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

WebEx Event – October 10, 2020

Attendance:

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

Members in Attendance: 8
Members Absent: 1

Others Present: S. Costantino, W. Emsley, J. Fox, F. Gibison, R. Goldsmith, B. Gordon, A. Harrison, E. Lewis, M. Marlin, D. Roose,

Opening Business: Ms. Magarik called the meeting to order at 1:30 p.m.

The minutes from the April 22, 2019 meeting were approved and submitted.

Review of Executive Order 25 and the Purpose of the Subcommittee:

Ms. Magarik reviewed how Executive Order 25 established the Health Care Spending Benchmark Subcommittee (the Subcommittee) and set the initial spending and quality benchmarks for calendar years 2019 through 2023. She reminded the Subcommittee that the Delaware Health Care Commission is tasked with setting the quality benchmarks, reporting on performance relative to both the quality and spending benchmarks, and engaging providers and community partners. After calendar year 2023, the Subcommittee must evaluate the results and methodology for calculating the spending benchmark and recommend any appropriate changes. The expertise on the Subcommittee should also be leveraged to advise the Governor and the Delaware Economic and Financial Advisory Committee (DEFAC) on current and projected trends in health care expenditures and industry trends.

The Subcommittee's timeline is slightly off due to the COVID-19 pandemic. Ms. Magarik hopes to be back on track for calendar year 2021. In March and April, the Subcommittee will review components of the calendar year 2022 spending benchmark. By May 31, the Subcommittee will report any changes in the benchmark calculation to the Governor and the Health Care Commission. In July, the annual spending benchmarks for the following calendar year will be announced.

Ms. Magarik reminded everyone that the spending benchmark went into effect on January 1, 2019. The spending benchmark is a target value in the change from the prior year' statewide health care spending per capita. The benchmark is equal to the potential statewide gross product based on long-term outlooks for population change, inflation, and labor force plus a temporary transitional factor for the first three years.

The quality benchmarks are a companion to the spending benchmark. As part of the stakeholder process initially, people were concerned that a focus on costs could lead to shortcuts in quality. The quality benchmarks are divided into two categories: health status measures and health care measures.

Preliminary Calendar Year 2018 Benchmark Spending Data:

Ms. Magarik reviewed information that was presented to the Health Care Commission in June 2020. Collection of calendar year 2018 benchmark spending data enabled insurers and the Health Care Commission to gain experience with the process and to identify process improvements going forward. Data came from the US Centers for Medicare & Medicaid Services for Medicare, the Delaware Division of Medicaid and Medical Assistance and insurers for Medicaid, insurers for commercial market, the US Department of Veterans Affairs for veterans health administration, and insurers or public reports for the net cost of private health insurance. The calendar year 2018 data was re-collected using revised data collection specifications to improve consistency, especially with regards to primary care spend. Revised data will be released in the first quarter of calendar year 2021. The data collection methodology is unique to the spending benchmark, and therefore, this data should not be compared to other sources of Delaware health care spending.

Based on preliminary calendar year 2018 data, overall Delaware total health care expenditure (THCE) was $7.8 billion and the THCE per capita was $8,110. Broken down by market and component: Medicare is 36.8% of spending at $2.9 billion, commercial is 31.2% at $2.4 billion, Medicaid is 25.1% at $2.0 billion, net cost of private health insurance is 4.5% at$0.4 billion, and veterans health administration is 2.5% of spending at $0.2 billion. Total medical expense by service category (excluding veterans health administration and net cost of private health insurance): hospital (inpatient and outpatient) is 41.4% of expenses at $3.0 billion, physicians (regardless of specialty) are 19.6% at $1.4 billion and pharmacy (net of rebates) is 15.2% at $1.1 billion. Hospital spending represented the largest proportion of dollars across market, ranging from 37% to 46% of total spending by market. The total net cost of private health insurance was approximately

$351 million, and the weighted average per member per year net cost of private health insurance across markets was $635. Per member per year amounts differ by market segment, from $3,011 for the commercial individual market to $196 for the self-insured market. Steve Constantino, Director of Health Care Reform, noted that this is one of the areas that may change when the revised calendar year 2018 data is collected.

Why the Spending Benchmark is Important, Even During a Pandemic:

Ms. Magarik described the decline in state revenues from pre-pandemic projections. The purpose of the health care spending benchmark is to look at health care inflation as it compares to the state's economic growth and revenues. Health care spending is a large portion of the state's budget and it impacts business growth and broader economic interests in the state. Rick Geisenberger, Secretary of Finance, noted that DEFAC will meet again on Monday with updated revenue projections and many of the projections shown in the presentation are from the spring at the height of COVID-19 spread. Although the declines may not look as bad today as they did in the spring, they do reflect that no state's revenues are growing to offset potentially rising costs. Ms. Magarik pointed out that COVID-19 is impacting how and whether patients seek care, especially for those who have lost health care coverage through their jobs. Declines in elective care result in reduced health care expenditures and therefore earnings for health insurers are twice as high as last year. Ms. Magarik pointed out that the Affordable Care Act does have medical loss ratio requirements, so a portion of the money collected from premiums will be returned to consumers but it is a delayed process. Primary care practices are expected to lose $67,774 in gross revenue per full-time physician over the course of the year. Some experts believe this financial strain will lead to increased market consolidation, and a growing body of research links provider market consolidation with price increases.

The Department of Health and Social Services believes there is a continued need to focus on the spending benchmark as we move through the pandemic and the uncertain economic future. The impact of COVD019 on health care spending growth will not be known for some time. Provider market consolidation and insurer profit gain can lead to an overall increase in what state government, employers and consumers pay for health care. Ms. Magarik reminded everyone that the spending benchmark is not a cap or tax and there is no automatic trigger if the state exceeds the benchmark. The process provides venues to dig into the data and look at why the benchmark was exceeded. Ms. Magarik explained that the Massachusetts Health Policy Commission voted to keep the statutorily defined benchmark and they intend to report spending against supplemental analysis of the impact of the pandemic on insurers and providers. Rhode Island also has a spending benchmark and is expected to do the same.

Mr. Geisenberger asked if it would be possible to do modified analysis on the adjusted health care spending for calendar year 2020 or 2021 if COVID-19 was not included. Mr. Costantino explained there are challenges with linking claims and clinical data. Fred Gibison added that the spending benchmark data does not contain the level of detail to do that type of analysis. It was determined earlier on to keep the data high level to make it easier for payors and entities to provide the data voluntarily. Cindy Bo wanted to clarify if

Mr. Geisenberger was concerned about the accuracy and validity of the data. Mr. Geisenberger thinks the Subcommittee should anticipate people asking what the spending growth would be if adjusted for COVID-19, understanding that they might need to rely on other data and national studies. Ms. Bo added that, in the future, the Subcommittee may need to know which areas need to improve in order to hit the spending benchmark. Mr. Constantino noted that we don't know if COVID-19 is an anomaly or if there will be a resurgence. Dr. Zhang suggested looking at the components in three categories: hospital, physicians, and pharmacy.

Mr. Constantino noted that provider relief funds are up to $330 million for the state and questioned whether those funds should be included in the expenditure calculation. Mr. Geisenberger noted that DEFAC deals with those types of situations by including an adjusted growth rate that takes into account federal tax policy, state tax policy, and legislative actions so that people can see the rate of growth and the real rate of growth. Mr. Gibison noted that the original benchmarks were intended to capture as much of the health care expenditures as possible and they did not anticipate relief funds of this magnitude. If the relief funds are included, they should be flagged as a separate category.

Assessing Performance Against the Spending Benchmark:

Dr. Sen asked what kind of data is being collected and the timing of collection. Ms. Magarik went over the components of the Total Health Care Expenditures (THCE): commercial total medical expense (TME), Medicare Advantage TME, Medicare fee-for-service TME, Medicaid/CHIP MCO TME, Delaware Division of Medicaid & Medical Assistance fee-for-service TME, Veterans Affairs TME, and insurer net cost of private health insurance. This sum is divided by the Delaware population to arrive at the per capita THCE used to assess performance against the benchmark. Mr. Gibison added that the collection of the data is well described in the implementation manual found on the Delaware Health Care Commission website. The data is collected by market, major service category, and by payor.

Regarding the timeline for measuring and reporting, Ms. Magarik explained that the goal is to report CY 2019 performance and CY 2018 data in the first quarter of CY 2021.

THCE Methodology Updates and Next Steps:

Ms. Magarik reminded the group of the earlier discussion on clarifying and further specifying some of the data collected. There are no methodology updates for calculating the benchmark for CY 2018. Next steps include continuing to collect CY 2018 and CY 2019 data and talking with insurers about the validation process.

Potential Gross State Product Growth:

Ms. Magarik explained the Potential Gross State Product (PGSP) methodology as set by Executive Order 25. Absent any changes from this Subcommittee, the CY 202 health care spending benchmark is to be 3.25%. Ms. Magarik reminded the Subcommittee that

projected average annual growth 5 to 10 years in the future was chosen in order to provide a stable figure. There was no change in the expected growth in national labor force productivity. There was no change in the expected growth in Delaware's civilian labor force. Expected national inflation decreased from 2.0% to 1.9%. Expected population growth in Delaware decreased from 0.5% to 0.4%. Based on the most recent data, the health care spending benchmark is still calculated to be 3.25% for CY 2021, but it is up to the Subcommittee to determine if there is a material enough difference from the Executive Order benchmark.

Ms. Jack asked why the population growth figure is lagged behind the other figures. Ms. Marlin explained that this subcommittee should have met in the spring of 2020 and the Delaware Population Consortium releases their annual report in the fall, so the fall 2019 figure is used for the CY 2021 benchmark and the fall 2020 figure will be used for the CY 2022 benchmark. Ms. Magarik noted the growth in older residents impacts population projections into the future. Mr. Geisenberger noted that this updated figure of 0.4% still projects growth, just a deceleration of growth, and that some of the neighboring states are shrinking.

A motion was made by Mr. Geisenberger to recommend to DEFAC to maintain the CY 2021 benchmark at 3.25%. The motion was seconded by Mr. Batta. Ms. Jack, as a health care provider, is worried that the benchmark will continue to move and that entities will not be able to build their resources in time to lower their costs to meet the new benchmark, especially given the pandemic. She believes it would be unfair to not keep the benchmark at the CY 2020 level of 3.5%. Ms. Magarik clarified that the 3.25% benchmark proposed is still growth and a target level for health care inflation for the entire health care system. Ms. Magarik also noted that many contracts from CY 2021 are already set based on the expectation that the benchmark be 3.25% in Executive Order 25. Dr. Zhang's immediate concern is how to reflect the impact of COVID-19 on CY 2021 benchmark. Ms. Bo thinks it would be helpful to have a few more years transpire and that the Subcommittee should bring along transparency and accountability in their learning journey. Mr. Geisenberger reminded the group that they will have more flexibility in CY 2023.

The motion was approved to recommend to DEFAC 3.25% as the health care spending benchmark for CY 2021. Ms. Jack opposed the motion.

Other Business:

There was no public comment offered. There being no further business, Ms. Magarik adjourned the meeting at 2:49 p.m.

Respectfully submitted,
Melissa Marlin