

DELAWARE HEALTH CARE COMMISSION
MAY 5, 2005
DELAWARE TECHNICAL & COMMUNITY COLLEGE
CONFERENCE CENTER, ROOM 400B

Action Item

MINUTES

Commission Members Present: John C. Carney, Jr., Chairman; Richard Cordrey, Secretary of Finance; Joseph A. Lieberman, III, MD, MPH; Robert F. Miller, Dennis Rochford; and Lois Studte, RN.

Commission Members Absent: Matt Denn, Insurance Commissioner; Carol Ann DeSantis, Secretary, Delaware Department of Services for Children, Youth and Their Families; Jacquelyne W. Gorum, DSW; and Vincent Meconi, Secretary of Health and Social Services

Guest Speakers: Alice Burton, Director, State Health Policy Group at AcademyHealth; James Rasa and Dan Sullivan, Delaware First Healthy Choices.

Staff Attending: Paula K. Roy, Executive Director; Judith A. Chaconas, Director of Planning and Policy; Marlyn Marvel, Community Relations Officer; and Jo Ann Baker, Administrative Specialist III.

CALL TO ORDER

Paula K. Roy, Executive Director, Delaware Health Care Commission called the meeting to order at 9:20 a.m.

APPROVAL OF APRIL 7, 2005 MINUTES

Robert Miller made a motion to accept the minutes of the April 7, 2005 meeting. Lois Studte seconded the motion. There was a voice vote. The motion carried.

Action:

The April 7, 2005 meeting minutes were accepted.

LOAN REPAYMENT PROGRAM

Joseph A. Lieberman, III, MD, MPH, made a motion to approve the applications for loan repayment to three OB-GYN physicians; Michelle Cooper, MD at OB-GYN Associates, Christian Peyton, MD at Del-Med Health, and Saima Kanwai Jehangir, Nanticoke Women's Health Center; and one Family Practice physician; Catherine DeLuca, MD at Mid Atlantic Family Practice. Lois Studte seconded the motion. There was a voice vote. The motion carried.

Action:

Loan repayment for three OB-GYN and one Family Practice physicians was approved.

UNINSURED ACTION PLAN

A. Cover the Uninsured Week May 1-8, 2005

Joseph A. Lieberman, III, MD, MPH, Chairperson of Covering Kids and Families, reported events in Delaware for Cover The Uninsured Week. Betsy Wheeler, Management Concepts, Inc., provided media packets to commissioners and audience. Cathy Imburgia, Creative Communications, prepared an Issue Brief On The Uninsured In Delaware. The Issue Brief is available on the Delaware Health Care Commission website at

Joseph A. Lieberman, III, MD, MPH, Chairperson of Covering Kids and Families, reported to the Commission the schedule of events in Delaware for Cover The Uninsured

1. Small business insurance/small group market issues
2. Public coverage expansion
3. Individuals

The May meeting focused on small business/small group issues.
The June meeting will focus on public coverage expansion issues.

Within small business/small group market category, options fall into two major sub-categories:

1. Policy interventions designed to preserve and maintain existing coverage.
2. Policy interventions designed to expand coverage.

The Commission's Small Business Health Insurance Committee has chosen to focus its work on preserving and sustaining coverage. The Commission, today, will focus attention on options designed to expand coverage. Alice Burton, Director, State Health Policy Group, AcademyHealth led discussions on Delaware Coverage Options. This presentation is available on the DHCC website at www.state.de.us/dhcc (presentations).

Delaware Prioritized Coverage Options

Private Insurance:

1. **Subsidized reinsurance**
2. **A. Purchasing pool with subsidy for adverse selection**
B. Purchasing pool with premium subsidy
3. **One-Third Share**
4. **Require Health plans to cover dependants up to age 26**
5. **A. Tax credits for individuals**
B. Tax credits for employers

Public Insurance:

6. **Limited Benefits for CHAP enrollees**
7. **Extend Medicaid/S-CHIP for parents of CHIP**

Common Design Decisions

Target population

- **Small firms**
- **Low wage-workers**
- **Individuals not offered insurance by employer**
- **Crowd-out rules – to assure that currently insured individuals don't drop coverage to take up a new program**

Cost Saving Features

- **Subsidy**
- **Limited benefits**
- **Cost sharing**
- **Limited networks**

Subsidy mechanism

- **Reinsurance (back-end)**
- **Premium (front-end)**

Options.

The May meeting focused on small business insurance issues. The June meeting will focus on public coverage expansion issues.

Financing

- **General funds**
- **Assessment on carriers or providers**
- **Dedicated funding source (tobacco tax)**

Option Descriptions

1. Subsidized Reinsurance

Target population: **Uninsured workers in small firms**

Cost to the state: **medium-high**

Cost per newly insured: **medium**

Description: Lowers premiums by shifting some of the expenses for high-cost enrollees. Goal is to encourage employers to offer insurance and for employees to buy it.

Example: New York runs the largest subsidized reinsurance program, called “Healthy New York.” Delaware could create a similar program:

- HMOs are required to offer a product under the reinsurance program – all HMOs must offer the same benefit package (Rx is optional).
- State agrees to (reinsure) pay 90% claims that are over \$5,000, but below \$75,000.
- Premiums are lower because insurer does not have to pay for high cost cases, but insurer still has incentive to manage the care effectively because they share some of the cost once threshold is reached and all the costs after the cap is exceeded.
- Program is open to small firms previously not offering insurance
- Brokers still sell products to small firms and individuals and HMOs set premiums under existing rules in state.
- In New York the program is funded by a portion of the tobacco tax set aside in a reinsurance (sometimes called “stop loss”) fund. In 2004, they anticipated spending \$25 million and enrolled approximately 77,000 people (or \$325/person). The 2004 anticipated spending is still less than 50% of available funds for the year.

Advantages:

- Lowers premiums
- Subsidy invisible to employers and individuals
- Does not require large administrative structure

Disadvantages:

- More difficult to predict state funding required
- No federal matching funds for state contribution

Design decisions:

- Do you want to limit this program to small firms with low wage workers?
- Do you want to include “crowd-out” provisions (rules that would limit the program to small firms that were not previously offering insurance so that firms do not

- drop coverage to enroll in this program)?
- Is the program open to individuals and/or sole proprietors?
- Funding source?

2. A. Subsidized Purchasing Pool with state subsidy for adverse selection

Target population: Uninsured workers in small firms and uninsured individuals

Cost to the state: \$1-\$17 million

Cost per newly insured: \$100-\$900

Description: Establish an entity to act as a purchaser of health coverage, negotiating with carriers and health plans on behalf of the target populations and then offering a choice of all the selected health plans to eligible employers and individuals. The expectation is that the lower premiums would be achieved through greater purchasing power. The state provides a subsidy for adverse selection in the pool.

Example: Several models exist (California PacAdvantage and Maine's DirgioChoice has some design elements of a purchasing pool), but the following model was developed for Delaware:

- Carriers to submit bid for a defined benefit package
- Pool negotiates with carriers and decides which health plans to offer
- State, rather than insurer, pays high cost cases
- Employers required to make minimum contribution (50%)
- Pool is open to low-wage small employers, any individual under 300% of FPL not offered coverage by employer

Advantages:

- Pool uses purchasing power to achieve lower cost premiums (experience shows this is slight, if at all)
- Subsidy for adverse selection lowers premiums
- Expands choice of health plans for individuals
- Could collect contributions from multiple sources (multiple employers, public subsidy, individual)

Disadvantages:

- Need to be very careful about establishing the same rating inside and outside of the pool so that pool does not attract a healthier or sicker population.
- Pool may become similar to high risk pool (if sicker people are attracted)
- Without sufficient buying power, may be difficult to lower premiums

Design decisions:

- Do you want to limit the pool to certain groups -- small firms with low-wage workers, low-income individuals?
- Do you want to include "crowd-out" provisions (rules that would limit the program to small firms that were not previously offering insurance so that firms don't

- drop coverage to enroll in this program)?
- What comes first: size of pool or savings? Do you want to build off existing large group such as state employees or Medicaid? Will there be a separate or shared risk pool? If a shared risk pool, what is likely impact on rates: will the newly insured group likely be more expensive or less expensive than existing group?
- Is carrier participation mandatory? If not, plan may not get carrier participation because of low volume.

2. B. Subsidized Purchasing Pool with premium subsidy

Target population: Uninsured workers in small firms and low-income uninsured individuals

Cost to the state: \$12-\$39 million

Cost per newly insured: \$700-\$1600

Description: Establish an entity to act as a purchaser of health coverage, negotiating with carriers and health plans on behalf of the target populations and then offering a choice of all the selected health plans to eligible employers and individuals. The expectation is that the lower premiums would be achieved through greater purchasing power. The state pays 1/3 of premiums for low-income individuals.

Example: Maine's DirgioChoice pools employers and individuals and offers a subsidy to low-income enrollees using Medicaid funds, but the following description was developed for Delaware:

- Carriers to submit bid for a defined benefit package
- Pool negotiates with carriers and decides which health plans to offer
- Employer pays 1/3, state pays 1/3 for low income, individual contributes 1/3
- Pool is open to low-wage small employers, any individual under 300% of FPL not offered coverage by employer

Advantages:

- Pools purchasing power to achieve lower cost premiums (experience shows this is slight, if at all)
- Subsidy for low-income lowers premiums
- Expand choice of health plans for individuals
- Could collect contributions from multiple sources (multiple employers, public subsidy, individual)

Disadvantages:

- Need to be very careful about establishing the same rating inside and outside of the pool so that pool doesn't attract healthier or sicker population.
- Pool could become similar to high risk pool, particularly if largely individuals enroll.
- Without sufficient buying power, may be difficult to lower premiums

Design decisions:

- Do you want to limit the pool to certain groups --

small firms with low age workers, low-income individuals?

- Do you want to include “crowd-out” provisions (rules that would limit the program to small firms that were not previously offering insurance so that firms don’t drop coverage to enroll in this program)?
- What comes first: size of pool or savings? Do you want to build off existing large group such as state employees or Medicaid? Will there be a separate or shared risk pool? If a shared risk pool, what is likely impact on rates: will the newly insured group likely be more expensive or less expensive than existing group?

3. One-Third Share Plan

Target population: Uninsured workers in small firms

Cost to the state: \$500,000-700,000

Cost per newly insured: \$600

Description: A subsidized coverage program with more limited benefits than a typical comprehensive plan. Employers contribute 1/3, individuals contribute 1/3, and public contribution of 1/3. Lower premiums are achieved through a limited benefit package and a public subsidy. Typically, these programs are developed at the community level.

Example: Several communities have developed 3-share programs. A Delaware option was developed:

- Small, low-wage firms are eligible to participate
- Streamlined benefits: coverage is less extensive than commercial. Benefits designed to keep overall costs low (approximately \$150/month). In 2001, an employee-only policy in Delaware was about \$250/month.
- The premium is split between the employer, employee and a public source. \$50 employer, \$50 employee, \$50 public

Advantages:

- Public subsidy results in lower premium
- Pools small employers together and may achieve some advantages of a larger group.

Disadvantages:

- Enrollment likely to be small
- Community-based coverage plan may not meet state insurance regulatory requirements (mandated benefits).
- Limited benefits plans traditionally have had low take-up rates.

Design decisions/Issues:

- What traditional benefits will be eliminated to achieve low cost product? Will this be attractive to currently uninsured individuals and employers not offering coverage?

- What community-level public financing is available?
- Should program be limited to small employers? Previously not offering insurance?

Discussion Points

- Intensive community based marketing and outreach is needed in order to be successful.
- Complicated to administer
- Would have to build from scratch/ground up

4. Require health plans to cover dependants to age 26

Target population:	Young adults
Cost to the state:	Low, only if state employees plan included
Cost per newly insured:	Low
Description: Typical private insurance policies allow dependants to be included while they are in college or up to age 21. Many young adults lose their insurance coverage when they finish school and have not yet begun working for an employer that offers health benefits. This proposal would allow dependants to stay on their parent’s policy longer.	
Example: Utah was the first state to require insurers and employers to define dependants as unmarried adults up to age 26, regardless of student status. This allows young adults to remain on their parent’s policy. A Delaware option could:	
<ul style="list-style-type: none"> - Require carriers and insurers to define dependants as unmarried child up to age 26, regardless of student status. - The State Employees plan could be required to adopt this definition. 	
Advantages:	
<ul style="list-style-type: none"> - Low cost - Maintains continuity of insurance coverage for young adults during time when they are most likely to be uninsured. - Keeps young adults in group policy, which is likely more affordable than individual policy. 	
Disadvantages:	
<ul style="list-style-type: none"> - Employers may not contribute to the costs of dependent coverage. - To offer this option to their employees because it could be an additional cost to them. - Number of uninsured individuals served is likely to be small. - Would not apply to self-insured employers (ERISA). 	
Design decisions/Issues:	
<ul style="list-style-type: none"> - Will employers have the option of using broader definition of dependant? - Will employer be required to contribute in the same way they currently do for dependants or will cost be paid by insured? 	

- Should this only be applied to state employees as a starting point? Will the state pay a portion of the dependant coverage?
- An alternative that states have considered is to require students at state schools to have health insurance while enrolled.

Chairman Carney reminded Commissioners that the Small Business Health Insurance Committee will focus on preserving coverage. He asked Commissioners' opinions on options to expand coverage.

The policy question for consideration is whether to spend \$10 million for 'private insurance' and/or expand S-CHIP coverage to cover the parents of S-CHIP eligible children (with an S-CHIP expansion, a 65% in federal matching funds would be available). Chairman Carney expressed his desire to do a little of both.

After discussing the coverage options it was decided to eliminate Option 4 – Require Health Plans to Cover Dependents to age 26.

Option 5 (Tax credits for individuals and for employers), Option 6 (Limited Benefits for CHAP enrollees), and Option 7 (Extend Medicaid/S-CHIP for parents of CHIP) will be discussed at the June 2005 meeting.

Commissioner Lois Studte inquired as to the role of the Commission with regard to health care legislation that has been or will be introduced. There are approximately 12-18 legislative days remaining of this fiscal year, and the Delaware Economic and Financial Council (DEFAC) is scheduled to release new revenue estimates later this month. A revenue surplus is anticipated. There will many competing demands for the surplus funds. Proposals could include those to improve health care.

Commissioner Dennis Rochford noted that the Delaware General Assembly created the Commission in statute and that it reports to the Governor and the General Assembly. Commissioners are appointed by the Governor, the Senate Pro Tempore and the House Speaker.

Commission representation should be present at all legislative briefings and hearings, and at meetings of the Delaware Health Fund Advisory Committee. This does not mean that the Commission must "vote" on all proposals, but Commissioners and/or staff should be available to provide testimony, injecting its research findings and fact-based conclusions that will inform the deliberations and the decision making process.

The Commission may not "control" the legislative process, but it can and should influence it. Such activity is expected and the

The Commission will be represented at Legislative and Delaware Health Fund Advisory Committee meetings, hearings and briefings that pertain to health care issues. The Commission has a broad and in-depth base of knowledge that must factor in and inform the decision making process.

Commission should accept this responsibility and assert itself.

Furthermore, it was noted that if there are specific proposals that the Commission wants to move forward, it would may beneficial to present or float them in the legislature now. While the probability that legislation introduced within the next few weeks may not be acted upon this session, which ends June 30, it is worthwhile to bring the general framework for the proposal(s) to the table now. Proposals introduced this session can be worked on over the summer in more detail in preparation for passage next session. Bills introduced but not passed this session will carry over into the next session.

D. First Healthy Choices

James E. Rasa, Chairman and Daniel T. Sullivan, Secretary/Treasurer, gave a presentation entitled “First Healthy Choices, Solving the Insurance Puzzle”. Mr. Rasa thanked the Commission, the State, and the three downstate hospitals for providing funds to do this study. The presentation will be available on the Delaware Health Care Commission website at www.state.de.us/dhcc (presentations).

Fifty to seventy percent of all healthcare costs have a behavioral root cause such as smoking, inactivity, and improper diet. Chronic diseases account for an estimated 75 percent of the healthcare budget. As many as 45 percent of adults do not receive recommended healthcare (New England Journal).

Because of problems in small group health insurance market the House of Representatives created the Small Business Health Insurance Task Force in 2002. It issued a report in June of 2003. The task force formed two teams; one to examine “out of the box” approaches, such as government single-payer, and one that examined the traditional insurance approaches. Jim Rasa was assigned to the traditional approach team, and Dan Sullivan assisted Jim in pulling together a realistic approach to the health insurance problem.

They wanted to develop a model that was a fully insured health plan, with claim processing, eligibility, underwriting, physician contracts, hospital contracts, global network contracts, professional insurance agents, premium rating, and a prescription program. They wanted to identify what really makes up the insurance market being studied. Gaps were found in the small business health plans available in the market. The missing pieces needed to be found.

Mr. Rasa and Mr. Sullivan met in October 2003 with Brian Hefferan of Health Network American (HNA)Triveris, a Third Party Administrator. HNA/Triveris through data collection and analysis provides information to doctors and patients to facilitate plans of care that promote health promotion and disease

Bills introduced but not passed this session will carry over into the next session. Proposals introduced this session can be worked on over the summer in more detail in preparation for passage next session.

James E. Rasa, Chairman and Daniel T. Sullivan, Secretary/Treasurer gave a presentation on First Healthy Choices, Solving the Insurance Puzzle.

management as a method of lowering claims costs. Mr. Hefferan presented the HNA/Triveris model at the meeting. The model was then presented to downstate chambers of commerce under sponsorship of the Rehoboth Beach/Dewey Beach Chamber of Commerce. Ten chambers signed up to support the work. In February of 2004, they met with a national foundation and received enthusiastic response to the concept. They were advised to explore non-profit status to manage the pieces unique to First Healthy Choices, as oversight of an insurance plan that would be endorsed by the community through chambers of commerce.

Governing Board. First Healthy Choices is a non-profit entity, with a governing board. Community Health Plan is the name of the insurance product. The board is comprised of hospital, physician, and business owner representative, who will review and approve all contracts and plans. It is their job to make sure that the healthcare needs of the community are being met.

Chamber – Government Advisory Board. This advisory board assures proper endorsement and communication about the Community Health Plan, and will include all member chambers in the development of First Healthy Choices. Its functions will include fundraising and promotion.

The Provider Advisory Board is made up of physicians and hospital representatives. They will review and approve all contracts with their peers, approve “Best Practice” guidelines to physicians and hospitals, and flag any areas of concern or opportunity in the health data gathered from the community. They will give a clinical overview of the pool data on a quarterly basis.

Identification of Health Risk. Every member will have a free biometric and blood study screening to identify any health risks. This is the key piece to the puzzle – it enables the member and his or her physician to be pro-active in addressing any health risks. Together they will form a plan of care, which they will be expected to follow.

Personal Responsibility on the part of the member to take medications prescribed, have follow-up visits with their physician or any physician referred by the PCP. Personal responsibility on the part of the physician to make sure they follow up with the patient. This has always been assumed in other plans but has seldom occurred. In this plan, the lack of responsibility results in higher co-pays or deductibles on the part of the member, and lower reimbursement rates on the part of the physician. It should literally “pay” to follow a doctor’s treatment plan.

Communication. Members and physicians will be given a written assessment with which to formulate their plan. The data from the tests go into an anonymous pool from which can be drawn a picture of the health of the community. Communication is both

personal and aggregate. First Healthy Choices will help distribute information from National Institutes of Health and Centers for Disease Control (i.e. flu vaccine shortages) to members of the community. It will hold seminars from time to time on various healthcare topics.

Nurse Advocates. First Health Choices will provide nurse advocates who will follow up with physicians and members to help them adhere to their plan. These advocates will also work with the national disease-based associations (i.e., the American Heart Association, Cancer Society, MS Association, Diabetes Association) to obtain the latest data for individual needs.

The input of Alternative Medicine Providers, such as chiropractors, naturopathic physicians, etc. will be made available to members if desired and recommended.

The services of Dieticians will be made available to members. They will formulate menus for specific conditions such as heart-healthy diets or diabetic diets. First Healthy Choices has also contracted with a nutritionist and chef who will develop recipes so that the recommended foods will actually taste good.

Fitness Programs. They will have arrangements with various gyms and physical therapists who will work with the members and physicians in developing programs that will help everyone reach their goals. It is seen as essential for long-term health improvement for chronic illnesses.

Data Sharing. The data gathered by physicians and hospitals will be shared on an aggregate, anonymous basis with the community so that needs may be addressed (i.e., a great number of diabetics would mean an endorsed diabetic care campaign) and costs contained.

Health Responsibility Model, or HRM, encompasses all the pieces necessary for a community to improve and maintain the health of the community.

The Community Health Plan will be the plan endorsed by First Healthy Choices and will include all the pieces of the puzzle.

PROJECT UPDATES

A. Health Professional Workforce Development – DIMER

Delaware State Loan Repayment Program

The DIMER Board reviewed applications for loan repayment from three obstetrician gynecologists and one family practice physician at its April 27 meeting. The Board recommended that all four proposals be funded. (As noted on page 1 of these minutes, the Commission endorsed this recommendation.)

Paula Roy updated the Commission on DIMER activities.

Medical Malpractice Insurance

The Board discussed malpractice issues and DIMER's role, if any, in addressing the issue. The Board was informed of previous Commission activities regarding malpractice. It concluded that the concern or activity should be only in the context of whether malpractice affected DIMER's mission.

Data on the 2005 Entering Class at Jefferson Medical College and Philadelphia College of Osteopathic Medicine (PCOM) were reviewed.

To date, PCOM has accepted 6 Delawareans in the 2005 entering class. All 6 are white males; 5 from New Castle County and 1 from Kent County.

To date, Jefferson has accepted 20 Delawareans in the 2005 entering class. Of those, 4 withdrew, leaving 16; 9 females and 7 males; 1 Chinese, 1 Indian/Pakistani, 1 Japanese, and 13 white; 14 from New Castle County, 1 from Kent County and 1 from Sussex County.

Concern was expressed over the limited number of minority students and students from Kent and Sussex County. An Area Health Education Center (AHEC) has opened an office in Dover. One mission of the AHEC is to target school children and promote health care careers as a profession, with the hope of increasing diversity among medical school applicants in the future.

Delaware State University and Jefferson Medical College are working together to find ways to encourage the Delaware State University students to apply to medical school. The possibility of a ten-week summer internship program at Jefferson may be explored.

Mid Level Practitioners

The Board discussed exploring the possibility of a program similar to DIMER and DIDER to assist mid level practitioners, such as physician assistants and nurse practitioners.

B. Information & Technology - DHIN

Project Management

A DHIN subcommittee on governance met with Charles Elson, director of corporate governance at the University of Delaware. The subcommittee plans to meet with experts on governance from the eHealth Initiative. A recommendation on the DHIN governance and operating structure is expected to be discussed at the May DHIN Board of Directors meeting.

Funding

On April 7, 2005, DHIN submitted a proposal to the Agency for Healthcare Research Quality (AHRQ) in response to the RFP entitled "Delaware Health

Gina Perez updated the Commission on DHIN activities.

Information Network HIT Demonstration.” A single award is anticipated for a period of five years. If awarded the contract, DHIN will receive \$700,000 (congressional earmark) for year one and \$1,000,000 each for the remaining four years.

Marketing

DHIN was featured in the Spring 2005 issue of Delaware Today Magazine. Commissioner and DHIN Board member Joseph A. Lieberman, III, MD, MPH, was quoted along with Mark Meister, executive director of the Medical Society of Delaware and Dr. Ed Ewen from Christiana Care Health System.

Lt. Governor John Carney was quoted in a Democratic Leadership Council health information network policy briefing on model initiatives published April 5, 2005.

OTHER BUSINESS

The DHCC and Delaware State Chamber of Commerce partnered the development of a website for business owners seeking information about buying health insurance for their employees. This website received a first place award from the Delaware Press Association for the development and creation in not-for-profit or education organization sites. The website is www.healthinsurancechecklist.com.

The Delaware Health Care Commission’s Annual Strategic Planning Retreat will be held September 7-8, 2005.

PUBLIC COMMENT

William Kirk stated that in the presentation for a purchasing pool with state subsidy, employers would be required to contribute 50 percent of the premium. If an employer is going to be in the program, he doesn’t believe the State can make him pay. Alice Burton responded by saying that if an employer chooses to participate and offer insurance, and they want to be in the ‘pool’ then they are aware of the 50 percent contribution.

Connie Hughes stated that for nonprofit organization, there are people making \$60,000 a year and paying \$1500 a month premiums. Limiting options to low-wage workers will not help the nonprofit sector.

Dr. Robert Frelick stated that First Healthy Choices sounds like a good plan and he hopes it is successful. He suggested that input be sought from the broader health care community as the plan is being developed.

Joann Hasse expressed her agreement with the Commission’s earlier discussion and consensus that the Commission should be present when health care proposals are being considered at legislative briefings and hearings. The Commission has a wealth of knowledge upon which legislator can draw.

Rita Marocco inquired as to whether First Healthy Choices insurance will cover mental health. Jim Rasa and Dan Sullivan both stated that mental health is covered.

Dr. Katherine Esterly commended the First Healthy Choices program. She hopes it will emphasize the care of children because that is where healthy lifestyle habits are formed. She also supports CHIP, but is concerned that only 50 percent of eligible children are enrolled. Covering the parents of these children is a very good start in trying to cover the poor who need help. There is also a lack of money for daycare in this State. Better daycare teaches children the right lifestyle.

Cynthia Smith asked Commissioners, and specifically Alice Burton, to provide information about suggested outreach strategies to reach the uninsured for whom these possible new coverage expansion programs are being created. She also raised the question of the degree of passion that may be had for assuring aggressive enrollment of the target population.

Ms. Burton clarified that as a consultant to the Commission she will have no role in the various day-to-day administrative options of any new coverage program. The Lt. Gov clarified that the Commission's focus of discussion on this date was on the broader level of health policy considerations for Delaware and not the various components of operations and managing programs. It was suggested that Ms. Smith consider the Delaware Covering Kids and Families Program as a good forum for addressing these kinds of grassroots strategies and advocacy activities.

Brian Olsen let the Commission know how excited La Red is for becoming a Federally Qualified Health Center. The funds provide the opportunity to expand the cornerstones of La Red, which are primary care and prenatal programs to better meet the needs of the uninsured in Sussex County. He thanked the Commission, its members, as well as the members of the public who have supported La Red all along.

NEXT MEETING

The next meeting of the Delaware Health Care Commission will be held at 9:00 a.m. on **THURSDAY, JUNE 2, 2005 in Room 400B** at the Delaware Technical and Community College Conference Center, Dover.

ADJOURN

The meeting adjourned at 11:32 a.m.

Next Meeting:

The next meeting will be held 9:00 a.m. on **THURSDAY, JUNE 2, 2005 in Room 400B** at the Delaware Technical and Community College Conference Center, Dover.

GUESTS ATTENDING

Jack Akester, Consumer Advocate
Brad Allen, Allen Insurance Group/New Castle County Chamber of Commerce
Joy Blasier, EDS
Anthony J. Brazen, D.O., Division of Social Services, Medicaid
Katina Clarke, Delaware Workforce Investment Board
Donald Cohn, AcademyHealth
Kathy Collison, Division of Public Health
Katherine Esterly, MD, Christiana Care Medical Center
Robert Frelick, MD, Medical Society of Delaware
Doug Gramiak, Office of the Lt. Governor
Joann Hasse, League of Women Voters
Pat Hawkins, Delaware Chamber of Commerce Healthcare Committee
Connie Hughes, Delaware Association of Nonprofit Agencies
Cathy Imburgia, Creative Communications
Barbara Jackson, EDS
William Kirk, BlueCross/BlueShield Delaware
Lolita Lopez, Westside Health Center
Rita Marocco, National Alliance for the Mentally Ill – Delaware
Anita Muir, Division of Public Health
Linda Nemes, Department of Insurance
Brian Olson, La Red Health Center
Gina Perez, Advances In Management
Tom Price, American Heart Association of Pennsylvania/Delaware
Faith Rentz, State of Delaware Budget Office
Debra Singletary, Delmarva Rural Ministries
Cynthia Smith, Child Abuse/Domestic Violence
Jose Tieso, EDS
Kay Wasno, EDS
Betsy Wheeler, Management Concepts, Inc.
Rob White, Delaware Physicians Care, Inc.
Calvin Young, United Auto Workers Healthcare
Joe Zingaro, Ph.D., Delaware Psychological Association