

**DELAWARE HEALTH CARE COMMISSION
JUNE 2, 2005
DELAWARE TECHNICAL & COMMUNITY COLLEGE
CONFERENCE CENTER, ROOM 400B**

Action Item

MINUTES

Commission Members Present: John C. Carney, Jr., Chairman; Matt Denn, Insurance Commissioner; Carol Ann DeSantis, Secretary, Delaware Department of Services for Children, Youth and Their Families; Joseph A. Lieberman, III, MD, MPH; Robert F. Miller, and Lois Studte, RN.

Commission Members Absent: Richard Cordrey, Secretary of Finance; Jacquelyne W. Gorum, DSW; Vincent Meconi, Secretary of Health and Social Services; and Dennis Rochford.

Guest Speakers: Alice Burton, Director, State Health Policy Group at AcademyHealth; and Elliott K. Wicks, Economic and Social Research Institute.

Staff Attending: Paula K. Roy, Executive Director; Marlyn Marvel, Community Relations Officer; and Jo Ann Baker, Administrative Specialist III.

CALL TO ORDER

John C. Carney, Jr., Chairman, called the meeting to order at 9:07 a.m.

APPROVAL OF MAY 5, 2005 MINUTES

Joseph A. Lieberman III, MD, MPH made a motion to accept the minutes of the May 5, 2005 meeting. Robert Miller seconded the motion. There was a voice vote. The motion carried.

UNINSURED ACTION PLAN

State Planning Grant

➤ Subsidized Purchasing Pool/Reinsurance Model
Insurance Commissioner, Matt Denn, spoke to commissioners on the unveiling of legislation creating a statewide health insurance purchasing pool designed to create lower health insurance premiums to over 30,000 individuals and small businesses in Delaware. Denn said that if the bill is enacted by the General Assembly, it will be the most comprehensive program of its type in the country.

By purchasing insurance as a group, buyers can receive a 22-30 percent discount over the current cost of private health insurance. The health insurance purchasing pool will be open to all resident individuals/families at or below the state median income, and all Delaware small businesses with 30 percent or more of employees at or below \$30,000/year salary. Among those businesses expected to qualify are daycare and childcare facilities, retail establishments, non-profit organizations, and dining

Action:

The May 5, 2005 meeting minutes were accepted.

Insurance Commissioner Matt Denn briefed commissioners on his proposed legislation to create a DELAWARE HEALTH CARE INSURANCE PURCHASING POOL Bill.

establishments. Target entities are those that have not offered health insurance, at risk for dropping health insurance or offering very limited health insurance plans.

A state-appointed Board will design the benefit packages and entrance limitations, based upon the amount of money appropriated by the General Assembly for the pool. Legislation establishes the framework for the pool but gives the Board the ability to make alterations.

The Pool will offer two benefit packages – one based on the State of Delaware employee benefit plan, and one more limited plan based on the Healthy New York package.

The legislation establishes limits on premium increases for pre-existing conditions. Plans will be offered on a guaranteed issue basis, even with pre-existing conditions. Rates for pre-existing conditions may vary by up to 35 percent.

The Pool would reduce premiums through three mechanisms: 1) a high-stakes bidding process for tens of thousands of policies which are currently sold piecemeal, 2) the requirement that insurance carriers administering the State Employee Benefit program also submit good faith bids to administer the Pool, and 3) the creation of a state-funded reinsurance fund which would limit the risk carriers would assume by participating in the pool.

The reinsurance fund is designed to cover catastrophic illnesses above a set amount for persons participating in the pool. The cost of that fund is estimated to be \$6.2 million in the first fiscal year and \$12 million in the following year.

It is hoped there will be at least two bidders.

The Board will have the ability to alter the benefit package or design of the program if it is necessary in order to receive good bids.

Residency requirements will prevent people from moving into Delaware for the sole purpose of joining the pool. Other regulations will place limits on entering and leaving the pool, to assure stability.

Comments:

Elliot Wicks, Commission consultant from the Economic and Social Research Institute, offered comments on the proposal.

1. Designing a pool to minimize adverse selection
Unless careful design features are built into a pool, there is risk of adverse selection; only unhealthy people in need of coverage will enroll. This makes the cost of the pool high compared to the outside market, thereby defeating the purpose of the pool

Elliot Wicks offered expert comments on the proposal.

2. Allowing individuals to join the pool

Allowing individuals to join the pool on a guaranteed issue basis creates the potential for the pool to become a high-risk pool. This is particularly true if people who cannot purchase insurance outside the pool are permitted to join the pool.

Suggestion: Do not provide guarantee issue to individuals for one or two years. This allows measuring the pool operations before opening it up to higher risk.

3. Consistency with small group market rules

The legislation does not specify how the pool will operate vis-à-vis other products in the small group market.

Experience shows that the rules should be the same if the pool is to be successful. If the pool accepts people on a more liberal basis and prohibits charging more for high risk people, it is almost certain to attract adverse selection. The pool will become too expensive. The reinsurance subsidy does make it attractive for carriers to bid on the pool, because their risk is limited by the state.

Suggestion: Give the Board discretion to assure that the pool will operate in a manner that is consistent with small group market rules outside the pool.

4. Effectiveness of reinsurance

The reinsurance subsidy is an attractive feature. However if the state assumes all the risk above a threshold dollar amount, carriers will have no incentive to worry about cost.

Suggestion: Change the legislation to require carriers bear some portion of the cost of care once the reinsurance threshold has been reached. Rather than the state assuming 100% of the cost, it could assume only a percentage of the cost.

5. Number of insurers participating in the pool.

As currently written the bill invites bids from multiple insurers, but selects only one to serve all the people in the pool. While research has shown pools are not effective in reducing the uninsured, there is strong evidence that they are attractive to employers because they offer choice and do not force people into only one plan. It is true that if bidders know they will get all the business in the pool they may bid a lower price. However, allowing employee choice will provide competition as well, since price will be a factor in choosing a plan. If employees become dissatisfied with a plan, they can change plans without the employer having to change plans.

Suggestion: Allow more than one carrier to participate in the pool

6. Relationship of the pool to government.

Experience suggests that small employers tend to be wary of government. In this case the pool would essentially be a part of the Department of Insurance. It may be more attractive to make it less obvious that it is part of government.

Discussion

Dr. Lieberman: Is the General Assembly willing to accept this plan this year? Will the lack of specifics (co-pays, benefit package design, etc.) in the bill be a barrier to passage?

Robert Miller: How does the pool concept line up with the Commission's commitment to the uninsured? It is important to consider support of strategies that will expand coverage to the uninsured in addition to this proposal.

Carney: The Commission, at its last meeting, expressed support for expanding the CHIP (Children's Health Insurance Program) to parents. This strategy would expand coverage.

Roy: The Commission, through the State Planning Project, has established two policy goals: (1) strategies to preserve coverage and (2) strategies to expand coverage. The pool concept preserves coverage, while the CHIP expansion would expand coverage.

➤ SCHIP Expansion

Alice Burton presented an overview of SCHIP (State Children's Health Insurance Program) expansion. A number of states currently use SCHIP to cover parents. This can be achieved either through the Medicaid program or SCHIP. SCHIP expansion is attractive because the federal match rate is higher than for Medicaid. SCHIP match rate is 65 percent, while the Medicaid rate is 50 percent. In addition, Delaware has not spent the total amount of federal money allotted to the State for SCHIP. Delaware might need to get a waiver under the SCHIP program to expand coverage to parents.

About 14 states cover parents over 100 percent Federal Poverty Level. About four or five states do it through SCHIP. Other states do it through Medicaid expansion.

Some advantages of extending Medicaid/SCHIP eligibility to parents are:

- 65 percent federal financial participation.
- Expansion can be structured as a "capped, non-entitlement" and higher cost sharing is available versus traditional Medicaid
- Administrative structure is already in place
- Creates seamless "family coverage" for families <200 percent of the Federal Poverty Level
- Family coverage promotes preventative care, access to

care

- Reduces pressure on the CHAP network by expanding the insured

Some disadvantages include:

- State budget liability
- Possible crowd-out
- Welfare stigma
- Limited to parents of CHIP eligible kids

Robert Miller made a motion the Commission support the advancement of the Delaware Health Insurance Pool bill AND expansion to the SCHIP program to cover parents of children covered by the CHIP program. Lois Studte seconded the motion. There was a voice vote. The motion passed.

➤ Federal Medicaid Reform

Alice Burton gave a presentation on discussions about Medicaid at the federal level.

In April, 2005 a budget resolution was passed by Congress for \$10 billion in Medicaid reductions over five years. A Budget Resolution is Congress' way of establishing a broad framework for the budget giving direction to appropriations committees about changes in the budget. The resolution is not binding but is a framework for Congress to move forward. Final Medicaid reductions might be more or less than the \$10 billion.

Congress created a Medicaid Commission with two primary deliverables. Its charter is "To advise the Secretary of Health and Human Services on ways to modernize Medicaid so it can provide high quality health care to its beneficiaries in a financially sustainable way." The short-term deliverable of this Commission is recommendations on how to achieve \$10 billion in saving over five years. They are due September 1, 2005. The long-term deliverable is a sustainability plan for Medicaid at both the federal and state levels. It is due December 31, 2006.

Congress must reauthorize SCHIP by 2008. There is speculation that it may occur earlier. Such action could impact State programs.

Some potential sources of Medicaid savings include:

- Limitations on provider takes
- Pharmacy pricing changes
- Long-term care coverage, specifically the practice of spending down or transferring personal assets for the purpose of becoming Medicaid eligible for long-term care
- Targeted case management

Action:

A motion was made and passed to support the Delaware Health Insurance Pool Bill AND expansion to the SCHIP program to cover parents of children covered by the CHIP program.

Alice Burton gave a presentation on Federal Perspective Changes in Medicaid.

The Medicaid Commission report is due in September. Congress is expected to act soon after, as federal appropriations are made. The federal fiscal year begins October 1, 2005.

State Activity

Many states facing revenue shortfalls are cutting eligibility for Medicaid. Tennessee, which had expanded eligibility to 400 percent of federal poverty level, is considering cutting 300,000 people. Missouri may cut 15,000.

Some states are considering including individual accounts. Florida is considering a plan that would permit people to keep unspent funds after coming off Medicaid.

A few states are looking at changes in their disproportionate share funding. Disproportionate share payments are generally given to public hospitals to compensate for the cost of caring for the uninsured. Some states are seeking waivers to allow use of the funds in community-based settings, rather than hospital or emergency room settings.

There is a desire on the part of Congress to cut Medicaid expenditures. It is unclear how that will impact state programs. The \$10 billion reduction is based on rate of growth, not the current level of spending. If the recommendations are passed, each state will have to make program changes in Medicaid to achieve those recommendations.

At this time, Medicaid has limited ability per case to charge co-pays. Co-pays are prohibited for pregnant women, children, or preventive services. When co-pays can be charged, (\$1 or \$2) and the Medicaid consumer presents and cannot pay that co-pay, the provider cannot collect it.

CHAP

Betsy Wheeler presented ideas for restructuring CHAP for FY '06.

The proposed structure of CHAP is a result of conversations at several CHAP meetings and a subsequent CHAP Disease Management Workgroup meeting, which included 100 percent participation of hospitals and community health centers. The proposed re-structure has a disease management/health promotion component.

Step 1 – A patient is referred to CHAP as a result of Medicaid denial, Covering Kids and Families outreach activities, or community-based referral. Patient enters through Customer Service.

Step 2 – Customer Service performs the following functions:

- Eligibility and enrollment (eligibility remains 200 percent

Betsy Wheeler presented new ideas/goals for the CHAP FY '06 budget.

Federal Poverty Level)

- Referral to other programs as appropriate (Medicaid, SCHIP, Screening for Life/Delaware Cancer Treatment Programs, WIC, Delaware Prescription Assistance Program, TANF, food stamps, and childcare)
- Health Risk Assessment
 - provides data for evaluation and also becomes tool for managing patient's care
- Marketing and Provider Relations
 - coordinate outreach activities
 - provide marketing and promotional materials
 - participate in community fairs
 - provide personalized orientation to providers
 - continuing provider education of CHAP

Step 3 – Primary health home assignment

- Case manager interprets Health Risk Assessment and initiates appropriate services/information for patient
- Patient receives periodic mailings targeting his/her specific needs
- Patient chooses primary care health home
 - VIP
 - Community health center
 - Access to subspecialty care, prescription assistance, allied health resources, ancillary services
 - Health Risk Assessment accompanies patient to new health home.

Step 4 – Community Resource Persons

- Two in Kent County
- Two in Sussex County
- Three in New Castle County
- Assist patient in getting resources in translation, transportation, health education, interface with providers and hospitals, and help with community presence and outreach.

UPDATED PROGRAM GOALS include:

- 1) Enrollment in available coverage
- 2) Coordinated use of existing programs and resources
- 3) Regular source of primary care and easy access to other health services
- 4) Most vulnerable population equipped with better health system navigation skills, better understanding of prevention, and improved self-survival skills
- 5) Improved health status

KEY FY '06 PROGRAM ELEMENTS to achieve these goals include:

- 1) Centralized enrollment and assignment to health homes VIP or Community Health Centers.

2) Aggressive linkage to/coordination with existing income-based health and social service programs and resources; e.g. SFL, DCTP, WIC, DPAP

3) Health prevention and promotion focused case-management predicated upon completion of a Health Risk Assessment

3a) Culturally appropriate, easy to understand patient education and health education materials focused on prevention and promotion.

4) Centralized access to subspecialty, allied health, and ancillary services.

5) Updated, more appropriate, roles of staff at health centers and hospitals. New reimbursement terms.

6) Grassroots outreach and more sophisticated physician education.

All enrollment will take place in a centralized way. Activities will include processing applications, getting people enrolled in the system, use of the 800 number, and working off Medicaid denials. Disease Management and outreach is being incorporated into the program.

The new functions are a result of responses from CHAP's partners. They are funded by one-time federal fiscal relief funds. Because the one-time investment results in a new framework this year, work with Dr. Gill and CHAP partners on new measurables and evaluation is critical.

PROJECT UPDATES

➤ Nursing Implementation

The Committee met May 16, 2005 which included two presentations:

- The Boy Scouts Explorers program is for male and female young adults ages 14-20 to participate in career orientation workshops. It enables students to gain practical knowledge of careers in health (and other industries). There are Explorer programs at Beebe Medical Center, Bayhealth Medical Center and Christiana Care Health System. Students spend time in the hospitals on a bi-weekly or monthly basis and speak with professions in different departments (heart surgeons, nursing, etc.) about the daily schedule, education requirements, and career tracks. Nursing is the predominant career of interest among respondents to a student survey administered by 17 high-schools to approximately 15,000 students to gauge interest areas for the Explores program.

Lois Studte updated Commissioners on Nursing Implementation Committee activities, DIDER, and the Delaware State Loan Repayment program.

- The Delaware Business, Industry, Education Alliance (BIE) Career Internship Program also spoke of their activities promoting health careers in schools and career internships.
- At the last meeting the Committee talked about licensure and getting statistics. One issue evolving is the workforce center. Judy Chaconas and Lois Studte attended TAKING THE LONG VIEW conference in Portland, Oregon. There are 24 states that have nursing workforce centers with five more evolving. A white paper is being created. The Workforce Center task force will be reconvened and look at some of these issues. The centers' functions span a wide range of activities, ranging from GIS mapping, revealing distribution of Medicaid providers and HMOs, Medicare providers and shortage areas. Some states do mentoring to increase retention. Vermont's mentoring program reduced turnover rates from 20 percent to single digits.

➤ Delaware State Loan Repayment Program

The State Loan Repayment Program has expended all its appropriation for physicians. A restructuring plan was recommended and was approved by the Commission.

➤ Delaware Institute of Dental Education and Research

The DIDER Board discussed pursuing an agreement with a dental school similar to that of DIMER with Jefferson Medical College and Philadelphia College of Osteopathic Medicine. Meetings will be scheduled with three dental schools: 1) Temple University School of Dentistry, 2) University of Maryland School of Dentistry, and 3) University of Medicine and Dentistry of New Jersey. DIDER anticipates asking the Commission to include a request for funding to enter an agreement with a dental school as part of its next budget request.

➤ Information & Technology - DHIN

Project Management

The Governance Workgroup of the DHIN Management Team presented a report of its findings to the Board of Directors at the May 24, 2005 meeting. It was determined that the current DHIN governance structure—and the board, provisions and protections afforded it by legislation—is the best model for governing Delaware's health information exchange utility. The governing entity, however, should be continually monitored and assessed for its ability to manage and operate the Utility in an ever-changing and evolving health information exchange environment.

DHIN entered into a contract with Health Care Information

Gina Perez updated Commissioners on DHIN activities.

Consultants (HCIC)—a Baltimore based health information technology consulting (HIT) company. HCIC began work by holding a kick-off meeting with the Technical Advisory Committee of DHIN. The first phase of work to be performed by HCIC includes an infrastructure analysis, consisting of approximately 50 stakeholder interviews, to establish an understanding of the current HIT environment in Delaware. They will then develop a technical requirements definition for the DHIN Utility. The following provides a timeframe for completion of the contract deliverables:

June 30, 2005 - Technical Infrastructure Assessment

July 31, 2005 - Architecture Design

August 31, 2005 - Requirements Definition

September 30, 2005 – Advanced Planning Document

October 31, 2005 – Cost-Benefit Analysis

November 30, 2005 -Sustainability Plan

August 15, 2005 – RFP Finalized

October 15, 2005 -RFP Review Criteria

December 31, 2005 - Complete Vendor Selection

Funding

On May 23, 2005, DHIN received questions from the Agency for Healthcare Research Quality (AHRQ) regarding DHIN's response to the RFP entitled "Delaware Health Information Network HIT Demonstration."

Answers to the questions are being crafted and are due to AHRQ by June 8, 2005. The proposed contract start date is July 1, 2005. A single award is anticipated for a period of five years. If awarded the contract, DHIN will receive \$700,000 for year one and \$1,000,000 each for the remaining four years.

DHIN anticipates a mid-June notice of grant award for the AHRQ small conference grant program. The grant for \$50,000 would support a Delaware HIT Symposium, which will be the culmination of DHIN's planning activities in the fall of 2005. The Symposium will offer DHIN stakeholders and the general public the opportunity to provide input on DHIN's plan for developing the clinical information sharing utility.

OTHER BUSINESS

The July 20, 2005 meeting will wrap up some of the coverage options and work for the State Planning Grant. It will also focus on CHAP. An update from Dr. James Gill will be presented on his evaluation of that program.

The Health Resources Board has gone through the Sunset Review process. With modifications, the Sunset Review board has recommended that the Health Resources Board should continue and the necessary legislation needs to be enacted by the respondent.

PUBLIC COMMENT

Joann Hasse asked for clarification that the waivers on SCHIP program have been given for some states to cover parents up to 100 percent of the Federal Poverty Level (FPL). SCHIP that covers children is 200 percent of the Federal Poverty Level.

In response, Alice Burton stated there are four states that cover up to 200 percent of the FPL, 185 percent for one state. The assumption is that it will be 200 percent for parents in Delaware.

William Kirk, Blue Cross Blue Shield of Delaware, understood Mr. Wicks to state there are differences between the pooling proposal on the table now and what the Lewin Group analyzed for the Insurance Commissioner.

Mr. Wicks responded that the model the Lewis Group analyzed would have allowed any insurer to choose to put someone in the reinsurance pool, whereas the proposal in Mr. Denn's bill would limit eligibility for reinsurance only to insurers who participate in the pool. This difference is important. Under the model that Lewin analyzed insurers would still bear the risk up to whatever the threshold is before reinsurance takes over. If only one insurer participates in the pool, other insurers would have an incentive to send people to the pool because they would no longer bear any of the risk. The adverse selection problems are greater.

Mr. Kirk wanted to know if there is a report from The Lewin Group available at this time or will be available to them.

Mr. Wicks responded that he does not know if that is a public document.

Dr. Robert Frelick commended Commissioners and speakers who used the microphones.

NEXT MEETING

The next meeting of the Delaware Health Care Commission will be held at 9:00 a.m. on **WEDNESDAY, JULY 20, 2005 in Room 400B** at the Delaware Technical and Community College Conference Center, Dover.

ADJOURN

The meeting adjourned at 11:05 a.m.

The next meeting
will be held
**WEDNESDAY, July
20, 2005, Rm. 400B,**
Delaware Technical
and Community
College Conference
Center, Dover.

GUESTS ATTENDING

Jack Akester, Consumer Advocate
Joy Blasier, EDS
Anthony J. Brazen, D.O., Division of Social Services, Medicaid
Kim Chappell, EDS
Donald Cohn, AcademyHealth
Robert Frelick, MD, Medical Society of Delaware
Doug Gramiak, Office of the Lt. Governor
Joann Hasse, League of Women Voters
R. Michael Herman, Coventry Health Care of Delaware
Kevin Kearns, MD, Coventry Health Care of Delaware
William Kirk, BlueCross/BlueShield Delaware
Lolita Lopez, Westside Health Center
Linda Nemes, Department of Insurance
Brian Olson, La Red Health Center
Betty Paulanka, University of Delaware
Gina Perez, Advances In Management
Suzanne Raab Long, Delaware Healthcare Association
Faith Rentz, State of Delaware Budget Office
Rosa Rivera, Henrietta Johnson Medical Center
Tonia Ryan, Chrysler
K. Seigel, National Alliance for the Mentally Ill – Delaware
Debra Singletary, Delmarva Rural Ministries
Jose Tieso, EDS
Lorie Tudor, Claymont Community Center
Patt Wagner, RN, Executive Director of Delaware Diabetes Coalition
Thowana Weeks, Division of Public Health
Betsy Wheeler, Management Concepts, Inc.