Minutes of the
Delaware Economic & Financial Advisory Council
Health Care Spending Benchmark Subcommittee

WebEx Event – June 10, 2022

Attendance:

Member	Present
N. Batta	No
C. Bo	Yes
K. Dwyer	Yes
R. Geisenberger	Yes
M. Jack	Yes
M. Magarik	Yes
A. Sen	No
G. Siegelman	No
Z. Zhang	Yes

Members in Attendance: 6
Members Absent: 3

Others Present: A. Aka, S. Constantino, N. Freedman, F. Gibison, J. Haynes, M. Marlin, E. Massa, D. McGonegal, M. Poland, D. Roose, J. Villecco

Opening Business: Ms. Magarik called the meeting to order at 1:05 pm.

The minutes from the April 1, 2021 meeting were approved and submitted.

Discussion of 2020 Health Care Expenditures and Performance to Benchmark:

Ms. Magarik gave a summary of the trendline report released by the Delaware Health Care Commission (DHCC). The discussion started with a review of money received as a result of the COVID-19 pandemic from the federal American Rescue Plan Act and the state Health Care Relief Fund. These COVID-19 funds are not included in the spending totals contained in the benchmark trend report. Based on data from calendar year 2020, total health care expenditures (THCE) per capita declined by 1.2%. The benchmark for calendar year 2020 was set at 3.5%.

THCE, totaling $8.1 billion, is made up of commercial, Medcaid, Medicare, Veterans Health Administration, and net cost of private health insurance. Overall, there were no significant changes to the distribution of components. Given some of the hospitalizations

and other trends that occurred in 2020 due to the pandemic, Medicare lost a bit and the net cost of private health insurance increased a bit.

Total medical expenses (TME) is spending on medical care and services reported by the payers. It excludes Veterans Health Administration data as well as insurers' administrative, operating and gains/losses. Hospital inpatient and outpatient continue to be the largest drivers of health care expenses, followed by physicians, other professional services, pharmacy, long term care, other and non-claims. There is not much redistribution between these categories from year to year, except for an increase in pharmacy benefits net of rebates.

Mr. Geisenberger asked if there are expectations for hospital outpatient and inpatient to increase in 2021 to make up for missed services in 2020. Ms. Bo responded that she expects pediatric care to jump up because of delayed care but to then steady out again. They are already seeing specialties that had delayed care leveling out to 2019 volumes after increasing in 2021. Ms. Magarik remarked that the Department of Health and Social Services has heard that the acuity is much higher; volumes are returning and adult health systems are seeing people who are sicker due to delayed care. Ms. Jack concurred. She also noted that behavioral health care and support needs are increasing.

Calendar Year 2023 Benchmark Calculation:

Ms. Marlin reviewed the Potential Gross State Product methodology used to determine the health care spending benchmark. Executive Order 25 set the calendar year 2023 benchmark at 3.0%. Based on the May 2022 Congressional Budget Office's Budget and Economic Outlook Report and the Delaware Population Consortium's 2021 Annual Report, the calendar year 2023 health care spending benchmark is calculated as 3.1%. The only change was a ten basis point increase in expected growth in Delaware's civilian labor force from 0.1% to 0.2%.

Ms. Marlin reminded the subcommittee that all of the components of the benchmark are forecasts for five to ten years out into the future to ensure a stable benchmark that avoids the volatility of year to year growth rates. This is most evident when reviewing the Personal Consumption Expenditure (PCE) rate. Annual PCE was as high as 5.5% in 2021 and as low as 0.3% in 2015, but the Congressional Budget Office maintains a long-term outlook of 2%. The Congressional Budget Office expects conditions in the labor and product markets to relieve upward pressure on prices, keeping inflation close to its projected long-run average. PCE is a preferred measure of inflation used by the Federal Reserve.

Delaware's civilian labor force is now expected to grow at 0.2% in the long run as opposed to 0.1% when Executive Order 25 was signed in 2018. This is not a very large increase, and it's the result of demographic changes over time. If the Delaware Population Consortium's estimates don't change drastically from their 2021 report, the long-term forecast will be 0.3% in two years.

Ms. Magarik asked for public comment on the calendar 2023 benchmark, and there was none. Next, she opened up the floor for discussion from the subcommittee members to determine whether they wanted to recommend the benchmark at 3.0% as presented in Executive Order 25 or whether they wanted to adopt the updated 3.1% benchmark. Mr. Geisenberger noted that a 10 basis point increase pay or may not be material on its own, but that over the past two years the updated benchmark calculations have been higher than the benchmarks set in the executive order. In light of what's going on with inflation, he is inclined to recognize the higher benchmark. He believes that recommending the higher benchmark based on latest data sends a signal that the subcommittee is willing to use this provision of the health care benchmark to recognize market pressures. Ms. Bo is also comfortable with recommending the benchmark of 3.1% in light of inflationary pressures and labor workforce changes. Although the increase isn't significant, she believes is shows flexibility in the subcommittee.

Ms. Dwyer inquired whether the benchmark is too low compared to pre-pandemic expenditures and if it is not too low, what are health care systems doing to bring spending more in line with the benchmark. Ms. Magarik expressed that the goal of the benchmark is to set a target for health care inflation that supports economic growth and doesn't create a crowding out effect. It is a target, not a cap. Mr. Gibison, from Mercer, agreed that if actual spending results are more or less than the benchmark, it doesn't necessarily mean the benchmark should change. The benchmark is a target for reasonable and appropriate levels of health care spending changes from year to year.

Ms. Jack expressed that this is very difficult in the face of a pandemic. She pointed out the workforce and supply chain issues facing the health care systems has made saving and being more efficient difficult. She agrees the benchmark should be higher than the 3.0% set in the executive order in light of the challenges the health care system is having in trying to keep costs down right now.

Dr. Zhang inquired as to whether the increase in the expected civilian labor force participation rate was due to the pandemic. Mr. Roose responded that it is not since this measure is a forecast for five to ten years out and the pandemic isn't broadly affecting the demographic factors that drive labor force. This component increased because of changing expectations for the demographic mix of the population. There are shifts in ethnic shares in the population that are resulting in stronger population, and thus labor force, growth. The 2020 census results were stronger than the population growth estimates immediately preceding the census.

Mr. Geisenberger motioned to recommend 3.1% as the calendar year 2023 health care spending benchmark. The motion was seconded by Ms. Dwyer. The motion passed unanimously.

2023 Review of Benchmark Methodology:

Ms. Magarik reminded the subcommittee that, based on Executive Order 25, it is their prerogative to look at the underlying components and make changes to the methodology.

Recommendations need to be made to the Delaware Economic and Financial Advisory Council before March 2023. In addition to today's discussion, Ms. Magarik asked subcommittee members to send any additional questions to be researched to Ms. Marlin by June 30. Ms. Marlin presented a few potential issues for the subcommittee to consider before they meet again to review the methodology.

Ms. Bo is interested to see what other states are doing, especially what economic indicators they are using. Dr. Zhang is interested in the different measures of inflation.

Mr. Geisenberger is interested in the subcommittee's thoughts on whether 5 to 10 years is the best range for each component and how much they value tight stability in the benchmark. He noted that the State's budget benchmark includes different measures of state growth, and the components are averaged over the past, current and next year. This has resulted in a wider, more volatile range of budget benchmarks. The subcommittee should decide how responsive they want the benchmark to be to immediate term issues, like inflation. Mr. Gibison noted that stability was one of the primary goals when the benchmark was created in 2018, but the world today is very different.

Mr. Constantino cautioned against changing the methodology from year to year because it would be harder to compare one year to another. Ms. Marlin confirmed that the proposed legislation to codify the health care spending and quality benchmarks allows the subcommittee to review the methodology annually. Ms. Magarik posed whether the subcommittee should mirror the constancy of the executive order and set the methodology for three to five years at a time to avoid the constant changes that Mr. Constantino spoke about. Mr. Geisenberger agrees that if they were to change the methodology, they should stick with it for four years to prove it out.

Ms. Bo has heard from others questioning if there are any consequences for not hitting the benchmark. Do other states have consequences? Ms. Magarik offered Department of Health and Social Services staff to provide a summary of what has changed in the national landscape around health care benchmarks. Ms. Bo offered to help with the environmental scan. Mr. Geisenberger is interested to see the range of how these benchmarks and related data are used by other states, health care delivery, and regulatory structures. Mr. Constantino noted that the National Academy for State Health Policy has a comparison of states on methodology and penalties.

Other Business:

Ms. Magarik introduced the proposed legislation that would codify the health care spending and quality benchmarks from Executive Order 25. She clarified that this legislation does not add anything around penalties; the intention is to move the components into legislation to have stability going forward. Mr. Constantino updated that subcommittee that the bill was voted out of the House committee recently and is headed to the House floor for a vote. Most of the changes are technical in nature, such as changing dates. The date for data submission was extended to account for the claims lag. Minor definitional changes ensure that the process encompasses all potential payers including

self-insurance. Mr. Geisenberger commented that the proposed legislation doesn't change the responsibilities of this subcommittee. He also noted the legislation gives duties to the subcommittee, but it does not create the subcommittee in Code. The composition of this subcommittee will continue to be governed by an executive order, which is consistent with the composition of the Delaware Economic and Financial Advisory Council and all of its subcommittees.

Ms. Magarik asked for public comment, but there was none. There being no further business, Ms. Magarik adjourned the meeting at 2:13 pm.

Respectfully submitted,
Melissa Marlin