

DELAWARE HEALTH CARE COMMISSION  
JANUARY 5, 2006  
DELAWARE TECHNICAL & COMMUNITY COLLEGE  
CONFERENCE CENTER, ROOM 400B  
DOVER

Action Item

MINUTES

**Commission Members Present:** John C. Carney, Jr., Chair; Matt Denn, Insurance Commissioner; Jacquelyne W. Gorum, DSW; and Dennis Rochford.

**Members Absent:** Richard Cordrey, Secretary of Finance; Carol Ann DeSantis, Secretary, Delaware Department of Services for Children, Youth and Their Families; Joseph A. Lieberman, III, MD, MPH; Vincent Meconi, Secretary of Health and Social Services; Robert Miller; and Lois Studte, RN.

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

**CALL TO ORDER**

Chairman John C. Carney, Jr. called the meeting to order at 9:15 a.m.

**APPROVAL OF DECEMBER 1, 2005 MINUTES**

Approval of the December 1, 2005 minutes was postponed as there was no quorum.

**UNISURED ACTION PLAN**

**Small Business Report & Discussion – Elliott K. Wicks, PhD**  
Elliott K. Wicks of the Economic and Social Research Institute gave a presentation on “Premium Variation in the Small-Group Market in Delaware: Analysis of the Problem and Possible Solutions.” The report was prepared for the Small Business Health Insurance Committee. The purpose of the report was to offer an analysis of the small group health insurance market and the current law regulating small group insurance.

The current law is commonly referred to as “Chapter 72” because it is found in Chapter 72 of Title 18 of the Delaware Code.

Mr. Wicks interviewed a variety of people in conducting this analysis, including insurance agents, brokers, regulators, business groups and insurance executives. Most agree that the current law is not working well, or as originally intended.

***Action:***

Approval of the December 1, 2005 minutes was postponed as there was no quorum.

Commissioners heard a presentation on “Premium Variation in the Small-Group Market in Delaware: Analysis of the Problem and Possible Solutions.”

Current law permits premium variations as wide as 9:1, that is the lowest risk small employers can pay only pay 1/9<sup>th</sup> the rate that the highest risk employer can pay. Actual variations in premium rates of 4 or 5 to 1 occur with some frequency; that is, an employer with a substantially older, less healthy work force may pay five times the premium that would be offered to an employer with the youngest, healthiest work force. A single employer can experience a very large increase from one year to the next, as might happen if one or two employees pass an age demarcation that puts the firm into the next higher risk category or because someone in the group develops a chronic disease or other serious illness. The largest premium renewal increases can be as high as 40 to 60 percent for some firms when changes in the characteristics (older, less healthy) of their employees cause rate hikes that are added to the general increases in premiums (“trend”) that all firms regularly experience.

An additional problem is instability in rates from year to year. Many small firms can manage to pay the rates if the increases were more stable from year to year but when they become as unpredictable as shown if becomes difficult to budget for them. Many small firms do not have profit margins commensurate with annual rate increases. .

There is not much evidence that small employers are dropping coverage. They are making adjustments such as passing on more costs to employees by increasing deductibles, and asking employees to pay a higher percentage of the premium. Insurance regulators indicated that a high proportion of the complaints they received from small employers are about high rates. Many express a sense of unfairness about how the system is working.

Insurers have little choice but to take advantage of what the law permits. If once carrier does not, another carrier will, forcing the first carrier to experience adverse selection. For example, if one insurer decided to do community rating while other insurers were taking advantage of the rate variation allowed by law, the community rating insurer would end up with the high risk people because they could get a better “deal” by getting a community rate and they would lose the low risk people because they would do better to get coverage from insurers that rate on the basis of risk. In any population group, approximately 10 percent of any population accounts for about 70 percent of the medical claims. There is strong incentive to try to avoid that 10 percent of high risk people.

Current state law governing small group health insurance permits wide premium variations among groups. Employers can experience large increases from one year to the next due to increased employee risk factors.

An additional problem is rate instability from year to year, making it difficult for small firms to budget for such high increases.

There is little evidence that Delaware employers are dropping coverage.

Market forces leave insurance carriers little choice but to take advantage of what the law permits in order to avoid adverse selection.

The solutions to this involve spreading the risk away from the high risk groups to somebody else. That can be spread across all small group markets, or more broadly over the whole population by using the tax system.

#### Option 1 – Adjust Law on Variation

One way to reduce the allowable rate variation is to adjust the law (Chapter 72 of the Insurance Code, which was passed in 1992) with respect to what kind of rate variation is permitted, making it more restrictive to reduce the current extent of premium variation. It is possible to change the law in a way that would both limit the amount of rate variation and still make it less complex than it is now. Maryland law has only two rating factors are allowed; age and location of the business. A more important feature of Maryland’s legislation is that the rate variation that is permitted is not to exceed plus or minus 40 percent from the lowest risk group to the highest risk group no matter how the rating factors are used.

#### Option 2 – Adjusted Community Rating

Many states have adopted what is commonly referred to as adjusted community rating. It has generally ruled out health status or previous medical history as a basis for determining rates. The argument for community rating is that no one has to pay a higher rate because of conditions largely beyond their control, such as age, where they work or live, or previous medical history. There are arguments against moving toward community rates. The theory is that if you compress rates too much low risk groups will have to pay more in order to make high risk groups pay less. In return low risk groups will drop out of the market making a reduction in insurance coverage of low risk groups. Evidence suggests that there has not been a large reduction in the number of low risk groups that are insured where states have moved toward adjusted community rating. If there are compressed ratings it will probably lead to increased coverage for high risk groups. The overall rate of insurance coverage will not dramatically increase. This is not primarily the way of increasing the number of people who have insurance but more a way of preventing the loss of coverage among employers who already offer coverage.

In a small state, like Delaware, there is a danger that some of the small insurers will leave the state under the circumstances of extreme rate compression. There are insurers that are profitable by being very good at medical underwriting and being able to draw off the low risk groups.

The solution is to find a way to more evenly spread risk.

Option 1: Adjust law on variation.

Option 2: Adjusted Community Rating.

Rate compression does not increase the number of people who have insurance, but does prevent loss of coverage among employers who offer it.

If using compressing rates, the best way to start is to decide how much rate variation is desirable (2:1, 3:1, 4:1). Policymakers could then move to deciding what rating factors to permit.

### Risk Adjustment

Another approach to rate variation is to adopt a system of risk adjustment. What this does is eliminate the financial incentive for insurers to try to draw off low risk groups and eliminates the advantage of doing so. Implementing would involve examining each insurer's risk profile and require monetary transfers from those insurers that have a low risk profile to those insurers with a high risk profile so that any financial advantage related to the risk differences are eliminated. Under these circumstances there would be no advantage to having low risk and no penalty to having high risk. There is no risk adjustment system in place that is so perfect it would achieve that result, but there is some experience with doing this indicating it can offset much of the risk and help reduce rate variations.

### Option 3 – Reinsurance Pools

A third approach is a reinsurance pool for selected individuals or groups. This allows insurers at the time they first insure a group to identify either a group or individuals within the group at high risk and to decide to pass off that risk. The insurers have a limited period of time to identify these high risk groups or individuals and then “cede” the risk to the insurance pool. This differs from traditional types of reinsurance in that the insurer has to identify the high risk groups before the costs are incurred. The idea is that every insurer who takes advantage of this has to pay a high premium to pass on these risks. Delaware law states that for a whole group they have to pay a premium of 150 percent of the already risk adjusted payment and for an individual person they have to pay 500 percent. The problem, especially in Delaware, is that large insurers often do not support mandatory insurance mechanisms and do not participate in them. They argue that they do not have to pass on the risk because they can absorb it; therefore they do not participate. If large insurers are exempt and do not participate, effectively there is no “pool” to which the risk can be passed on. The system will not work unless the large insurers are required to participate and bear their share of the risk. Only two insurance companies ever chose to be a reinsuring carrier and participate in the program in Delaware. At this time the law is dormant.

Option 3:  
Reinsurance Pools.

### Subsidized Reinsurance

Another approach is subsidized reinsurance, which depends on government to finance the reinsurance. For example, the insurer

would be responsible to pay all costs up to a threshold (i.e. \$80,000 for an individual episode of care) and then the government would pay a large proportion of the remaining cost (i.e. 90 percent). The insurers could lower premiums because they do not have to bear much of the risk after the high cost cases. It would also make them somewhat more willing to accept high risk groups because they would not have to pay all of the cost that group incurred. It protects them from some of the worst effects of adverse selection. The advantage of this approach is that it spreads risk very broadly across the whole tax paying population. The disadvantage is that it requires government spending that is not cost efficient. This is because of the cost the government would be paying for, when the high cost case reaches that threshold, is now being paid by people who buy insurance that covers that cost. You are essentially transferring the cost from the private sector to the public sector.

The size of the reinsurance subsidy could be substantially less if it was decided to limit the group that is eligible, for example, small employers that have low-wage employees. Many of those firms do not provide coverage at all so if the government is subsidizing the cost of the high cost cases for these groups, they are not substituting public dollars for private dollars because the people were not insured.

#### Option 4 – Purchasing Pools

Purchasing pools is another approach. Purchasing pools have merits but they cannot separately pool risks and reduce rate variations for small employers. In general they cannot because if they use more lenient rating rules and the rest of the market does not, they will end up with all the high risk groups because it is less expensive to buy coverage in the pool and they will lose all the low risk groups, failing financially. A scenario in which pools might work would be if some groups are required to use the pool as their source of coverage and can not go outside the pool. If, for example, all groups with 25 or fewer employees were required to buy coverage through the purchasing pool, risk could be more evenly spread close to community rating because that is the only choice low risk groups have. A second scenario would be if there are large subsidies available only to people who only use the pool. Under those circumstances, if the subsidies are sufficiently large, even the lower risk groups would find it attractive to stay in the pool.

**Option 5 – Combination High Risk Pool/Subsidized Reinsurance**  
The last approach is a combination approach by using the state employees' plan as a basis for coverage. It combines elements of a high-risk pool, subsidized reinsurance, and collective

Option 4:  
Purchasing Pools.

Option 5:  
Combination High  
Risk  
Pool/Subsidized

purchasing. Like subsidized reinsurance it requires government subsidies, but unlike reinsurance, the subsidies are targeted to just the high-risk groups and not spread across the whole small-group market. Another advantage is that it provides small businesses with a source of coverage that is more efficient because of the state plan's greater purchasing clout and administrative economies, including the fact that the state would not have to do medical underwriting. A possible disadvantage is that the state is not experienced in serving small employers, and that process would involve some significant administrative costs.

Several private-sectors efforts have been initiated to make health coverage more affordable and available for small employers. They include

- New Castle Chamber of Commerce Plan
- State Chamber of Commerce Health Plan
- First HealthyChoices

The private-sector efforts to offer affordable coverage have met a need by enrolling a substantial number of small employers. However, approaches such as these cannot solve the problem of rate variation among firms in the small-group market because they have no choice but to use medical underwriting and to vary rates based on differences in group risk according to the provision of Chapter 72. .

The full presentation may be viewed on the Delaware Health Care Commission website: <http://www.state.de.us/dhcc/>.

Insurance Commissioner Matt Denn stated he has some concerns about rate variations and rate compression as presented in the report. He also stated that passing legislation to revise Chapter 72 of the Insurance Code this year is not a priority because he would like to focus on legislation establishing an insurance pool.

The report has been presented to the Small Business Committee. The Committee will reconvene and develop recommendations for the Commission.

### **SPECIFIC HEALTH CARE ISSUES**

#### **Chronic Illness and Disease Management Task Force**

Paula Roy reported on activities of the Chronic Illness and Disease Management Task Force. The Task Force met in December 2005, and received updates of chronic illness and disease management activities within the Medicaid program. The legislators who are members of the Task Force have requested the Commission to convene a group to develop a stroke system of care in Delaware through the Chronic Illness

## Reinsurance

The full presentation is available on the Delaware Health Care Commission website: <http://www.state.de.us/dhcc/>.

Paula Roy received a written request from Representative Bethany Hall-Long, Representative Pamela Maier,

and Disease Management Task Force or Health Care Commission. They believe it is not necessary to pursue a legislatively created stroke task force to develop statewide stroke systems but rather work through this existing Task Force and/or Health Care Commission.

The Commission will honor the request through the Chronic Illness Task Force in collaboration with the American Stroke Association.

### **ANNUAL REPORT & STRATEGIC PLAN**

Edits were made to the Annual Report and Strategic Plan however approval was postponed as there was no quorum.

### **INFORMATION & TECHNOLOGY**

Delaware Health Information Network (DHIN)

#### **Request for Proposal**

A DHIN Workgroup is in the process of providing guidance to Health Care Information Consultants (HCIC) for the development of the request for proposal (RFP) to build the Utility. The RFP is expected to be released in February 2006. DHIN will require that respondents to the RFP provide a prototype of their solution for DHIN to evaluate. This process will afford DHIN the opportunity to have hands on experience with the solution as well as speed the implementation time once a contract is signed. DHIN has a requirement under the Agency for Healthcare Research Quality (AHRQ) contract for data interchange to be in place by March 2007.

#### **Financing**

Health Care Information Consultants (HCIC) is working with DHIN members of the Finance Committee to develop a capitalization and financial plan. A cost-benefit analysis has been finalized. The group now will be establishing a model for short and long-term financing and sustainability, which will be rolled out to the stakeholders in the next 30 days.

#### **Operations**

Two operations models are being evaluated by the Executive Committee to best support the ongoing management and oversight of the Utility. One model is a non-government, not profit and the second is a variation of the current government based, public-private partnership. Both models will be evaluated on merits for management effectiveness, community input and participation, financial solvency and operational efficiency.

Senator Patricia Blevins and Senator Dorinda Connor to develop a stroke system of care in Delaware through the Chronic Illness and Disease Management Task Force or Health Care Commission.

#### ***Action:***

Approval of the Annual Report and Strategic Plan was postponed as there was no quorum

A DHIN Workgroup is in the process of providing guidance to Health Care Information Consultants (HCIC) for the development of the request for proposal (RFP) to build the Utility.

HCIC is working with DHIN members of the Finance Committee to develop a capitalization and financial plan.

The Consumer Advisory Committee (CAC) met on December 6 and determined that it wanted to have greater input into the Utility development process in 2006. The Committee's next meeting is January 18, 2006 and beginning in April the CAC will meet bi-monthly.

The next DHIN Board meeting is January 30, 2006, 3:00 to 5:00 p.m. in Dover (location to be determined).

**Next 30 days**

- Continue to develop RFP
- Continue to develop an economic model for DHIN start-up and ongoing sustainability
- Develop Utility operational model options

An Ad Hoc finance group meeting was held January 4, 2006 to work on a finance/capitalization plan. Recommendations will be given in terms of upfront financing and who/where DHIN may be looking for revenue.

Any funding proposal must go through the Technology Investment Council prior to submitting a budget request.

Chairman Carney questioned when DHIN will receive the HCIC report. Project Manager Gina Perez stated there is no "report." There are multiple reports and deliverables. The delay is in the advance planning document which pulls together all the work. The reason for the delay is because DHIN has a workgroup focusing on the RFP. Until the work of the finance group and the work of the RFP are completed, the advance planning document will be complete.

Chairman Carney asked about the wisdom of issuing an RFP prior to seeing that document HCIC prepares. Ms. Perez responded that the work being done by the finance group and the RFP group will handle those questions. A DHIN presentation will be given at the February meeting.

**OTHER BUSINESS**

Sarah McCloskey updated Commissioners on activity of the Health Resources Board. A meeting was held on December 15, 2005. The Board approved the plans for the Delaware Surgery Center which will be a free-standing, multi-specialty surgery center at the new Eden Hill Medical Center in Dover.

Review committees were assigned for two projects:

- The Dover Surgery Center, which is affiliated with Bayhealth Medical Center. It was previously operated from 2001 to 2003, and then closed. It is an 11,000 square foot facility, expecting to serve 3,700 cases per

Sarah McCloskey updated Commissioners on activities of the Health Resources Board.

- year.
- The Abby Surgery Center, in Newark. It is located one-half mile from Christiana Care, with 75,000 square feet of office space and a 12,500 square foot surgery center. It will contain four operating rooms and two minor procedure rooms. What makes it unique is its focus on breast cancer.

The next meeting is in January 2006 where the review committees will present recommendations.

Chairman Carney asked for volunteers from the DHCC to serve on the Health Resources Board.

Dr. Jacquelyne Gorum stated David Paul, MD was appointed chairperson for the Healthy Mother and Infant Consortium. Dr. Gorum is co-chair. The first meeting should be held the end of January, mid-February of this year, when they are hoping to set up the Consortium's infrastructure. At this time the Consortium is scheduled to meet in Dover on a quarterly basis. Meetings are open to the public, welcoming persons interested in contributing to solve the infant mortality issues.

#### **PUBLIC COMMENT**

Spiros Montzavinos, American Heart Association and American Stroke Association, thanked the Commission for its support of developing a stroke system of care in Delaware through the Chronic Illness and Disease Management Task Force. He extended an offer to present an overview to the Commission on what stroke systems are and how they have been implemented in other parts of the country.

Dr. Robert Frelick commented on the costs of not having health insurance. Wal-Mart employees are a good example of how the State is supporting a group who does not have health insurance. We need to look at the cost of not doing something as well as the cost of doing something. There is a lot of subsidy not only by the government but by hospitals and physicians for the uninsured.

Rita Marocco stated there was a recent report on World News, on television, regarding the increase in bankruptcy due to medical issues. Seventy-five percent of the bankruptcies filed were by insured people. The problem goes beyond the uninsured, with high deductibles, co-pays and the high costs of what the insurance companies won't pay.

Dr. Jacquelyne Gorum is co-chair of the Healthy Mother and Infant Consortium which will meet in late January, mid-February to set up its infrastructure. Dr. David Paul is chairman and Dr. Gorum is co-chair.

**NEXT MEETING**

The next meeting of the Delaware Health Care Commission will be held at 9:00 a.m. on **THURSDAY, FEBRUARY 2, 2006** at the Delaware Technical and Community College Conference Center, Terry Campus, Room 400B.

**ADJOURN**

The meeting adjourned at 10:45 a.m.

***Next Meeting***

The next meeting is 9:00 a.m. on Thursday, February 2, 2006 at the Delaware Tech Terry Campus Conference Center, Room 400B.

## **GUESTS ATTENDING**

Jack Akester, Consumer Advocate  
Michael Duva, Delaware Healthcare Association  
Robert W. Frelick, MD, Medical Society of Delaware  
Joann Hasse, League of Women Voters of Delaware  
Kay Holmes, Division of Medicaid and Medical Assistance  
Paul Lakeman, Bayhealth Medical Center  
Lolita Lopez, Westside Health Center  
Spiros Montzavinos, American Heart Association  
Rita Marocco, NAMI, Delaware  
Miranda Marquez, Division of Vocational Rehabilitation  
Linda Nemes, Department of Insurance  
Brian Olson, La Red Health Center  
Gina Perez, Advances in Management  
Suzanne Raab-Long, Delaware Healthcare Association  
Jose Tieso, EDS  
Diane Treacy, Planned Parenthood of Delaware  
Betsy Wheeler, Wheeler and Associates Management Services