DELAWARE HEALTH CARE COMMISSION
APRIL 7, 2011
DELDOT ADMINISTRATION BUILDING
FARMINGTON/FELTON CONFERENCE ROOM
DOVER

MINUTES REVISED JUNE 2, 2011

Commission Members Present: Bettina Riveros, Chair; Theodore W. Becker, Jr.; A. Richard Heffron; Rita Landgraf, Secretary, Delaware Health and Social Services; and Janice E. Nevin, MD

Commission Members Absent: Thomas J. Cook, Secretary of Finance; Dennis Rochford; Karen Weldin Stewart, Insurance Commissioner; Vivian Rapposelli, Secretary, Services for Children, Youth and Their Families; and Fred Townsend

Staff Attending: Paula Roy, Executive Director; Marlyn Marvel, Community Relations Officer; and Robin Lawrence, Executive Secretary

CALL TO ORDER

The meeting was called to order at 9:00 a.m. by Bettina Riveros, Commission Chair.

MEETING MINUTES OF FEBRUARY 3, 2011 AND MARCH 3, 2011

Action could not be taken on the February 3, 2011 and March 3, 2011 meeting minutes due to the lack of a quorum of Commissioners.

Action could not be taken on the February 3, 2011 and March 3, 2011 meeting minutes due to the lack of a quorum of Commissioners.

RESEARCH & POLICY DEVELOPMENT – AFFORDABLE CARE ACT - Exchange Planning

Ms. Riveros reminded Commissioners that they had identified three main priorities in activities to implement the Affordable Care Act in Delaware: (1) Health Insurance Exchange, (2) driving new delivery systems of care and fostering innovation, including patient centered medical homes and accountable care organizations, and (3) health professional workforce capacity and development issues.

Because the planning and implementation timeline for the Health Insurance Exchange is so pressing, it continues to be a very strong focus for the Health Care Commission and the Health Reform Workgroup chaired by Secretary Rita Landgraf.

For the past two months the focus has been on stakeholder outreach. Meetings have been held with the broker agent community, business community, providers, and non profits, among others, to understand peoples' concerns as Delaware moves forward in implementing the Exchange.

In addition to stakeholder outreach, work is underway with the Health Care Reform Workgroup to look at information technology and operational issues because of the high integration required between an Exchange and the current Medicaid system.

The Workgroup has also been focused on governance and policy issues and what the Exchange enabling legislation might look like.

Work has begun through Delaware's Exchange Planning Grant. The consultants from the Public Consulting Group (PCG) for the planning grant were in attendance at the meeting.

Ed Ratledge, the Director of the Center for Applied Demography and Survey Research at the University of Delaware, is doing an environmental scan to set the stage on what is going on in other states to provide a platform from which Delaware can build.

The task now is to continue sharing the information with the Commission to determine what needs to be done to move forward with the Exchange.

Issue Brief #1 – Ed Ratledge

Ed Ratledge, Director of the Center for Applied Demography and Survey Research at the University of Delaware, gave a presentation on Health Benefit Exchanges. A copy of the full presentation is posted on the Delaware Health Care Commission's website at http://dhss.delaware.gov/dhcc/.

The following five basic issues are being addressed:

- What are the Health Benefit Exchanges that currently exist and how does their experience help Delaware plan?

- How does the law impact Medicaid and the Children's Health Insurance Program (CHIP) and what enrollments could be expected in 2014?

- What provisions impact the young uninsured and what are the tradeoffs between the penalties and insurance costs? How many are affected?

- What provisions affect employer sponsored health insurance options related to cost and how will they impact the enrollees?

- Assuming the law will reduce the number of uninsured, what is the need for additional health care workers?

What Health Benefit Exchanges Exist?

- The key decision is whether to form an exchange at all, or to default that responsibility to the federal government.

- Four states have the framework in place: California, Massachusetts, Utah, and Washington (at the time this report was prepared).

- Massachusetts' exchange is currently in operation but planning and modification activities continue.

- There is no dominant organizational model adopted by these states. Only California and Massachusetts have committed to a particular model. The balance is in the recommendation or draft legislation stage.

- Decisions need to be made on who is included in the exchange; i.e. small groups, individual market.
-

How are Medicaid and CHIP Affected?

- The law requires an expansion of Medicaid eligibility from 100 percent to 133 percent of the federal poverty level (FPL). It encourages expansion above that level as well.

- Previous CHIP enrollees who are under 133 percent FPL move to the Medicaid program.

- CHIP expands above 134 percent to 200 percent FPL.

- For ages 19 and 20, the aged and disabled, parents, and childless adults eligibility expands to 133 percent FPL in Medicaid from levels much lower.

- Key issues are how many in these groups are eligible and how many will enroll.

Mr. Ratledge noted that the key question is how many people are eligible, and how many will enroll in this process. In 2009, a total of 177,000 people were enrolled in Medicaid. The current Medicaid enrollment is 196,000 people.

He provided an overview of the groups of people enrolled in Medicaid who are contributing to cost issues. The number of non-disabled adults enrolled has increased significantly over the past decade. He suggested that may be the result of policy changes.

Steve Groff, Deputy Director of the Division of Medicaid and Medical Assistance, explained that Delaware implemented a demonstration waiver in 1996 that allowed the State to save money by moving its acute care populations into managed care. Those savings were reinvested to expand eligibility for Medicaid to adults, including childless adults, which most states do not serve categorically beneath 100 percent of the federal poverty level. Normally a state would only serve adults and families at the old limit, which for Delaware would be about 75% of the federal poverty level. Adults and families plus childless adults up to 100 percent of the federal poverty level are eligible for Medicaid in Delaware. With the economic down turn, as people began to lose jobs and access to employer sponsored coverage, they applied for Medicaid. Families came with children who may be in Medicaid or may be in the Children's Health Insurance Program (CHIP).

In addition to the 196,000 people enrolled in Medicaid, there are 6,000 children enrolled in CHIP.

Mr. Ratledge said that the number of uninsured in Delaware has remained around 100,000, plus or minus about 15,000, since 1982.

How are the Young Uninsured Affected?

- The law requires that the young uninsured be insured or pay a penalty of $95 initially which increases to $695 by 2016. This is still in the courts.
- Parents will be able to keep "young adults" up to age 26 on their health insurance if they so choose.
- Health savings accounts and catastrophic insurance will play a large role in reducing the cost and avoiding the penalties.
- The major question is how many are there now and in 2014 and will they choose to buy insurance if not covered by their parents?

How Are Employers Affected?

- Current expectations are that those who currently provide the required level of insurance will be affected marginally.
- Seasonal workers (under 120 days a year) and part-time workers (less than 30 hours per week) are excluded.
- Large employers (> 50 employees) who do not offer insurance will pay $3,000 per subsidized employee.

- Large employers (> 50 employees) who do not offer adequate insurance will pay $2,000 per subsidized employee.

- The first 30 employees above 50 who are subsidized do not count in the penalties.

- The issue is measuring the numbers affected and likely to use the exchange. There is good survey data for small employers with < 50 employees and slightly less data for larger employers.

What about the need for additional health care workers?

- As the access to health insurance increases, the need for primary care physicians, nurses, and lab technicians will increase.

- This can be estimated if the take-up rate can be estimated on the new insurance products.

- There is a serious squeeze on primary care physicians and the law will likely increase the pressure.

- Increased demand for health care workers will drive costs higher as salaries increase.

- This pressure is in addition to the overall increase in services needed as the boomers age and the overall population grows. Both will affect the hospitals as well.

Mr. Ratledge added that the major demographic changes which are taking place are going to continue independent of whether an Exchange is established or not. He displayed a graph to illustrate the likelihood of hospitalization by age and gender. Those numbers are likely to increase substantially and costs will continue to rise.

He displayed a map of Delaware 2010 census results. New Castle County is not growing. The population is moving south. The result is increasing demand for hospitals, primary care physicians and other health care providers in areas where there is a significant shortage.

The Center for Applied Demography and Survey Research (Center) will estimate how many people it thinks at this point are going to end up wanting to use the Exchange. That will help the State decide what kind of products it will want to have represented in the Exchange. The State needs to know what products are currently on the market and determine what new things will need to be developed in order to deal with an Exchange.

Ms. Riveros asked Mr. Ratledge to comment on the full scope of his activities.

Mr. Ratledge responded he is currently working on projections. He is also considering the financial aspect and the question of what Delaware can pay for. He acknowledged the multiple information technology issues. He estimated that the dual Medicaid Medicare population will grow, but it is not known what the rate or splits will be in the future. He thinks he will be able to get fairly good estimates on the health care work force. One thing to consider is that the Baby Boomers will be leaving the health care workforce at the same time they will need more services due to aging. Boomers will be exiting the workforce at a rate that is twice as fast as the younger population is growing.

Dr. Ray Sukumar asked Mr. Ratledge if he will be able to calculate the Exchange implementation cost, how much of the funds will remain in Delaware and how many jobs will it create in Delaware. Mr. Ratledge responded that the Center has a fairly sophisticated regional economic model that it can work with; however, trying to determine the impact of border crossing is difficult.

Another public observer asked Mr. Ratledge if, with regard to the health care workforce, he is looking at the scope and roles of practice. Mr. Ratledge responded that the Center conducts a physician's survey every three years. Among other things the survey reveals the type of workers they are hiring. The history can be reviewed to project what the future workforce might look like. Currently the trend appears to be a mix between physician assistants and advanced practice nurses with respect to workers in primary care physicians' offices.

Dr. Janice Nevin said the national residency match was at the end of March. This year there was an increase in the number of students interested in pursuing primary care. However, they will not be ready to practice for another three to four years, so any action taken now will take years to make an impact.

One of the concerns with graduate medical education is that medical schools are actively increasing their class size. There are many new medical schools in the pipeline, the osteopathic schools

are growing, and the off shore schools are growing, but the number of training slots is not. This has a lot to do with how training slots are funded. Institutions are unlikely to expand those slots without funding. Delaware can project how many physicians it needs, but may not be able to produce them.

Ms. Riveros responded that this issue came up in recent discussions with the Public Policy Institute and Dr. Robert Laskowski, CEO of Christiana Care Health System. He reported that all of the training slots had been filled early in the year.

The Delaware Health Sciences Alliance is looking at opportunities to grow and develop a relationship with Christiana Care Health System, Jefferson Medical College, A.I. DuPont Hospital for Children and the University of Delaware and look at coordinated training opportunities there.

Mr. Ratledge said that the Center will be issuing five issue briefs over the next two weeks; one on each of the five topics he addressed in his presentation. The issue briefs will be available on both the Center for Applied Demography and Survey Research website http://www.cadsr.udel.edu/ and the Delaware Health Care Commission website http://dhss.delaware.gov/dhcc/.

Jo Ann Hasse, of the League of Women Voters, said that a breakdown is needed on the number of people who are in Medicaid. Of the 196,000 on Medicaid, how many are in long term care nursing homes, how many are disabled, and how many are in other categories?

Mr. Groff responded that, of the 196,000 people enrolled in Medicaid, 160,000 are in managed care. There are about 22,000 people enrolled in Medicare and Medicaid, about 3,000 in nursing facilities and 2,000 on home and community based waivers.

George Meldrum, of the Nemours Foundation, reported that the Kids Caucus is scheduled to meet at 11:30 a.m. on Thursday, April 14, 2011 in the House Hearing Room on the second floor of Legislative Hall. The Children's Hospital of Philadelphia will be giving a presentation on the implications of the Affordable Care Act on children's' health services.

<u>Stakeholder Engagement Report</u>
Ms. Roy reported that meetings have been held with brokers, insurance companies, small employers and consumers to get their views on Health Insurance Exchanges. During the meetings the Exchange concept has been reviewed, along with the required and optional functions for states to set up Exchanges and the pros and cons of each choice.

The information that has been collected will be passed on to the planning consultant, Public Consulting Group (PCG), to incorporate into the planning process. The Commission will use the research and analysis of PCG and Ed Ratledge to make recommendations to the Governor and General Assembly on a path forward for the Exchange.

An Exchange will be a place where people shop for insurance. The initial targets are individuals, small businesses and their employees. It is intended to be a tool to help people comply with the individual coverage mandate that is currently in law.

There will be subsidies for individuals making up to 400 percent of the federal poverty level to purchase insurance in the exchange and there will be tax credits for employers with fewer than 25 employees, but there are some wage limitations.

Exchanges must:

- Certify qualified health plans that will be offered in the Exchange
- Offer a toll free telephone number for people to call
- Maintain a website that shows standardized information on plan options
- Electronic calculator to allow people to calculate if they qualify for a subsidy and how much of a difference that will make in terms of the premium that they will pay
- Provide information on public programs and allow people to access public programs through the Exchange so it is another door into Medicaid, CHIP and other public programs
- Assign ratings to plans based on quality and price
- Establish Navigator program. Navigators are intended to be people who help consumers understand about the exchange and understand their choices and options and facilitate enrollment in a plan in the Exchange.

The following are the key decisions for Delaware to make:

Delaware must decide whether to establish an Exchange. There is the option to do a state based Exchange, a regional Exchange, or have the federal government operate an Exchange.

It must decide whether to have one or two Exchanges. The law says that states can have one Exchange for small business and one for individuals. Or there can be one Exchange with two markets.

Delaware must decide whether to keep the small group market separate, or merge it with the individual market, which is what Massachusetts decided to do.

There is the issue of where the Exchange resides and how it is governed. Should it be governed by an existing State agency? Should a quasi state agency be created? Or should it be completely private non-profit?

Sustainability and scope must be determined. Delaware is currently operating under a planning grant. There will be an opportunity to apply for an implementation grant to build the Exchange. Federal funding will be available up until 2015 when the Exchange must be up and running and it will need to be determined how it will be funded going forward.

There is the option to change the definition of small group. Current Delaware law defines small group as groups from 1 to 50. Federal law allows states to expand that definition up to 100.

A critical point for Delaware is products sold inside and outside of the Exchange, and how to make it attractive for small employers, their employees and individuals to purchase through the Exchange. Almost 200,000 of Delaware's total population of 876,000 are enrolled in Medicaid. It needs to be determined what products are available for people who are likely to purchase insurance in the Exchange and whether there are enough people to make it sustainable. If there is a robust outside market where products can be purchased at a lower cost, young and healthy people will most likely purchase outside of the Exchange and the Exchange runs the risk of becoming a de facto high risk pool, which is not the purpose of an Exchange.

The role of brokers and navigators has sparked some lively discussion. Brokers are trained professionals who are licensed and regulated by the Department of Insurance to provide advice and assistance and enroll people in insurance. Brokers are concerned that navigators may replace them. States are required to establish a navigator program so careful consideration needs to be given to this issue. It is believed that there is room for both brokers and navigators.

The final decision to be made is how much choice will be available and how many plans will be offered in the Exchange.

Ms. Roy displayed a series of grids that reflect the opinions offered during the stakeholder meetings. The first reflected opinions on whether or not to establish an Exchange and, if so, if it should be state, regional or federal. Most of the stakeholders were in favor

or a state Exchange. No state is currently seriously considering a regional exchange. It would be difficult for states to align their regulatory and political environments to come together and efficiently be able to operate an exchange.

Dr. Nevin said that a regional exchange seems like it could be helpful; particularly in a small state. Ms. Riveros responded that it is difficult to coordinate insurance regulations across state lines.

Rich Heffron said that lessons learned from Worker's Compensation rate experience could be applicable to Exchanges. In Worker's Compensation, Delaware must depend on the Philadelphia and Maryland markets. The experience is that the larger states usually end up driving the costs and market, rather than Delaware.

A public observer said, in terms of governance, market rules and eligibility systems, the history of multi state cooperation is pretty dismal. Given the timeline, he thinks approaching an Exchange from a governance and regulatory model at the state level makes sense with an eye toward leveraging services.

Ms. Roy said, when stakeholders were asked how many Exchanges Delaware should have, those in the insurance industry had some strong feelings. Many people did not understand or appreciate the impact of having one or two Exchanges as much as those in the insurance industry did. One broker recommended two Exchanges. After a discussion there was recognition that there might be some administrative efficiencies in having one Exchange with two pools.

Next there was discussion about whether to merge the markets. Merging the markets would make the pool bigger, which would be good. However, there is a fear among some that those in the individual market tend to be higher risk and have higher health needs. Therefore, by merging them with the small group market their high utilization might increase premiums for everyone. Additional data will be needed to help drive that decision.

When the stakeholders discussed selling products inside versus outside the Exchange, those who were sensitive to Delaware's small numbers seemed to gravitate toward not having an outside market

With regard to the number of plans that should be offered, there was agreement that too much choice is too confusing for people wanting to purchase. More data is needed before a decision is made.

On the governance issue there was pretty much alignment around a quasi-government agency with an independent board, although this is not a uniform view. Some people thought more discussion was needed.

The following other issues were raised.

- Employers were concerned about how to handle full time, part-time, and seasonal employment. In the beach community there is the issue of foreign students who are legally in Delaware and work for a short period of time. This is an issue in the resort community.

- Small employers expressed concern about what to do about employees who work in Delaware but live in Maryland, Pennsylvania and New Jersey.

- For employers and young adults, the way penalties are currently structured; it is less expensive to pay the penalty than provide or obtain insurance.

- Stakeholders requested that a test site be established when the Exchange website is established.

- If a regional Exchange is not feasible, perhaps some "back room" operations may be shared.

<u>Exchange Planning Activity Review</u>

Organizational chart
Ms. Riveros called everyone's attention to the Delaware Health Reform Organizational Chart that was being displayed. She highlighted that there are Finance, Technical/Operations and Governance and Policy sub-groups reporting to Secretary Landgraf's Health Care Reform Workgroup. Delaware Health and Social Services, Division of Medicaid and Medical Assistance is charged with implementing the Exchange planning grant as the designated agency in the State. A contract has been entered with the Public Consulting Group (PCG) to assist with implementing the grant.

Core activity organization flow
Ms. Roy said there are nine core areas that must be completed as part of the planning grant. She displayed a Core Area Assignments Organizational Chart to illustrate where those activities will reside.
Background research, stakeholder involvement, and resources and capabilities will reside within the Health Reform Workgroup.

Finance and business operations will reside within the Finance Sub-group.

Program integration and technical infrastructure will reside within the Technical/Operations Sub-group.

Governance and regulatory or policy actions will reside within the Governance and Policy Sub-group.

Introduction of planning project coordinator: Crystal English
Steve Groff introduced Crystal English, the new project director for the Health Exchange Project.

Introduction of planning consultant: Public Consulting Group
Mr. Groff introduced the members of the Public Consulting Group.

The Commission meeting was an excellent opportunity for them to get some information on activities in Delaware and the role of the Health Care Commission.

Ms. Riveros told the Public Consulting Group that that the Commission has information to provide them that would be a good starting point for them as they work with the Commission.

Bob Carey, of PCG, said they are very anxious to get started, and will be setting up meetings and introductions. They will be convening workgroups to address the issues required by the grant.

Lessons Learned: Massachusetts & Utah Experience

Report & Highlights
Ms. Riveros called attention to "The Massachusetts and Utah Health Insurance Exchanges: Lessons Learned" article published by the Georgetown University Health Policy Institute. She recommended that the Commissioners read the article, which provides very good insight and background.

UNINSURED ACTION PLAN
The Commission has been working on a plan to bring together the eligibility and enrollment processes for the Community Healthcare Access Program (CHAP) and Screening for Life.

Jill Rogers, Division of Public Health, has been working with Ms. Roy and Betsy Wheeler on this project. Ms. Rogers said that they are close to finalizing a single application for the two programs so that everyone enrolled will automatically enroll in both. They are also working through other aspects of the enrollment and eligibility

and are beginning to have a discussion around if and how to integrate the care coordination.

OTHER BUSINESS

Ms. Riveros introduced Lauren Brittingham. Ms. Brittingham is a graduate student who has been providing support for the Exchange planning effort; specifically, looking at small business concerns.

PUBLIC COMMENT

Joann Hasse, of the League of Women Voters, asked if the Department of Insurance or health insurers might be asked for help to determine why some of the health care insurance plans who originally participated in the Medicare Advantage process in Delaware pulled out. Perhaps there was not a large enough pool of people, and Delaware could learn from that experience to know how many people insurance companies believe would be profitable in order to have an Exchange.

Linda Nemes, of the Department of Insurance, responded that decisions made by Medicare Advantage companies about whether to come into a state are business decisions based on independent business models and whether that company feels they can actually engage in business in that state.

Jim Lafferty, of the Mental Health Association, thanked Ms. Riveros for taking the time to meet with people around the state to inform them about the Health Insurance Exchange. It is important and helps alleviate suspicions that people might have about what the state is doing. The transparency is great and the opportunity provided the public to comment is great.

Dr. Sukumar asked Ms. Roy, with regard to health reform, if the number of employees for small business is full time employees or just the number of employees. Ms. Roy responded that it is full time employees.

Dr. Robert Frelick said that he read an interesting article on Vermont having a single payer system. He suggested that the Commission consider what has been learned in Vermont.

Dr. Frelick expressed concern with the fact that there has not been a quorum at the last two Commission meetings and minutes have not been able to be distributed. He asked if there was an alternative way that information could be distributed. Perhaps there could be a Chairman's report that does not need to be approved by the Commission.

NEXT MEETING

The next meeting of the Delaware Health Care Commission is May 5, 2011, at the Department of Transportation Administration Building, First Floor, Farmington /Felton Conference Room, 800 Bay Road, Dover.

ADJOURN

The meeting adjourned at 11:00 a.m.

NEXT MEETING
The next meeting of the Delaware Health Care Commission is May 5, 2011, at the Department of Transportation Administration Building, First Floor, Farmington /Felton Conference Room, 800 Bay Road, Dover.

GUESTS

Thomas G. Bastholm, OD	Delaware Optometric Association
Bob Carey	Public Consulting Group
Robin Chacon	Public Consulting Group
Jeanne Chiquone	American Cancer Society
Barbara DeBastiani	Wheeler and Associates
Dr. JoAnn Fields	Family Practice Physician
Dr. Robert Frelich	Medical Society of Delaware
Steve Groff	DHSS/Division of Medicaid and Medical Assistance
Joann Hasse	League of Women Voters
Cheryl Heiks	Cozen O'Connor
Alicia Holmes	Public Consulting Group
James Lafferty	Mental Health Association in Delaware
Travis M. Lehman	
Lolita Lopez	Westside Family Health
Michael McDonough	Public Consulting Group
Linda Nemes	Department of Insurance
George Meldrum	Nemours
Sheila Nutter	Hewlett Packard
Brian Olson	La Red Health Center
Rosa Rivera	Henrietta Johnson Medical Center
Jill Rogers	DHSS/Division of Public Health
Wayne Smith	Delaware Healthcare Association
Kay Wasno	Hewlett Packard
Betsy Wheeler	Wheeler and Associates