

**DELAWARE HEALTH CARE COMMISSION  
FEBRUARY 17, 2005  
DELAWARE TECHNICAL & COMMUNITY COLLEGE  
TERRY CONFERENCE CENTER, ROOM 400A  
DOVER  
AMENDED**

*Action Item*

**MINUTES**

**Commission Members Present:** John C. Carney, Jr., Chair; Matt Denn, Insurance Commissioner; Jacquelyne W. Gorum, DSW; Joseph A. Lieberman, III, MD, MPH; Vincent Meconi, Secretary of Health and Social Services; Robert F. Miller; A. Herbert Nehrling, Jr.; and Lois Studte, RN.

**Members Absent:** Carol Ann DeSantis, Secretary, Delaware Department of Services for Children, Youth and Their Families; and Dennis Rochford.

**Speakers:** Alice Burton, Academy of Health; Jack A. Meyer, Ph.D. and Elliott K. Wicks, Ph.D., Economic and Social Research Institute; and Betsy Wheeler, Management Concept, Inc., and Project Manager, CHAP.

**Staff Attending:** Paula K. Roy, Executive Director; Judith A. Chaconas, Director of Planning & Policy; and Jo Ann Baker, Administrative Specialist III.

**CALL TO ORDER**

John C. Carney, Jr., Chairman, called the meeting to order at 9:10 a.m.

**APPROVAL OF JANUARY 6, 2005 MINUTES**

Robert Miller made a motion to accept the January 2005 minutes. Joseph A. Lieberman, III seconded the motion. There was a voice vote. The motion passed.

**UNINSURED ACTION PLAN**

Alice Burton, Director, State Coverage Initiatives, AcademyHealth, provided an overview of the federal environment within which the current State Pilot Planning process is occurring and revisited the four coverage expansion options that evolved during the Commission's early State Planning activities.

FY 2006 Federal Budget Highlights (recently introduced)

- Pledge to reduce deficit in half by 2009
- Record deficit of \$427 billion
- Non-security, discretionary spending will rise 1 percent
- U.S. Department of Health and Human Services will decrease discretionary funding by 1.2 percent  
17 percent increase in Medicare – Revised cost estimates for Medicare Modernization Act

*Action:*

There was a motion to accept the January 6 2005 minutes. There was a voice vote and motion carried.

Alice Burton, State Coverage Initiatives/Academy Health, gave a presentation on national context within which the State Pilot Planning efforts are occurring and 2004 Policy

(MMA). MMA (which included the new, yet to be implemented, prescription drug benefit) cost estimates now has grown to \$742 billion (from \$400 billion)

considered by the Commission.

#### President Bush's Health Agenda

- Economic opportunity and ownership
  - Health Information Technology (HIT) – follows the concept of providing information needed to make more informed health decisions; HIT project includes electronic prescriptions, medical records and advancing the adoption of HIT by providers
  - Comprehensive, consumer driven health care: examples include health savings accounts, tax credits, association health plans and medical liability reforms
- Compassionate society
  - Providing access through community health centers
  - Medicaid and SCHIP reforms
- Protecting America (bio-terrorism)
- Making government more effective
- Health insurance tax credit
  - credit to pay up to 90 percent of a premium with a maximum credit of \$1000 (individual) and \$3000 (family of four) and would phase out above income thresholds (\$30,000 individual, \$60,000 family of four; questions remain about the sufficiency of the credit to actually enable significant increase in insurance take up rates)
- Health Savings Accounts (HSA)
  - Some characteristics include:
    - Tax credit
    - Above the line deduction
    - Rebate to small employers
  - Consumers could use a portion of their tax credit for the purchase of a HSA and high deductible health plan and deposit a portion (\$300 for the individual/\$2000 for family of four) into their HSA.
- State Purchasing Pools
  - It is not yet clear how credits for state purchasing pools and health savings accounts will fit together
- Association Health Plans (AHP) – The new proposal allows small businesses, private, non-profit, and multi-state entities to form AHPs
- SCHIP outreach – \$1 billion for a national outreach program that will provide grants to enroll eligible children
- Community Health Centers – The president wants to

fund 1,200 new centers

#### Medicaid Proposals

- U.S. Health and Human Services Secretary Leavitt identified \$60 billion in cuts over 10 years by
  - Eliminating inter-governmental transfers: \$40 billion in estimated saving
  - Addressing fraud and abuse: \$5 billion in savings
  - Amending the Medicaid drug rebate formula: \$15 billion in savings
- Medicaid and SCHIP modernization (SCHIP is up for reauthorization next year, and there is some discussion about doing it earlier to ease the way for reforms) Strategies include: capped Medicaid administrative payments, Medicaid and SCHIP audits, close down of SCHIP Inter-Governmental Transfers (IGT) provider taxation loopholes, and a provider payment schedule.

#### Delaware's guiding principles:

These are the principles that the Commission and key stakeholders agreed to early on in the State Planning process:

- Lowest ratio of dollars to newly insured
- Targeting policy at low income populations
- Administratively feasible
- Avoidance of entanglement with federal law
- Build on older programs and successful structures

More recently identified activities speak to the goals of developing a benefit package that incorporate research on health disparities in order to assure that the package is relevant to addressing the needs of populations with lower health status. Additionally, the goals include identifying how the Delaware Health Information Network (DHIN) can provide clinical decision-making support as a first step in moving to disease management. Finally, is the desire to work with CHAP partners and the Medical Society of Delaware to create a statewide provider network, with consideration to a fee schedule.

Additionally, the Commission's Single Payer Committee has identified the following additional criteria for evaluating coverage expansion proposals:

- Coverage: Who is covered and how good is the coverage?
- Cost and Efficiency: Is the plan efficient and economically practical?
- Equity and Fairness: Does the plan promote fairness and equity?
- Choice and Autonomy: How much choice does the plan permit.

Ms. Burton described the four policy options identified during the early stages of the State Planning Program as the most

appropriate for further consideration and more in-depth analysis (including updates to the cost and coverage actuarial analysis):

1. Limited Benefit Plan

- Low-cost insurance product or direct reimbursement program, emphasizing primary and preventative care
- Targeted at low income
- Affordable for low income individuals via minimal cost sharing

The target population would be the CHAP-eligible population. The program if implemented could provide charity care providers with reimbursement and additional incentives to enroll people into CHAP. The state would pay 100 percent of the cost. There would be no federal funding. One advantage is that it would encourage affordable access to primary and preventive health care for those with low/modest incomes and help strengthen the safety net. It would not include hospitalization. However, the premise is that some hospitalizations would be prevented or shortened as a result of increased preventive and primary care. The original actuarial analysis (2001) resulted in an estimated per capita cost of \$400-\$507.

2. One-Third Share Plan

- Employer, employee and the state each pay one-third of total premium
- Streamlined benefit package
- Affordable “coverage” for the working uninsured employed by small businesses

The target population would be the working uninsured. The state would pay 1/3, the private employee 1/3 and the employer 1/3. One advantage is that it is relatively affordable (employee and employer would each pay approximately \$50 per month). Questions include: how would you leverage private dollars? Who would get the subsidy? Who determines the benefit design and eligibility? What about crowd out (employers now offering full dropping it in favor of this plan)?

3. Delaware Healthy Children Expansion

- Expand Delaware’s CHIP program to cover parents of Medicaid and CHIP eligible children between 100 percent and 200 percent of the Federal Poverty Level
- 1115 HIFA waiver allows state additional freedom for benefit, cost-sharing and enrollment caps

Target population(s) would be parents of minor children. This would not include individuals without children. This type of plan requires a federal waiver (to use SCHIP funds to cover parents of children on that program) and Centers for Medicare and Medicaid Services (CMS) approval, but the state can realize a 65 percent federal match. Additional components could include premium

assistance for employer-sponsored insurance (ESI) to avoid crowd-out. One advantage is that total family health coverage has a positive impact on access for children. One disadvantage is there can be a welfare-type stigma.

#### 4. Purchasing Pool

- Pool negotiates with private carriers and determines which plan to offer
- Employers pay minimum premium percentage and enroll a minimum percentage of employees
- State absorbs adverse selection with subsidy

Target population(s) would be small business, those who decline employer-sponsored insurance, or those otherwise without access to coverage. Pools can be funded via a combination of private, state and employee funds. One advantage is the availability of a lower cost insurance product to the previously uninsured. On a cautionary note, pools must be designed to avoid unintentional morphing into a high-risk pool. The original estimated cost to the state: \$1 million-\$17 million and about \$2000-\$3000 per person. Questions pertain to the cost of the subsidy that would be needed and how much risk the state is willing or able to shoulder.

#### Single Payer/Universal Coverage Initiative

Jack Meyer, PhD and Elliott Wicks, PhD, from the Economic and Social Research Institute (ESRI), gave a presentation on the three approaches to achieving universal coverage that the Commission's Single Payer Committee decided to devote attention. The Commission engaged ERSI to provide an analysis of the issues and approaches to single payer/universal health care for Delaware. ERSI has extended its initial work with the Committee to analyze each of the approaches against the above - mentioned four criteria (coverage; cost and efficiency; equity and fairness; and, choice and autonomy). The three reforms include: the (1) "building blocks" approach, (2) the employer mandate approach, "play or pay" and the (3) "single state purchasing pool" approach, including single payer and multi-payer variants).

A copy of the executive summary from the committee's report, outlining each approach was included in the meeting packet as well as copies of the slides used in the presentation.

During the introduction of the topic, Mr. Meyer stated that: "The federal government is not only in dire straits but it is finally beginning to dawn on people on both sides (of the aisle) in Congress that they are in dire straits." They have been in dire straits for a long time but reality is setting in. It has also begun to dawn on people that when you take Medicaid, Medicare and Social Security into a cluster -- Social Security is the good news - - and run them out in 20-30 years, if we don't do anything with the benefits structure for these programs, (it has to be asked) how

Jack Meyer, PhD and Elliott Wicks, PhD, from the Economic and Social Research Institute, gave a presentation on the approaches to achieving universal coverage in Delaware from the Commission's Single Payer Committee: the "building blocks" approach, the employer mandate "play or pay" approach and the "single state purchasing pool" approach. A copy of the executive summary from the

much do we have to raise taxes to keep them functional? If we don't raise taxes and only cut benefits, how much do you think it will cost? If you don't do either, how far will you have to increase the age of eligibility? These programs will devour the whole budget in the period of a generation or two. States can anticipate huge cuts in some Federal programs."

committee's report, outlining each approach was included in the meeting packet.

Other comments by Mr. Meyer:

- To solve the problem of the uninsured, a program may have to work in a few states and then bring it up to the national level. Costs are going to have to be controlled, yet the costs drivers are not being diagnosed correctly.
- One of the factors contributing to the increasing the number of uninsured is the disparity between the rate of growth of health premiums and the rate of growth of wages. The number of workers who decline to purchase health insurance that is available to them is a big reason for the increase in the uninsured.

Regarding the three options:

1. Building Blocks Approach

This approach would achieve nearly universal coverage. Employees and dependents would be covered by either their employers or under a state pool.

Elements

- Medicaid and SCHIP become a single program
  - Cover everyone up to 200 percent of poverty
  - Make enrollment automatic, where possible

The funding would be seamless and transparent to the patient. A card would be issued that would be re-branded to look like "regular" insurance. There also could be "express" eligibility, under which if you qualify for other subsidy programs, such as food stamps or public housing, you would be automatically eligible. There could be presumptive eligibility for children, without a requirement for face-to-face interviews with parents. Outreach should be significant and occur wherever children are present. Another option is to require enrollment as a pre-requisite for enrollment in public schools, such is done now with certain vaccinations. Overtime, this would lead to universal coverage for children. However, children turn into you young adults. To address this reality, you could increase the eligibility age for SCHIP from 18 to 21 and enable children to stay on their parents' employer-sponsored insurance policies until that age or older (up to

Jack Meyer discussed the Building Blocks Approach

25 years old, for example).

- State purchasing pools for small employers and individuals – offering multiple plans to those not eligible for a government program but not wealthy enough to afford health insurance on their own. There would be subsidies.
  - Reduce insurers' ability to rate premiums based on risk
  - Have young adults covered under parents' policies
  - Institute state-funded tax credits, graduated by income for:
    - high risk individuals
    - people with incomes 200 percent to 300 percent of poverty

#### Assessment of the Building Block Approach

- Substantially more people covered
- Fragmented system remains
- Portability somewhat improved for those in new combined SCHIP/Medicaid program and those in the state pool (automatic enrollment/express lane eligibility)
- Resource (medical services consumed) costs higher because more people covered; little change in administrative costs
- Substantial increased budgetary cost to pay for those newly eligible for public programs and for those with tax credits
- Improved equity: more equal treatment of equals; broader sharing of risks
- No new tools to control costs
- Little government compulsion or disruption of status quo

Mr. Meyer elaborated:

Parents have two options: if income is under/near poverty children can go into "First Care" and if income is a little higher, up to 300 percent of poverty (\$56,000-\$57,000 family of four), they go into the statewide pool and get a tax credit if qualified. If parents are higher income (\$60,000 depending on family size), you are required to participate.

Again, when young adults slip off their parents' insurance policy, under the "First Care" program, there would be the enhanced SCHIP match and there could be a rise in the eligibility age from 18 to 21. The insurance industry in Delaware would be entrusted to enable young adults to stay on their parents' insurance policies up to age 25 even though they have completed high school or college. Nationwide this age cohort represents 7 to 8 million people.

The pool would be set up on a statewide basis. The pool would be established for employees of small firms with employers with 50 or fewer employees who would participate in this pool and pay premiums. Individuals who otherwise would not have access to affordable insurance would be eligible. Sixty percent of the working uninsured work for employers that do not offer coverage.

About 20 percent work for employers who offer insurance but they do not qualify for some reason. The other 20 percent turn it down when it is offered.

If the premium contribution under this plan exceeds 7.5 percent of adjusted gross income, a tax credit from the state would kick in, which would be refundable even if there is no state tax liability. It would be advance-able, which means you do not have to wait until the next April to get it back from the state. It would be received monthly through an adjustment on the paycheck. This would help make it more affordable.

The pool would offer a range of plan choices; three (3), four (4) or five (5) plans, and the worker would choose the plan – not the employer.

There would be limits on how high the premiums could vary around the average (40 percent is suggested). If an individual comes into the pool their maximum premium is suggested to be no more than 250 percent of the average premium in the pool.

The state would have to finance its share of the plan cost and the tax credit. This would be structured in ways that would encourage people to participate, through tax penalties, for example, or a lack of credits that otherwise would be available, but participation would not be a requirement.

This program would build on the current system. Some advantages are that it does not destruct the current system and it is not compulsory; no one is required to do anything. The disadvantage is there are no guarantees of universal coverage and some of the inconsistencies of the current system remain - multiple payers and lots of paperwork remain. It would not have full portability, but portability would improve.

Elliott Wicks reviewed two models for universal coverage, the “play or pay” approach and the “single payer” approach. They represent greater departure from the status quo when compared to the building blocks approach. He said that they are more encompassing, cover more people, probably are more expensive, but they would get closer to universal coverage.

Elliot Wicks discussed two models for universal coverage: Play or Pay and Single Payer

2. The Employer “Play or Pay” Mandate, would require employers to provide coverage or pay a fee

Elements:

- Employers not offering coverage pay a fee to cover cost of coverage for standard plan.
  - Employers pay 80% for employee and dependents
  - Employees contribute 20%
- Fee is waived for employers who offer coverage and pay 80% of the premium.

Under the provisions of the federal ERISA law states cannot affect the benefits package of any employer sponsored insurance (ESI) plan and therefore the State does have the power to levy taxes on employers. So you start with the fee and then waive the fee if the employer provides coverage.

- Temporary subsidies for low-wage, low-profit employers. You cannot expect employers who are now not offering coverage to suddenly pay the whole bill themselves.
- State operates a Delaware (statewide) Health Insurance Pool
  - Contracts with multiple insurers.  
Individuals could choose which plan they wanted.
  - Provides coverage for those without employer coverage
- All people below 150% of poverty covered by Medicaid/SCHIP (up from 100% and 200% FPL respectively)
- Non-employees are required to buy coverage through the pool, premiums graduate by income, with the state then providing the subsidies
- Insurers cannot sell any policy except those offering at least the “standard” benefits and also requiring employer to pay 80% of the premium.

Again, ERISA allows only insurers to do this. States cannot control what employers can do in the way of benefits packages. They can control the policies that insurers sell. This would not affect self-insured employers but most self-insurers offer pretty comprehensive policies already. The ERISA problems are significant because of state limitations on being able to mandate employers to do anything.

Employer “Play or Pay” Mandate Assessment

- Nearly everyone covered, but coverage sources fragmented (Medicaid, SCHIP, different insurance plans)

- Improved portability if in the pool, because they would be able to choose any plan in the pool.
- Increased real resource cost – more people covered; little administrative cost savings, because you still have a multiple-payer system
- Budgetary cost not greatly increased – employers and employees bear most new costs, so new costs are “off budget”
- Broader risk sharing,
- Improved equity: essentially people who are in equal circumstances in respect to income are treated equally regardless of their family status or if they are parents, etc.
- Increased compulsion on employers and all residents. All employers must either “pay or play” and all residents must get coverage.

### 3. Single State Purchasing Pool Approach (including single payer and multi-payer variants)

- Eligibility: all legal residents
- Automatically enrolled in state pool
- Two variants
  - Single state plan (like “Medicare for all”) with no insurance companies involved other than as an administrator; or
  - Multiple insurers (like state/federal employees’ plan)
- Benefit package:
  - Up to 150% of poverty: Medicaid benefits
  - Everybody above 150% of poverty: actuarially equal to most popular small-group plan (but could buy supplemental coverage)
- Financing: (these two separate approaches are only illustrations, they could be reversed)
  - Single payer:
    - Premiums (community rated) – with graduated subsidies up to median income; others pay full cost. The employer could choose to pay the premium but there would be no subsidy for those who above the median.
    - General revenues cover subsidies
- Multiple payer:
  - Employer: 8% of payroll
  - Employees: 2% of wages between \$10,000 and \$200,000
- Health Care Commission would administer this program

#### Single State Purchasing Pool Assessment

- Universal coverage, automatically.

- Full portability of coverage. You can move from one plan to another any time, with no loss of coverage.
- Real resource cost (medical services consumed)
  - Single payer: Higher because of new people covered; reduced by large administrative savings (coordination of benefits, determining medical underwriting)
  - Multiple payer: Somewhat less administrative savings, but essentially the same resource cost.
- Substantially higher government budgetary costs
  - Single payer: to cover subsidies (other costs paid by premiums)
  - Multiple payer: Payroll tax a major source of financing, but expenditure is “on-budget”
- Cost control:
  - Single payer: State has great leverage to bargain with providers and vast data on all procedures done within the system and can more easily identify problems
  - Multiple payer: State bargains with insurers; insurers compete for enrollees (like state employees’ plan)
- Much greater equity:
  - No penalty for high-risk people; risk very broadly shared
  - Subsidies based on income (need, not family status)
  - Equals treated equally
- Substantial compulsion and disruption of status quo. That means you are automatically covered but you are also automatically paying as well.

Discussion:

Alice Burton asked the Commission which of the eight options they want to move forward with in terms of pursuing more detail and analysis. The options include: (1) limited benefit plan, (2) one-third share plan, (3) SCHIP expansion, (4) subsidized purchasing pool, (5) building blocks approach, (6) play or play approach, and the (7, 8) two single state purchasing pool approaches (single payer and multi-payer).

Discussion/comments:

When the Commission went through this process several years ago, about 18 options were reviewed and narrowed down to four which appeared to be the most reasonable. None of the options on their own were particularly impressive, particularly when looking

at the impact on coverage as compared to cost.

The building blocks approach incorporates multiple components of the original four options and may likely yield a more comprehensive result.

Before making a final decision, it is important to recognize that there are two committees of the Commission that are exploring options. It is important to let them complete their work and make their recommendations. One of the committees is working on insurance options specifically designed to address the unique needs of the small business community. The other is exploring the single payer and other universal coverage options. In fact, it was through the single payer committee's work that the building blocks, the play or play and the single state purchasing pool approaches evolved as warranting consideration.

With any model or combination of models, determining how many newly insured people you would impact for each dollar invested is important to know.

One way to maximize the number of participants in a plan offered through an employer is to make the assumption that a person is enrolled unless they "opt out."

There is a desire to incorporate disease management aspects into coverage plans.

U.S. HHS Secretary Leavitt has indicated that the Medicaid "modernizations" being considered at the federal level will likely allow states the flexibility to use strategies, such as disease management, to make programs more cost efficient -- as long as any savings that are realized as a result are used for expansions in the number of people covered.

Regarding associated health plans, research indicates that taking mandated benefits out of benefit packages does not reduce premiums enough to make it the "tipping point" for increased participation.

Subsidies are required to make options affordable for those with modest or moderate incomes.

It is important to address the premium cost gap among small businesses. The cost difference between a company with eight employees who are all healthy and a company with eight employees, two of whom are very sick, is huge.

Plans need to be somewhat portable.

State funding has to be considered, particularly in terms of the necessary subsidies. Already, health care consumes a significant part of the state's budget.

Assuring equity and fairness in cost across populations is important. There are structural ways to address this, including certain types of risk adjustments. It does not lower the cost, but evens it out across populations.

A significant problem with getting the uninsured health coverage is having them enroll. Those who are employed would be relatively easy to enroll but those who are unemployed would have to be enrolled "door-to-door".

Health savings accounts: Initial national experience indicates that they are able to lower the total premium cost by up to 30 percent. Of those who are purchasing them it appears as if approximately 30% were previously uninsured. The research results indicate that health savings accounts are not attracting younger workers. However, they are attracting healthier workers. The average age of the people who purchase HSA are about the same age as the people enrolling in health maintenance organizations and preferred provider organizations (PPO).

### **LEGISLATIVE REQUEST**

Senator Liane Sorenson submitted a written request asking the Commission to review and discuss a proposal from a constituent regarding the length of time between a patient's receipt of laboratory and diagnostic services and receipt of the results. A relative of the constituent had received a diagnostic procedure in August and received the results in October. The patient's assumption that "no news was good news" turned out to be incorrect and the patient had a serious condition.

In anticipation of this discussion, Commission staff contact was made with the Medical Society of Delaware and the Delaware Healthcare Association. A letter from the Delaware Medical Society suggested that rather than addressing this concern through legislation, it appears far more appropriate to do so through the development of a "best practice" standard, which specifically establishes professionally recognized guidelines for the timely and effective communication of a patient's test results. Such guidelines could be utilized by the Board of Medical Practice in its evaluation and investigation of complaints concerning a physician's professional conduct in this regard.

Ms. Roy noted that when operational the Delaware Health Information Network (DHIN) utility will alleviate situations such as those described by the constituent. It will allow physicians and

Senator Liane M. Sorenson requested the Commission to review and discuss a proposal from a constituent suggesting legislation requiring health care providers providing laboratory services to inform patients how long they will need to wait for the results.

patients to access lab results and other information more quickly.

Additional points:

The development of the DHIN, one of the components is going to be personal health records with clinical information and results being transmitted back to the ordering physician. Legislation governing actions between physician and patients would be very difficult to enforce. The wrong party may be held responsible, and there often is a third party involved, such as a hospital or free-standing laboratory.

Joseph Letnaunchyn, President of the Delaware Healthcare Association, concurred and reiterated a point made by Commissioner Lois Studte in that it is also the personal responsibility of the patient to follow up with their physician.

Mark Meister, Medical Society of Delaware, clarified that the “best practice” standard could be adopted and carried out by the Board of Medical Practice.

Insurance Commissioner Matt Denn noted that there already are some incentives for the health care providers for physicians in place to contact their patients in a timely manner - built-in civil justice incentives.

Chairman Carney suggested that the Commission’s response reflect the discussion. Additionally, it may be of benefit to research what other states have done in this regard.

## UPDATES

### Uninsured Action Plan

#### **CHAP**

As of January 31, 2005 CHAP enrollment had reached 2580, up from 2371 as of December 31, 2004. Other key statistics:

Total CHAP applications ever received	10754
Total CHAP ever enrolled	6627
Current Medicaid enrolled	1816
Total referred to VA	95

#### **Federal Fiscal Relief Fund**

The draft document reviewed and approved by the Commission in January was presented to the Health Care Access Improvement Coalition – CHAP providers and partners - for review and discussion on January 28, in accordance with the Commission’s wishes. The document was accepted, and HCAIC members volunteered to form a workgroup to outline program design and

Included in this months updates are activities by CHAP, DHIN, Health Professional Workforce Development, DIDER, State Loan Repayment, and Federal Fiscal Relief Fund.

implementation details.

Of particular note was the disease management proposal, which received enthusiastic support. Among HCAIC workgroup activities outlined in the proposal would be defining caseloads, defining target populations for disease management programs and developing a customized care plan.

The group agreed that one target sub-population of CHAP enrollees might be those who receive social security disability payments. These payments make them over income to be Medicaid eligible, and they must wait two years before they can enroll in Medicare. They are eligible for the Delaware Prescription Assistance Plan, however. Additional discussion will be required to determine how and if this sub-population should be targeted, and, more specifically, which of the four projects outlined in the document would best serve this sub-population.

Although most of the community health centers in the network were aware that the issue was to be discussed at the January 28 meeting, representatives from three were not in attendance. A conference call with these centers is being scheduled to allow comments and feedback. Upon completion of this call commissioners will be informed of substantive changes if there are any. If not, the report will be submitted to the Budget Office, as required.

It was concluded that there would be research and investigation into assuring safeguards (implementing reimbursement within CHAP and protect VIP II participants, FQHCs, and health centers treating uninsured patients).

The DIDER Board had been looking into this and a report was received from Delaware's Deputy Attorney General assigned to the DIDER Board. The specific proposal included potentially someone from private counsel and the conclusion may we may need that or we may not. It might be that we can get what we need from services already available.

There is money for that purpose to use or redirect to programmatic components of the overall proposal and the interest is around juggling these kinds of programs (disease management and outreach). The next step is to looking into FQHCs having disease management practitioners within their facilities. There are volunteers from the health centers and hospitals to connect care management and community education programs to help the patient.

## **Health Professional Workforce Development**

### Health Careers workshop for guidance counselors

Fifty-four K-12 guidance counselors and teachers attended the February 8 health careers workshop, with 16 of the 19 school districts represented at the conference. Speakers included Valerie Woodruff, Secretary of Education and Joseph Letnaunchyn, President of the Delaware Healthcare Association. A review of the evaluation forms received show ratings of “excellent” on all fronts. Secretary Woodruff delivered a powerful speech about the influence and positive impact on students’ futures that counselors can make. Mr. Letnaunchyn encouraged counselors to suggest to their students that they explore academic pathways that will lead to “excellent job opportunities” in the health professions. Following the presentations, the counselors participated in three or more roundtable discussions with 15 organizations representing employers of health professions, schools of health professions and community organizations involved in health careers, such as Junior Achievement, the Delaware Business Industry Education Alliance and the Girl/Boy Scouts. The counselors were also provided information about available scholarships and other financial aids, web links and a “Guide to Careers in Nursing and Allied Health” that students can use to learn more about the many career opportunities health has to offer. School districts identified a point person that we can contact to distribute additional materials as needed. The project was carried out under the leadership of the Commission’s Nursing Implementation Committee, with sponsorship from the Commission in partnership with the Department of Education. The Nursing Implementation Committee at its February 15 meeting reviewed the results to determine next steps. Follow-up will include re-engaging organizations who may have programs or materials that will assist in the effort to encourage youngsters to pursue health careers. Information will be funneled to schools via the Delaware Department of Education and school-based health career liaison’s identified at the workshop.

Reports on nurse education scholarship awards made available by the Governor via her allocation of Workforce Investment Board discretionary funds to the Department of Health and Social Services. The Delaware Healthcare Association, the Delaware Health Care Facilities Association and the Department itself each received \$125,000 to distribute to students. The funds were distributed as follows:

- Department of Health and Social Services: 21 scholarships awarded
- Delaware Health Care Association: 49 scholarships, in varying amounts
- Delaware Health Care Facilities Association: 30 scholarships

All students receiving the awards attend classes at Delaware

Technical and Community College.

An additional \$125,000 was allocated to the Delaware Higher Education Commission. Those funds were distributed to students enrolled in baccalaureate and diploma nursing programs.

Federal rules require the funds be spent by a certain date or they will revert. There is a difference of understanding regarding exactly what the date is, and clarification is being sought. Regardless of the date, there is concern that some students will not have completed their education by then, due to first year start up difficulties with distributing the funds, waiting lists for classes and clinical rotations and the need for some students to repeat classes or take college preparatory classes. There also is some uncertainty as to whether WIB funds for scholarships will be available in Fiscal Year 2006. Clarity on this issue is being sought as well.

Lois Studte and Judy Chaconas will attend a national conference in April that will focus on developing strategies for strengthening the nursing workforce, including the establishment of state nursing work force centers. Ms. Chaconas is also participating in a Health Resources and Services Administration project to develop a national methodology for identifying facilities and agencies with critical shortages of Registered Nurses. The first meeting took place in February.

#### State Loan Repayment Program

Discussions within the State Loan Repayment Committee over the past year, attendance at a national SLRP partnership conference, changes in federal tax law and a site visit from the federal Health Resources and Services Administration have resulted in a set of recommendations for structural changes. The goals are to increase the number of participating clinicians, increase the program's effectiveness in addressing provider shortages and maximize the use of available federal matching program funds. The recommendations include:

- Focus on retention of providers, as well as recruitment
- Expand the eligible specialties list to include all those allowed under federal rules
- Identify sites eligible for placement under federal guideline; targeting them for marketing
- Reduced the minimum services requirement from three years to two years (the federal minimum)
- Increase allowable award thresholds to the maximum allowed under federal rules
- Engage an intern to focus exclusively on administering these program changes
- Consider alternative "economic incentives", i.e. loan assistance for capital expenditures to establish a practice

in a high-need area

DIDER approved the recommendations at its February 9 Board of Directors Meeting. DIMER will consider the recommendations on March 2. **The Commission will be asked to consider the recommended changes at its March 3 meeting.**

#### DIDER

In addition to its review and approval of structural changes to SLRP, the DIDER Board considered a set of approaches developed by a DIDER workgroup to improve opportunities for Delaware residents to obtain a dental education and to address issues related to access to care. These include:

- Purchasing dental seats at nearby schools
- Making scholarships available to dental students, regardless of where they attend
- Utilizing funds to enhance and expand the general practice residency program in Delaware (possibly via downstate satellite sites and/or a mobile van)
- Establish a flexible fund account that could be used depending on need

The Board will most seriously pursue the first three options.

#### **DHIN Clinical Information Sharing Utility**

##### Project Management

DHIN received 11 responses to its RFP for services to support technical and operational planning for the clinical information sharing utility. As a result of a panel review process, three respondents have been called for interviews, which will be held on Friday, February 18. The purpose of the RFP is to seek support in helping the DHIN stakeholders refine the technical requirements and project scope. This will better prepare DHIN to seek system design, development and implementation services to build a system that will interface with current systems as well as meet the needs of its users.

##### Marketing

DHIN representatives were interviewed for a *Delaware Today* magazine article on medical informatics. The article should be published in the next issue of the magazine.

In follow up to the December 20, 2004 press conference announcing DHIN funding and interest in developing an electronic medical card, the DHIN project director was interviewed for a cover story in *The Medical Banking Report*, an industry publication to provide news, analysis and commentary on the emerging integration of financial services and healthcare.

##### Funding

DHIN was approved for an extension of the January 18

deadline for AHRQ State and Regional Demonstrations in Health Information Technology RFP funding. The contract is for \$1.0 million for each of five years. AHRQ has continued interest in funding Delaware and negotiations continue for support of the system development phase of the project.

AHRQ also will administer the \$700,000 in federal funding appropriated to DHIN in the congressional budget. AHRQ intends to develop a request for contract for which DHIN will need to respond in order to draw down the federal appropriation.

### **Mental Health Provider Capacity - Data Gathering**

Chairman Carney reported that Jim Lafferty, Mental Health Association in Delaware, had shared his appreciation for the Commission's assistance regarding the adequacy of mental health services. When the report from the Commission's Committee on Mental Health Issues was presented in March 2004, it included a set of recommendations. The recommendation identified as needing first action data gathering to provide information on the number, distribution and characteristics of mental health professionals in the state. The data gathering activities should ultimately address both the demand and the supply side. The Division of Public Health has offered to sponsor the data gathering activities and Gina Perez, Advances in Management, has been retained to coordinate the project. Recently, there was a meeting of the Mental Health Issues Committee in which the process was discussed. A survey will be conducted by Ed Ratledge. The survey activity will be supplemented by focus groups. Proposals from universities to help analyze the data will be reviewed.

### **OTHER BUSINESS**

#### **Perinatal Board**

Commissioner Jacquelyne Gorum shared that the structure or function of the Perinatal Board may change in light of recommendations from the Governor's Infant Mortality Task Force.

### **PUBLIC COMMENTS/QUESTION AND ANSWERS**

Question: Under the one-third share option, how would employers participate in the program? Would there be enabling legislation to force them to join? Would they need the minimum tests of size and income of the workforce?

Response: It would be voluntary. That's why there is the range of take-up rate. It has never been done on a statewide basis either. To date, it has been tested in only local communities.

Comment by Mark Meister: There is a body of national data that

shows that appropriate access to primary and preventive care results in a decline in emergency department utilization and hospital length of stay. Although, (under the limited benefit plan) hospitals would continue to subsidize inpatient, they might be doing so to a lesser degree.

Response: That is why the hospitals in Utah agreed to the approach.

Question: When the SCHIP expansion approach was examined, was a premium for adults considered (as is now in place for eligible children)?

Response: I think so. The Commission will have to go back and research that.

Question: At a previous presentation there was a population cohort of uninsured who were qualified for existing coverage but not enrolled. Do we want to enroll all these people in the programs they are eligible for before instituting a new program?

Response: A significant portion of the Delaware uninsured (approximately 23 percent) are eligible for an existing public coverage programs. The Robert Wood Johnson grant-sponsored Covering Kids and Families program, is being led in Delaware by the Medical Society of Delaware is specifically focused on Medicaid and SCHIP outreach and enrollment. It would not be necessary to enroll everyone who is eligible for existing programs before instituting a new program designed to reach the next tier of the uninsured.

Question: Under the subsidized purchasing pool, was there a federal requirement that resulted in it being targeted to the low-income?

Response: At the time, 2001, when this option was developed, the primary focus was on the low-income uninsured. The situation was very different in 2001 than it is today.

Question: Dr. Meyer talked about his concerns about the demise of the health care system. Dr. Meyer, when do you predict it will happen? How long until we see that happen?

Response: I do not think the system will fall apart within the next couple of years. Examining employer coverage data over the last 15 years indicates it is eroding but not falling apart. What I am seeing now is that more and more low-wage workers are declining to purchase insurance that their employers offer or they are working for employers who do not offer health coverage. In my view (unless something is done) in five years this system will fall apart. Medicaid and Medicare are not sustainable. Medicaid was 10 percent of the average state budget in 1987 and today it is 22 percent and headed for 30 percent.

Further comment by Mr. Meyer: If the (government) says ‘we

The next meeting of the Delaware Health Care Commission will be 9:00 a.m. on **THURSDAY, MARCH 3, 2005** at the Delaware Technical and Community College, Conference Center, Room 400B, Terry Campus, Dover.

are going to provide more money so you can show us you can cover more of your poor people' by introducing premiums, cutting benefits, etc., I think all these things will make a (positive) contribution. It would be good to have a target where you want to be in 5-10 years and then take a look at the limited benefits package and some of the other options, and determine if they are taking us the right direction; explore how you can build on it.

Kay Holmes: I heard discussion around expansions in public programs. I want to point out that the assumption is that the underlying federal match to public programs would continue. However, our expectation is that this may not be the case. The reality is that within the next couple of years we are going to be in what federal officials call "allocations" and states call "block grants." This may be putting us (states) in a bind when it comes to state resources. Dr. Jaime Rivera and I are beginning some meetings between the Delaware Department Public Health and Delaware Office of Medicaid to examine strategies, such as disease management, to improve efficiency and cost.

Chairman Carney shared that he is supportive of building disease management and personal responsibility strategies into plans and programs.

#### **NEXT MEETING**

The next meeting of the Delaware Health Care Commission will be held at 9:00 a.m. on **THURSDAY, MARCH 3**, at the Delaware Technical and Community College, Conference Center, Room 400B, Terry Campus, Dover.

#### **ADJOURN**

The meeting adjourned at 11:50 a.m.

## GUESTS ATTENDING

Carol Barna, Mid Atlantic Health Plan  
Joy Blasier, EDS/CHAP  
Lisa Brack, Delaware Workforce Investment Board  
Anthony Brazen, III, MD, Division of Social Services, Medicaid  
Charles Case, MD, Henrietta Johnson Medical Center  
Jason Danner, Kelly  
Judy Diogo, Central Delaware Chamber of Commerce  
Cynthia Dwyer, The Wellness Community  
Katherine Esterly, MD, Christiana Care Health System  
Carol Everhart, Rehoboth-Dewey Beach Chamber of Commerce  
Matt Fink, Congressman Mike Castle's Office  
Edward Goate, Central and Southern Delaware Health Partnership  
Doug Gramiak, Office of the Lt. Governor  
Robert Hall, Delaware Ecumenical Council  
Nicole Hermanns, Westside Health  
Nancy Hoag, St. Francis Hospital  
Cathy Holloway, American Cancer Society  
Kay Holmes, DMAP/Division of Social Services  
Connie Hughes, Delaware Association of Nonprofit Agencies  
Bill Kirk, Blue Cross/Blue Shield of Delaware  
Joe Letnaunchyn, Delaware Healthcare Association  
Lolita Lopez, Westside Health Center  
Spiros Mantzavros, American Heart Association  
Mark Meister, Medical Society of Delaware  
Iran Naqui, Mid-Atlantic Association of Community Health Centers  
Linda Nemes, Department of Insurance  
Brian Olson, LaRed Health Center  
Betty Paulanka, Dean of Nursing, University of Delaware  
Brian Posey, AARP  
Tom Price, American Heart Association  
Jim Randall, Coldwell Staffing  
Rosa Rivera-Prado, Henrietta Johnson Medical Center  
Tonia M. Ryan, Daimler Chrysler  
Debra Singletary, Delmarva Rural Ministries  
Joan Sloan, AmeriHealth Insurance Company  
Mark B. Thompson, St. Francis Hospital  
Jose Tieso, EDS  
Lori Walsh, Mid Atlantic Health Plan  
Ellen Wasfi, League of Women Voters of Greater Dover  
Mary Watkins, Delaware State University, Nursing Department  
Rob White, Delaware Physicians Care, Inc.  
Linda C. Wolfe, Department of Education  
Calvin Young, UAW Community Health Care Initiatives  
Joseph Zingaro, Clinical Director, People's Place Counseling Center