Minutes of the
Delaware Economic & Financial Advisory Council
Healthcare Spending Benchmark Subcommittee
November 18, 2024

Teams/DHSS Chapel 1901 N DuPont Highway, New Castle, DE 19720

Attendance:

Member	Present
N. Batta	No
K. Dwyer (Vice Chair)	Yes
R. Ford	Yes
R. Geisenberger	Yes
M. Houghton	Yes
J. Manning (Chair)	Yes
G. Siegelman	Yes
D. Tam	Yes

Members in Attendance: 7
Members Absent: 1

Others Present: M. Bailit, D. Bentz, C. Cardillo, S. Costantino, J. Coverdale, B. Frazee, A. Jenkins, B. Khanal, R. Kidner, B. Leshine, M. Marlin, E. Massa, S. Mueller, D. Roose, H. Shanehsaz, K. Tabeling, M. Tweedie, J. Van Gorp, M. Walls, M. Williams, M. Winters, and L. Wright.

Opening Business:

A quorum was established. Chair Manning called the meeting to order at 1:02 pm. Members introduced themselves. The minutes from the October 24, 2024 meeting were approved.

Delaware Healthcare Association Presentation on Benchmark Methodology:

Brian Frazee, of the Delaware Healthcare Associate (DHA), provided a presentation on the current benchmark methodology and the DHA's proposed alternatives. Mr. Frazee expressed that the current benchmark methodology is confusing and arbitrary and that it should be better aligned with national healthcare cost trends and key drives. He noted that Delaware's benchmark does not account for the older and the sicker population in Delaware and pharmacy costs, which are key cost drivers. He also noted that the benchmark used to be just a goal, but House Bill 350 has changed it to a measure of growth with consequences only for hospitals. He discussed some of the expenses growing beyond hospital control. DHA proposed two alternative methodologies for calculating the benchmark. The first is to calculate the average of national consultants' projections for healthcare costs. For 2025, the average of projected national healthcare cost growth is 7.68%. The second proposal maintains the PGSP structure

but replaces the long-term Personal Consumption Expenditure (PCE) inflation measure with the average projected CMS National Healthcare Expenditure (NHE) growth rate for the average of the two prior years. For 2025, the revised benchmark would be 8.35%. Both methodologies would calculate a benchmark higher than the 4.2% that the subcommittee recommended for CY 2025 back in the spring.

Subcommittee Discussion:

The subcommittee discussed the difference between actual inflation and the long-term forecasted Potential Gross State Product (PGSP) currently used in the benchmark. Mr. Geisenberger described the state budget benchmark and how it was created. The subcommittee discussed how the state budget benchmark is similar to and different from the current healthcare spending benchmark. Mr. Geisenberger emphasized that personal income growth was included because it forms a significant part of the tax base. The state budget benchmark uses an inflation measure, the State and Local Government Price Deflator, that reflects the basket of goods and services that the government purchases.

Mr. Tam believes that healthcare spending could be aligned with state GDP rates in the long-term, but House Bill 350 will be comparing short-term spending growth to a long-term benchmark. Ms. Manning shared the healthcare spending benchmarks enacted by other states, which are no where near 7%. She worries that abandoning growth goals in favor of growth predictors defeats the entire purpose of the benchmark.

Ms. Manning acknowledged Mr. Frazee's efforts to provide alternatives and asked members to share any thoughts they had on other alternative methodologies. Ms. Dwyer inquired about potential adjustments to the PGSP methodology, including using personal income growth and CMS National Healthcare Expenditure growth. She also wondered why the national consultants' projections were so high. Mr. Roose noted that the consultants measure total healthcare cost, not price inflation. Mr. Tam noted that pharmaceutical inflation is outpacing the benchmark in other states with healthcare spending benchmarks. He's concerned the inflation measure used in the benchmark is not accounting for pharmaceutical price growth.

In a discussion of new, expensive technology, Ms. Ford noted that the "haves" will go to out-of-state hospitals that have the new technology if Delaware hospitals cannot purchase it and the "have nots" will stay in Delaware with subpar technology, thus creating disparities in care. Ms. Manning noted that some in-of-network providers are out-of-state. In response to a question from Ms. Dwyer, Mr. Costantino explained that the administrative profits of insurers are included as net cost of private health insurance in the Total Healthcare Expenditure data collected by DHSS. Ms. Ford shared that labor is the largest cost driver for hospitals, with pharmaceuticals coming in second. Mr. Tam agrees but noted that hospitals have more control over how much they spend on labor but they have no price control on pharmaceuticals. Mr. Siegelman and Ms. Ford discussed supply chain issues that hospitals have faced over the past few years.

Public Comment:

No one signed up for public comment.

Other Business:

There being no further business, Ms. Manning adjourned the meeting at 2:48 pm.

Respectfully submitted,
Melissa Marlin