

**DELAWARE HEALTH CARE COMMISSION
MARCH 3, 2011
DELDOT ADMINISTRATION BUILDING
FARMINGTON/FELTON CONFERENCE ROOM
DOVER**

MINUTES

Commission Members Present: Bettina Riveros, Chair; A. Richard Heffron; Rita Landgraf, Secretary, Delaware Health and Social Services; Dennis Rochford, and Fred Townsend

Commission Members Absent: Theodore W. Becker, Jr.; Thomas J. Cook, Secretary of Finance; Janice E. Nevin, MD; Karen Weldin Stewart, Insurance Commissioner, and Vivian Rapposelli, Secretary, Services for Children, Youth and Their Families

Staff Attending: Paula Roy, Executive Director; Marlyn Marvel, Community Relations Officer; Robin Lawrence, Executive Secretary and Linda G. Johnson, Administrative Specialist

CALL TO ORDER

The meeting was called to order at 9:05 a.m. by Bettina Riveros, Commission Chair.

MEETING MINUTES OF FEBRUARY 3, 2011

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

UNINSURED ACTION PLAN

Bettina Riveros reminded Commissioners there have been discussions over the past several years about the integration of *Screening For Life* (SFL) and *Community Healthcare Access Program* (CHAP), which have a similar target population. Blending the programs could increase efficiency and reduce costs.

Screening For Life – Jill Rogers

Ms. Rogers told the Commission that SFL reimburses health care providers for cancer preventive services and early detection services.

Since SFL and CHAP have similar target populations there must be ways to identify efficiencies and end up with a better service for those patients. CHAP eligibility is up to 200 percent of the Federal Poverty Level (fpl) and Screening For Life eligibility is 250 percent fpl.

The goal is to integrate CHAP and SFL eligibility and enrollment. A patient ideally will be enrolled in both programs at the same time, but the fact that there are two programs will be invisible to the patient. That piece is hoped to be completed by the end of the next fiscal year.

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The goal is to ultimately streamline patient services, eliminate duplication and provide a more efficient program which costs less in terms of time and money.

One of the benefits of the SFL program is everyone enrolled and eligible for a cancer screening because of income, insurance status and age, gets an annual preventive health visit reimbursed. This will allow for prevention and health promotion services beyond the cancer arena. Every CHAP patient is, by definition, eligible for Screening For Life. Many funding gaps will still remain, such as acute care. Federal funds pay for breast and cervical screenings and colorectal screenings are newly funded but the Center for Disease Control mandates only seeing average risk patients. State dollars fund breast, cervical, colorectal and prostate screenings for others.

Paula Roy pointed out the important distinction that those screenings and preventive services Ms. Rogers described are taking place in CHAP now. All CHAP patients receive all primary care services now. There will not be new services for CHAP patients because of program integration. The difference will be that SFL brings is the ability to reimburse providers for cancer screening services.

Ms. Riveros asked Jill Rogers to report back to the Commission at its next meeting to provide an update on progress of the SFL and CHAP integration.

CHAP Monthly Reports – Betsy Wheeler

Ms. Wheeler provided statistics on activities in CHAP to date.

- Enrollment for the month end Feb 28, 2011 is at 10,595. An all-time program high, and a 38% growth over the same point in time last year (February 2010).
- Nearly 700 new enrollees in February 2011, an all time monthly high.
- The minimum service delivery volume in the second quarter of FY 11:
 - 24% presenting with indicated risk of hypertension, diabetes and asthma
 - 5011 primary care medical visits
 - 257 medical specialty visits
 - 3491 direct service encounters for lab/x-ray
 - 629 filled prescriptions at an estimated \$158,283 in retail savings.

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Quarterly trends and interesting observations include: increased self-employed; over income Medicaid, and uninsured due to unaffordability of private coverage; increased insurance drop because of premium affordability; continued demand from 'newly uninsured.'

Representatives from all CHAP vendor sites participated in a meeting in February 2011. Key statewide themes were:

- Statewide consumer/enrollee concern and confusion about the Affordable Care Act (ACA) and how it will affect them, the future of the CHAP program and need for continued service delivery, and generalized anxiety
- Growing demand for mental health services directly from consumers for ambulatory/community services and as demonstrated by increased presentation of alcohol and prescription medication abuse, attempted suicide, and depression in all emergency departments.
- 'Overflow' caseload as result of State Service Center staffing gaps. Increased interface with clients for basic human services needs, increased interface with State Service Center staff to assist with clients.
- Concern for absence of discussion in ACA about medical care for non-citizens

Other activities which took place within the program are:

- A detailed review completed by management staff at the three participating hospital sites (Beebe, Christiana Care Health System, and Nanticoke). Total combined fiscal year 2010 write off for outpatient and inpatient services for CHAP enrollees at the three campuses equaled \$12,767,484.00 (uncompensated).
- Educational presentation to the Delaware Medical Group Management Association in February 2011. Seventy three registered office staff attended an hour long program.
- Continued work with J-1, State Loan Repayment and Health Resources Board programs for mandatory program participation to satisfy various charitable care/service delivery requirements associated with those respective programs.
- A meeting is scheduled next week with a new Cardiac PET Scanner facility with proposed statewide services that received certificate of need approval and wishes to donate services.

The official national week of 'Cover the Uninsured' was announced by the Robert Wood Johnson Foundation last week as *May 1-7, 2011*. The *Healthy Delawareans Today & Tomorrow* initiative, originally spearheaded by AstraZeneca, now led by United Way of Delaware, is leveraging activities to raise awareness of the uninsured for month of April 2011.

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Covering Kids & Families Program is now planning a method for conducting statewide consumer targeted information sessions. Objectives will be to get feedback, share info about current programs, and to overview ACA. The target is May 2011 for completion and is believed to coordinate nicely with DHCC stakeholder engagement activities.

Ms. Riveros asked Ms. Wheeler if she could provide statistics on how many CHAP enrollees would potentially transfer into the expanded eligibility Medicaid (up to 133 percent Federal Poverty Level) when/if there is an expansion.

DHSS Secretary Rita Landgraf asked Ms. Wheeler if she would elaborate on the (State Service Center) overflow caseload issue. Ms. Wheeler responded that when the vendors met to discuss what they were experiencing in providing services to clients, one of the trends they commented on was the number of calls they are getting for basic human service needs. Clients are coming in with inquiries around electric, food and heat, and it was their perception that perhaps that caseloads increased because of staffing limitations at State Service Centers. Ms. Wheeler thought there had always been a feeling that the initial intake and assistance offered to CHAP enrollees is broad. Secretary Landgraf asked to meet with Ms. Wheeler to discuss how to leverage a holistic approach to the overflow caseload concerns.

Ms. Roy said that a new element of enrollment in CHAP is that there are a lot of people new to the program who find themselves in a situation that they have never been in before and they don't know where to go (for assistance).

Rich Heffron asked if 1.) Ms. Wheeler has an indication whether the growth (in CHAP) is because of economic conditions or because people are more aware of CHAP and, 2.) The statistics seem to indicate the 24% presenting with an indicated risk of hypertension, diabetes and asthma is higher than normal. Is there an indication that those people maybe had coverage when they were working, lost their coverage, knew they had a (medical) problem and came to CHAP or are these people who knew they had a problem, advised each other and came to CHAP. Ms. Wheeler responded she believes there is quite a bit of 'word of mouth' and institutionalization of the program. When reviewing the October–December 2010 source of program information, applicants were asked a question on *source of enrollment* and almost 1/3 (27%) of the enrollment base for that quarter cited '*other*' as a source of information. This is significant because enrollment is increasing, but there are no formal outreach activities. Going into 2010, outreach was eliminated as a vendor function.

Sheila Nutter, representing the CHAP enrollment broker HP Enterprise Services, added that another factor is that if clients apply for Medicaid and are deemed ineligible, they receive a letter which indicates as an option, there is an opportunity to gain access to care through CHAP. Ms. Nutter believes the application growth is reflective of the economy.

With respect to January CHAP data, Ms. Riveros wanted to know if CHAP is seeing more re-enrollees or new enrollees compared to other months? Ms. Wheeler said that re-enrollment is higher than it was in previous years. She offers that as an indicator that people are deriving value in the program and want to stay in it.

Ms. Nutter said a re-enrollee is someone who has a history with CHAP, meaning the person was a CHAP enrollee at one point. The hospitals were a factor, too. The fact that hospitals accept 'carte blanche' CHAP enrollees, who have gone through the financial verification process of the program, and they get a write off is huge.

Ms. Roy pointed out the success of CHAP, saying enrollees have improved health outcomes, with the preventive care and preventive screenings, and are three times less likely to use a hospital emergency room.

HEALTH PROFESSIONAL WORKFORCE DEVELOPMENT

State Loan Repayment Program

There were no applications from clinicians new to Delaware. All of the applications which came before the DIMER and DIDER Boards in the recent review period were requests for continuation of previously awarded contracts with additional funds. Given the limited availability of State funds (\$60,000 available in DIMER funds and \$42,214 available in DIDER funds through June 30, 2011) and both Boards recommended that no action be taken on these applications. Both Boards chose to wait until the final round of application review in May for FY11 to make a decision on awards, preferring to award funds to new clinicians coming in to Delaware rather than extending current contracts.

Dennis Rochford asked for clarification on the progression of continuation contracts. Ms. Roy explained the State Loan Repayment Review Committee and the DIMER or DIDER Boards make a recommendation to award the clinician an amount of money, which is paid to the lender in increments over a two year period in exchange for a two year contract to practice in Delaware. An extension of that contract is for an additional year with additional new money.

One hundred thousand dollars in Federal money for each FY 11 and FY12 has been awarded to Delaware to recruit one or more pediatric dentists in South Kent or Sussex Counties. The application process will go through the State Loan Repayment Program but it needs to be clear this is a separate award from the regular program, with significantly higher funding and different guidelines.

Inasmuch no State funds are involved in the Pediatric Dentist Loan Repayment award, making application details available to the public does require a Commission vote. Guidelines and the application forms will be posted on the DHCC website and in other relevant places.

RESEARCH AND POLICY DEVELOPMENT

Update: Division of Public Health Grant Award/Affordable Care Act and Exchange Planning Activities – Steven Groff, Deputy Director, Division of Medicaid and Medical Assistance (DMMA)

The Federal government has awarded each of the 50 states a \$1,000,000 Exchange Planning Grant. Utilizing these funds, Delaware awarded a contract to Public Consulting Group (PCG), selected to analyze and assess all aspects of the feasibility of establishing an Exchange in the State and if so, how to implement.

PCG will be taking the lead in project management by bringing in expert consultant resources needed to address the core areas of the Grant which center on every aspect of the Exchange development. Core areas include looking at background research, governance options, fiscal sustainability, and IT requirements, which will be very important to DMMA. Medicaid will need to integrate in the Exchange to offer people the easiest access to the information they need to enroll in coverage and provide a mechanism for that coverage to be continuous and seamless regardless of changes in their economic situation over the course of a year. With this population, it is very likely that people's circumstances will result in fluctuations that may have them move into government sponsored coverage, then maybe into an Exchange offering and back. There is a lot to deal with from the integration perspective.

Stakeholder engagement activities are critical at this point because Exchange planning needs to be very inclusive and to solicit information. This is going to have impact throughout the provider community and on all of the citizens of Delaware and as much stakeholder involvement as possible is needed. It is hoped the consultant will be able to accelerate stakeholder activities, broaden it to get more public outreach and pull those results together and bring some meaningful information to guide us towards helping to meet these very aggressive deadlines.

Ed Ratledge, Director of the University of Delaware Center for Applied Demographics and Survey Research of the University of Delaware has been engaged to do environment scanning. Mr. Ratledge will perform background research activities - focusing on population estimates, looking at the uninsured, those who are eligible for Medicaid and CHIP, those who are likely to be eligible for those programs, individual and small group markets and help gather information about what is going on in the other 49 states because the states are all doing this at the same time. We want to leverage opportunities to gain from other's experiences and knowledge. It is important that some aspects of the Exchange will be compatible with other states in the future because people don't stay within one geographic border and providers don't serve just one geographic border. Interoperability is necessary to be able to function collaboratively.

Ms. Roy noted that Public Consulting Group runs the Massachusetts Connector and can bring that valuable experience to the table Delaware planning process.

Mr. Heffron wanted to know if there is any indication of the Federal government's plans for a Federal Exchange program. Mr. Groff said no and he believes that the Federal government does not want to encourage states to take that option. Without Federal guidance, states have the incentive to develop their own Exchange at the state level or perhaps, at the regional level. Another factor is that the Federal Exchange has to integrate with Medicaid, CHIP and the insurance regulations within the state and those are different in every single state. How will the government develop an Exchange at the Federal level which will tie in to multiple states with multiple policies and multiple populations?

Mr. Rochford asked what the deadline is to make a decision with respect to the Delaware Exchange. Mr. Groff said Delaware has to be prepared to make that decision and recommendation to the Secretary of Health and Human Services by January 2013. Delaware has to be up and ready and the government has to determine Delaware is ready to begin enrollment activities in the

second half of calendar year 2013 so the Exchange can be in operation by January 2014. In order to meet that deadline, Mr. Groff estimates we have about 1 year to do all of the research, make the recommendations and give the decision makers the opportunity to review information and make an informed decision, obviously before that date - probably in early 2012.

The Federal government has issued guidance for the next phase, which would be the Implementation funding. Federal officials have been very flexible, recognizing that states are in a variety of places right now with multiple deadlines. The current planning grant is set to expire in September 2011. Delaware hopes to be in a position to apply for the Implementation funding in either June or September. The Implementation funding is substantial and the government has committed to 100% funding for development activities around the Exchanges. After an Exchange is up and running, it will need to be fiscally self sustaining for operation and the States will need to determine how to do that. In this instance, Delaware's size will be a disadvantage because costs will not be spread across a very large population.

There was initial thinking Delaware would apply for Implementation funding on the June 30 deadline but it may be wiser to wait until September 30.

States have to document progress in their planning efforts to meet certain milestones before they are eligible to apply for Implementation funds. Mr. Groff can report on that at the next DHCC meeting. Next week there is an all states conference call to provide additional guidance on the Implementation funding opportunities.

Mr. Rochford wanted to know about the Federal Exchange option. Mr. Groff said the law provides for a Federal default for a state that chooses not to or is unable to have an Exchange up and running as of 2014. That is one of the things PCG will be looking at. The very first goal of the planning project is for states to make the decision to set up an Exchange individually, to collaborate with other states in the development of a regional Exchange or default to a Federal Exchange.

With the exception of New England, there doesn't seem to be a lot of interest for states geographically co-located looking at a regional Exchange. Smaller states have expressed interest in what potential there might be to collaborate even though they are not co-located geographically. The concern is that this is a difficult task to complete within a single state. To align insurance regulations and policies across states in the tight timeframe of 2013 is unlikely. Delaware has reached out to other states to

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Delaware will apply for Implementation Funds September 30, 2011

discuss the possibility of shared activities the Exchange requires – some of the administrative, back office functions. We will look for opportunities to leverage some savings that way by sharing costs.

Mr. Rochford believes that while it cannot be accomplished by the Commission, there has to be some effort to push these deadlines back, maybe along with some other states. States should have a bigger window to deal with this.

Ms. Roy explained that the dates are in the law and U.S. Department of Health and Human Services does not have the authority to change them. It would require legislation.

Ms. Riveros pointed out that Maryland is on the fast track towards implementation and New Jersey and Pennsylvania are both opposing implementation, so that complicates any real opportunity for a Regional Exchange. News received earlier in this week with respect to flexibility in how states implement the Affordable Care Act provisions may provide some of the latitude Mr. Rochford is addressing. There may be potential opportunity to address things in the best way.

Update: Linda Nemes, Delaware Department of Insurance (DOI) Ms. Nemes reminded everyone that the Federal Center for Consumer Information and Insurance Oversight (CCIIO) is coming to Delaware to host an event at Henrietta Johnson Medical Center at 9:30 a.m. on Monday, March 7 to talk about high risk pools and the Consumer Assistance Program (Ombudsman program). DOI regards this as the kick off of the Ombudsman program.

The Ombudsman program is officially in place. It is intended to help consumers with questions about their insurance coverage and access, issues with claims, internal appeals process, external appeals process and basically any issues consumers may have concerning the insurance program. This goes beyond what has traditionally been done in the Consumer Services area. The Consumer Services area will be a back up to the Ombudsman and will help with the overflow that could occur with that. Outreaches are planned to get the word out to consumers that this program is available so if there are any events that would be amenable to this type of outreach, DOI would appreciate knowing about it. Access is available through the Consumer Services toll free number and calls will be routed to the appropriate area. One additional area DOI traditionally does not delve into but will be with the Ombudsman program is helping people who have coverage through self-insured employers who are exempt from state insurance regulations by the Federal ERISA law with their appeals process.

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Denise Warnett, who is a member of the staff at the Department, will be taking over the Ombudsman duties.

Another announcement Ms. Nemes made is about the Premium Review Grant. DOI has posted a chart on its website that provides the rates that were filed for last year and the amount approved for those rates. It is posted by company and plan and it will be updated on a monthly basis. This going to be a big help to people in the State.

Ms. Riveros reported that the Health Care Reform Steering Committee, headed by Secretary Landgraf, and the Health Care Commission have been very busy and are probably mid-stream with stakeholder outreach effort planned for February and March. There has been a great series of outreach with businesses, broker-agents, consumers, providers and the broader community in Delaware to have conversations about concerns about the Exchange, how they envision the Exchange, what an Exchange would look like, how best to implement in Delaware – some of them are to the point of brainstorming creatively about how to do things in Delaware.

Ms. Roy said there are some specific policy issues they are trying to probe and get feedback to bring to the Commission. Current projections are to bring data analysis results and aggregated results of the stakeholder meetings to the Commission in late Spring. Meetings thus far have focused mainly on the broker-agent community, identified as a group to talk to early on because they have very specific issues. One meeting was with a group of small employers (high tech, small firms), represented by an organization called Delaware Bio.

At the meetings, issues were explored about should Delaware have an Exchange, the complexities of a regional Exchange, whether Delaware should have one or two Exchanges, or if there will be a Federal Exchange. Flowing from that is an idea of merging small group and individual markets and the pros or cons associated with that. Opinions were sought about where an Exchange should reside – in a State agency, in a new State agency, a quasi State agency, or a private not for profit. Unless the rules for purchasing products are not the same within the Exchange as the rules for purchasing products outside the Exchange, there is a chance of the Exchange attracting the higher risk, sicker population. Healthier people would purchase products outside the Exchange because it would be less costly. That puts the Exchange at risk of being more costly and not successful, becoming a de-facto high risk pool. This is why the rules are very important. Also discussed was that there are four tiers of plans

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required to be offered and finally the definition of small groups. Delaware's current law defines of a small group is 1 – 50 but the Federal definition allows expansion to groups of 100. There seems to be a growing consensus to expand to 100.

By April, there will be a broader, much deeper report to present. The consensus so far is that Delaware should go ahead and establish an Exchange. In the beginning of meetings there was a lot of interest in a regional Exchange but as the issues were thought through, people began to realize that Regional Exchanges are not practical in the short time frame. Questions about cost drove the small businesses to the table. One group had a very strong opinion at the beginning of the meeting that there be two separate Exchanges but by the end of the meeting they acknowledged some benefits of one Exchange with two paths – one for the individual market and one for the small group market.

In terms of where the Exchange resides, people are moving towards a quasi State agency, exempting it from State provisions which would drag it down. The Exchange needs to be flexible enough to respond to market conditions.

One group thought there needs to be a way to attract more providers to Delaware to provide competition and lower rates.

Some thought has to be given about how to use brokers in the Exchange. An Exchange could be structured so purchases are made directly on line by a consumer. Clearly, most small businesses rely upon their broker for advice on making purchasing decisions.

There are some new rules on medical loss ratios, which is defined as how much of a premium dollar is spent on medical care versus administrative costs. For small groups, that ratio is 80% on medical services and 20% on administrative services, for large groups that goes up to 85%. Brokers are also paid a commission and depending on if that goes into administrative costs, their commissions may be "squeezed" by carriers.

Linda Nemes added that it was interesting to note the fact that whether a broker was used or not did not impact the rate.

Ms. Roy said the role of brokers versus navigators will have to be sorted through. The Affordable Care Act requires navigators to help people understand their options. In terms of actually giving advice over what product someone should purchase, that is a broker's role. Brokers are trained, licensed and regulated by the Department of Insurance. There is a line across which navigators cannot cross.

Fred Townsend was curious over whether there was a discussion over the potential impact over increasing the size of small employer groups from 50 to 100. He can remember being led to believe that we were capturing the vast majority of our small employer with group eligibility that goes up to fifty. He wondered if increasing the group from 50 to 100 affects that many more people.

Ms. Riveros wondered if there was any downside to expanding the size of what is considered to be a small business to 100.

Mr. Townsend said some of the debate at that time that 1-50 was set centered on the cost of the consumer protections that were offered to people in terms of elimination of pre-existing conditions once the waiting period was satisfied. Now the Federal legislation is addressing some of those issues, if not all of them. Someday there is not going to be a great distinction between people in the small employer market and people with coverage through ERISA – exempt plans. Maybe there would be less opposition to expanding the group for reasons like that.

A guest, representing a community health provider, said the rumor on the street is that the Exchanges are going to have Medicaid level reimbursement rates for services and a lot of physicians won't accept Medicaid. The person asked when that conversation was going to take place and how can the public participate in that conversation to make sure the Exchange has the widest number of providers possible.

Ms. Roy replied that would be an operational issue that the Exchange would have to decide once it is established. That would be significantly down the road.

Ms. Riveros said that also goes to the question of how open the Exchange is with respect to inviting in as many health plans as possible, if they are simply qualified health plans, if the Exchange is established in such a way as the legislation provides that if you meet the minimum and offer essential benefits, you're in. Or is the Exchange more restrictive. As we did some of the initial outreach on that front, especially as we bring on our consulting assistance, that will be part of the discussion. Stakeholder outreach began because we felt the pressure of time to begin these discussions. It is anticipated that the Exchange Planning activity will also include the stakeholder outreach. When PCG comes on, all this information will be shared and hopefully they will help aggregate it and bring some of their expertise to the table.

Ms. Roy said some employers have expressed concern that if purchasing insurance, as required in the Affordable Care Act, gets too complicated, they may opt to not offer insurance, pay the penalty fee and refer their employees to the Exchange.

Wisconsin Exchange Prototype

Paula Roy provided a walk through for Commissioners and guests as they viewed the on-line prototype of the State of Wisconsin's Exchange model. An Exchange will be required to maintain a web portal, offer information based on quality and price in a uniform way. It is available for viewing through the DHCC website at <http://dhss.delaware.gov/dhcc/>.

If there are other groups or organizations that would like to have stakeholder meetings with the Health Care Commission and the Health Care Reform Steering Committee, contact Paula Roy or Robin Lawrence to get them on the calendar.

PUBLIC COMMENT

Dr. Joann Fields asked Mr. Groff about the contract with PCG – when does it take effect and how much money is it for? Mr. Groff said it will take effect as soon as it can be signed and are hoping to have a kickoff in the next couple of weeks and the amount is slightly over \$700,000.00.

Dr. Fields commented that since PCG is closely connected with the Massachusetts Connector, one possibility may be for Delaware to have a non-contiguous regional Exchange with Massachusetts. We wouldn't be re-inventing the wheel, Massachusetts has already done it.

Dr. Fields congratulated the leadership in the Commission for how aggressively it is going after setting up the Exchanges.

Regarding the recommendation due to Federal Health and Human Services Secretary by January 2013, Joann Hasse of the League of Women Voters asked if that involves legislation.

Ms. Riveros said Delaware will be required to create a governance structure and grant authority to run an Exchange. There will have to be enabling legislation in Delaware to create that Exchange. It may have to be done as a predicate to receiving some of that funding. By 2013 HHS will be assessing whether Delaware can run an Exchange or assert whatever the Federal option is. The Exchange basically has to be in testing mode, developed, working, implemented and basically, final touches going on to the Exchange in order for it to be operational by July 1, 2013 to start enrolling people for plan periods to start January 2014. If we move forward

in this regard, there has to be enabling legislation, then the development grant to get it funded to develop it, do all the work to get the Exchange developed, by 2013 a determination that, yes, Delaware is in good shape to run this, and by July 1, 2013 the Exchange can start enrolling people for plans that start January 2014.

Joann Hasse wanted to confirm that at the outside, the enabling legislation would have to have been through the Legislature by 2012.

Dr. Robert Frelich said that today was the first time he has heard a report from the Division of Public Health and hopes they can report more often.

Dr. Frelich asked for the Commission to use microphones to ensure the guests can hear everything being said.

NEXT MEETING

The next meeting of the Delaware Health Care Commission is April 7, 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 April 7, 2011, at the Department of Transportation Administration Building, First Floor, Farmington /Felton Conference Room, 800 Bay Road, Dover.

GUESTS

Rebecca Byrd	The Byrd Group
Jeanne Chiquone	American Cancer Society
Kathy Collison	DHSS/division of Public Health
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
Michele Haranin, OD	Delaware Optometric Association
Deborah Hanultin	Cozen O'Connor
Joann Hasse	League of Women Voters
Cheryl Heiks	Cozen O'Connor
Rebecca Kidner	
Emily Knearle	Planned Parenthood of Delaware
James Lafferty	Mental Health Association in Delaware
Lolita Lopez	Westside Family Health
Kathy Matt	University of Delaware
Suraina Menawat	Maximus
Linda Nemes	Department of Insurance
Mary Nordenson	Delaware Physicians Care (Aetna)
Sheila Nutter	Hewlett Packard
Brian Olson	La Red Health Center
Christine Schiltz	Parkowski, Guerke and Swayze
Wayne Smith	Delaware Healthcare Association
Kay Wasno	Hewlett Packard
Betsy Wheeler	Wheeler and Associates
Patricia Wright	Delaware Physicians Care (Aetna)