data, revisions will be required.

The methodology for calculating THCE and TME are exactly as written in version 1.2 of the Implementation Manual. The methodology for the NCPHI varied slightly in that DHCC had to perform estimations of the PMPM NCPHI for certain market segments when insurers did not report the market segment using the standard financial forms identified as the source. Further, DHCC did not separately calculate NCPHI for Medicare Advantage insurers that offer both a stand-alone prescription drug plan and the Medicare Advantage plans with Part D inclusion.