

**DELAWARE HEALTH CARE COMMISSION
OCTOBER 7, 2010
DELDOT ADMINISTRATION BUILDING
FARMINGTON/FELTON CONFERENCE ROOM
DOVER**

MINUTES

Commission Members Present: Bettina Riveros, Chair; Theodore W. Becker, Jr.; Thomas J. Cook, Secretary of Finance; Rita Landgraf, Secretary, Delaware Health and Social Services; Janice E. Nevin, MD; Dennis Rochford; Karen Weldin Stewart, Insurance Commissioner; and Fred Townsend

Commission Members Absent: A. Richard Heffron, and Vivian Rapposelli, Secretary, Services for Children, Youth and Their Families

Staff Attending: Paula Roy, Executive Director; Marlyn Marvel, Community Relations Officer; 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.

Ms. Riveros observed that the current environment presents challenges on many fronts, in both the private and public sectors. Employers struggle to pay for rising costs; the Medicaid population is increasing and adding to the State's roles; health care providers at hospitals work hard to meet the needs of their patients and the State of Delaware as we work to increase access to health care services. Great challenges lie ahead and it will be important to work together collaboratively to address those challenges. She is hopeful to contribute in any way in her role as Commission chair.

Ms. Riveros invited anyone wanting to arrange an input meeting to contact her through the Health Care Commission or via e-mail at *bettina.riveros@state.de.us*.

As the Commission works on increasing and sustaining its transparency, Ms. Riveros asked for input on what other information people would like to see posted on the DHCC web site.

MEETING MINUTES OF SEPTEMBER 2, 2010

Dr. Janice Nevin made a motion to accept the September 2, 2010, meeting minutes. Ted Becker seconded the motion. After a voice vote the motion carried.

Action Item

Bettina Riveros may be contacted through the Health Care Commission or by e-mail: *bettina.riveros@state.de.us*

Action

The Commission voted to accept the September 2010 meeting minutes.

INFORMATION AND TECHNOLOGY

Update: Delaware Health Information Network (DHIN)
Chris Manning, Director of External Affairs, Delaware Health Information Network

DHIN views one of its greatest assets that of its relationships with a wide variety of its stakeholders. Over the course of the past couple of weeks, DHIN has been partnering with the Delaware Academy of Medicine, the Medical Society of Delaware and Quality Insights of Delaware in sponsoring a number of different forums and workshops to help people in Delaware understand what opportunities exist for them to be engaged in health information technology, including the DHIN.

After many years of hard work by a wide group of individuals, DHIN is bringing St. Francis Hospital live as a data sender. Over the next two weeks DHIN will be rolling out St. Francis. Practices and organizations will be able to access information from St. Francis on the DHIN.

The September 2010 summary of DHIN activities include:

- Fifteen new practices were trained on the DHIN in September. This brings the total number of practices live on the DHIN to 266, a 6% increase from August.
- Thirty practices are currently in the pipeline (enrollment form complete and scheduling set-up and training);
- For practices going live on the DHIN in FY2011, the average time from receipt of a completed enrollment form to the completion of training was 17 days compared with 21 days the month prior.
- Three practices signed off on the DHIN in September. This brings the total number of practices signed off on the DHIN to 74, a 4 percent increase from August.

Practice Status by County

Practice Status	New Castle	Kent	Sussex	Total	% change last month
Total DHIN Practices	143 (54%)	62 (23%)	61 (23%)	266	+6%
Signed Off Practices	28 (20%)	23 (37%)	23 (38%)	74 (28%)	+4%

DHIN has been partnering with the Delaware Academy of Medicine, the Medical Society of Delaware and Quality Insights of Delaware in sponsoring a number of different forums and workshops to help people in Delaware understand what opportunities exist for them to be engaged in health information technology, including the DHIN

St. Francis will go live as a data sender after a brief test period.

Of those 266 practices, the goal is to get as close to 100 percent as possible to have those practices use the DHIN as the exclusive method of receiving results from the data senders it has.

HEALTH PROFESSIONAL WORKFORCE DEVELOPMENT

Action: State Loan Repayment Program – Paula Roy

The Loan Repayment Committee met on Tuesday, September 7, 2010, the DIDER Board of Directors met on Tuesday, September 14, 2010, and the DIMER Board of Directors met on Wednesday, September 15, 2010 to review the current applications for loan repayment.

Funding Updates

The Loan Repayment Program has the following funds available for distribution:

- \$150,000 available in State DIMER funds through June 30, 2011
- \$92,214 available in State DIDER funds through June 30, 2011
- \$100,000 available in federal matching funds through August 30, 2011
- \$100,000 available in ARRA federal matching funds through September 29, 2011

Unobligated Fiscal Year 2010 federal funds

- A carry over request was submitted on September 3, 2010 for the remaining unobligated balance of \$143,000 in Fiscal Year 2010 federal matching funds. A decision is still pending.

Review of DIDER Application

The Loan Repayment Committee reviewed the following application and made the following recommendation.

1. Site: Smile to Smile Family Dental & Sedation Center, P.A.,
429 South Governor's Avenue, Dover, DE
 - applying for capital loan expenditure reimbursement
 - new dental practice in Kent County in a federally designated dental health care shortage area.
 - plan is to open mid-August 2010

Dr. Dawn Grandison, the sole dentist opening the practice, was born in Trinidad, West Indies, and, although not a citizen of the U.S., she is a permanent U.S. resident. The equipment debt burden is about \$94,000 (verified)

Linda Johnson asked Deputy Attorney General Stuart Drowos for an opinion on eligibility of non-citizens who are permanent residents. After reviewing the eligibility criteria, he advised a permanent resident of the U.S., though not a U.S. citizen, *would* be eligible to apply for and possibly receive an award under the program, as long as all other requirements were met.

- Funding: State funds only

Recommendation:

The Loan Repayment Committee recommended that the Smile to Smile Family Dental & Sedation Center be awarded \$25,000 for a two year commitment.

The DIDER Board of Directors recommended that the award be made with the condition that all permits are in order and the practice is open.

The practice received its Certificate of Occupancy and opened on September 20, 2010.

Review of DIMER Applications

The Loan Repayment Committee reviewed the following applications and made the following recommendations.

2. *Site: La Red Health Center, 504 West Market Street, Georgetown, DE*

- previously approved federally qualified health center

Coleen Brogan, Certified Nurse Midwife - extension

Coleen Brogan graduated from Graceland University, Lamoni, IA, in 1996 with a BSN, Case Western Reserve University, Cleveland, OH, with a Masters in Nursing in 1996, and from the Frontier School of Midwifery, Hyden, KY, in 1999. She is certified by the American Midwifery Certification Board. Her employment with La Red Health Center (40 hours per week) began in September 2007. She was awarded \$30,000 State and Federal funds April 2008 to March 2010. Her current debt burden is about \$46,000 (verified). Ms. Brogan is requesting a one year extension.

- Funding: State and Federal matching funds

Recommendation:

The Loan Repayment Committee and DIMER Board of Directors recommended that priority be given to new applicants and that extension requests not be funded at this time.

3. *Site: Internal Medicine at Millville, 609 Atlantic Avenue, Millville, DE*

- this is a new community practice sponsored by Beebe Physician Network, in underserved area (Sussex County)

Andrea Matthews, MD

Andrea Matthews grew up on the Eastern Shore of Maryland and graduated in June 2010 from the Medical University of South Carolina (Charleston) where she completed her residency at Trident Medical Center. Dr. Matthews has received a license to practice medicine in Delaware and is looking forward to working near home in an underserved, rural area. She will be treating Medicaid or S-CHIP, Medicare, CHAP and private pay patients at least 40 hours per week. Dr. Matthews' debt is about \$193,000 (verified).

- Funding: State and Federal matching funds

Recommendation:

The Loan Repayment Committee and DIMER Board of Directors recommended that Dr. Andrea Matthews be awarded \$60,000 (\$30,000 state funds plus \$30,000 federal funds) for a two year contract to practice at Internal Medicine at Millville.

Ted Becker told the other Commissioners that in addition to the \$30,000 from the State and \$30,000 from federal matching funds awarded to Dr. Matthews, Beebe is considering making a contribution which would be added to the State's funds. This would qualify her for an increased federal match. Beebe is still in negotiations with Dr. Matthews at this time. Based on a conversation Mr. Becker had with James Bartle, Treasurer of Beebe Hospital, yesterday, it looks as though Beebe will be contributing between \$10,000 and \$20,000.

4. *Site: Beebe Medical Center, 424 Savannah Road, Lewes, DE*

- previously approved practice site

Afshin Adili-Khams, MD

Dr. Khams is a hospitalist and Board certified in internal medicine. He is now a permanent U.S. resident who graduated from the University of Ottawa (Canada) in 1994 with a BS in, the University Medical School of Debrecen (Hungary) in 2000, and completed his residency in 2004 through Seton Hall University School of Graduate Medical Education at Trinitas Hospital in Elizabeth, NJ. He has a student loan from RBC Royal Bank in Ontario, Canada of about \$33,000 (verified).

- Funding: State funds

Recommendation:

The Loan Repayment Committee and DIMER Board of Directors have placed priority on primary care physicians practicing in the community over hospitalists. It is not recommended that hospitalists be funded at this time.

5. *Site: Dedicated to Women, 200 Banning Street, Suite 320, Dover, DE*

- previously approved practice site

Jemine Wayman, Certified Nurse Midwife - extension

Ms. Wayman holds a Bachelor of Science degree in Nursing from Delaware State University, a Bachelor of Science degree in Public Health from Southern Connecticut State University and she received a Master of Science degree in nursing from Wesley College as a clinical nurse specialist. She received a certificate in Midwifery from the University of Medicine and Dentistry of New Jersey and is a Board Certified Midwife. Her debt burden is about \$108,000 (verified) and she is requesting a one year extension.

- Funding: State funds only

Recommendation:

The Loan Repayment Committee and DIMER Board of Directors recommended that priority be given to new applicants and that extension requests not be funded at this time.

6. *Site: Westside Family Healthcare, 1802 W. Fourth St., Wilmington, DE*

- previously approved FQHC practice site

Patrice Moore - MD

Dr. Moore received her Bachelor of Science degree in Biology from the State University of New York in New Paltz and a Certificate of Completion in the medical/dental education preparatory program from Southern Illinois University in Carbondale. Ms. Moore graduated with a degree in medicine from Drexel University College of Medicine in Philadelphia and completed her residency with a focus in obstetrics and gynecology at Nassau University Medical Center, East Meadow, NY. Her debt burden is about \$288,000

- Funding: State and Federal matching funds

Recommendation:

The Loan Repayment Committee and DIMER Board of Directors recommended that Dr. Patrice Moore be awarded \$60,000 (\$30,000 state funds plus \$30,000 federal funds) for a two year contract to practice at Westside Family Healthcare.

7. Nanticoke Family Practice Seaford (Mid-Sussex Medical Center), 1320 Middleford Road, Ste. 202, Seaford, DE

- Nanticoke Hospital sponsored practice site. Site application is forthcoming.

Jennifer L. Beare, Certified Nurse Practitioner, Family Practice

In 2003, Ms. Beare graduated Salisbury (MD) University with a Bachelor of Science in Nursing and Wilmington University, New Castle, DE, with a Master of Science in Nursing in 2010. She worked at Nanticoke Hospital for seven years before accepting a position at Mid-Sussex Medical Center (Nanticoke Physician’s Network) as a board certified Family Nurse Practitioner in July 2010. Ms. Beare is bi-lingual. The total patient population at this site is one percent Medicaid or S-CHIP and 94 percent Medicare. Her debt burden is about \$80,000 (verified)

- Funding: State and Federal matching funds

Recommendation:

The Loan Repayment Committee and DIMER Board of Directors recommended that Jennifer Beare be awarded \$10,000 (\$5,000 state funds plus \$5,000 federal funds) for a two year contract to practice at Nanticoke Family Practice Seaford.

Update: LaRed physician recruitment

Funds have been set aside for La Red to recruit one Family Practice physician.

Action

Dr. Nevin made a motion to approve the funding recommendations of the DIMER and DIDER Boards. Ted Becker seconded the motion. After a voice vote the motion carried.

BUDGET ENVIRONMENT

Tom Cook, Secretary of Finance

The Delaware Economic Financial Advisory Council (DEFAC) is responsible for projecting the revenues for the State. DEFAC met in June 2010 and projections from that meeting were used to balance the budget for the State.

DEFAC met again in September 2010 and gathered information from various economists. The second quarter real gross

Action

The Commission approved the SLRP funding recommendation of the DIMER and DIDER Boards.

The Delaware Economic Financial Advisory Council (DEFAC) is responsible for projecting the revenues for the State. DEFAC met in June 2010 and projections

domestic product grew at 1.6 percent but had been expected to grow at 4.4 percent. The bottom line is the economy is not recovering as quickly as people hoped and thought. Secretary Cook observed that jobs and putting people back to work is needed in order to turn the economy around. There is good news that in the current fiscal year (FY11) revenue estimates were up \$24,000,000 but for the next fiscal year (FY12) the projection is that Delaware will be down \$12,000,000.

The Budget Office has met with all of the respective State agencies to discuss the situation and emphasize the need to live within our means. There are some good programs and good ideas. The State will need to focus resources in the proper areas to get the most return for investments. The Governor and State officials are working daily to restart the economy and bring jobs to the State.

When the resources are restricted the demands for services increases. It is important to provide those resources. Delaware has been able to work across party lines to make sure that we keep those core services. Tough decisions will be required. Neither tax increases nor cuts alone will solve the current problem.

Rita Landgraf, Secretary, Delaware Health and Social Services

The mission of DHSS is to support Delawareans who are adversely impacted either through health conditions or lack of self-sufficiencies. The Department has been seeing an increase in demand for its services, primarily in SNAP, the food stamp program. There are approximately 112,000 currently accessing that program.

Secretary Landgraf predicts that by the end of the 2010 calendar year, there will be 200,000 Delawareans on Medicaid, in a total State population of less than one million. This is primarily due to the fact that loss of income means they have reached the federal poverty level and become eligible for Medicaid.

DHSS feels very strongly about preserving those two programs. For Medicaid there is a State match obligation.

The Office of Management and Budget, along with Secretary Cook, has been working with the state agencies to look at targets for fiscal year 2012. Secretary Landgraf has to cut \$177,000,000 out of the DHSS budget, an approximately 16 percent decrease. This is primarily because of the loss of the ARRA (American Reinvestment and Recovery Act) funding.

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Secretary Landgraf has to cut

The fiscal year 2011 was a very difficult one, especially for DHSS. What the Department could do in FY11 was look at one time ways to bridge the gap that it was facing in FY11. In FY12 cuts are likely to impact services.

DHSS has employed a triage system to identifying cuts by assigning values of 1, 2, or 3. It evaluates the impact of cuts and tries to determine the unintended consequences of making cuts. The 3s are gone and DHSS is now in the 1s, which are very hard cuts to do. DHSS is attempting to involve people outside the government in helping identify ways to leverage resources together to meet demands for services. DHSS is looking at the most pressing issues impacting Delawareans at this time and trying to determine how to consolidate, coordinate, and leverage if it is to preserve these programs. If the State's General Funds aren't available to match Federal money, services will be impacted and there is nothing we can do. As a community, it will be important to determine the most pressing needs in a triage fashion, and come together to address them.

Secretary Landgraf said the DHSS budget hearing is November 16 and welcomed people to attend. The budget is an evolving process. This is more or less the first look at DHSS' evaluation of its most pressing needs, and there is the ability to keep communicating up until the end of June relative to the needs. The hope is the revenues will swing forward as we go deeper into the year.

Secretary Landgraf had the opportunity to visit with some colleagues over the weekend and all were faced with the same and talking the same script; trying look at how to become more efficient and glean cost savings that we can ensure goes back out to the ground. A lot of that has already been taken from the years past.

Ms. Riveros said it will be all the more important for the Commission to ensure that, as it makes recommendations to spend or not spend money, it is focused on the needs of Delawareans, moving forward on quality of care, the affordability of care, and those roles that we have and making sure that we get the best return on anything we are spending. There will be belt tightening as a result around the state, not only in state government but in the private sector as well.

Ms. Riveros noted a New York Times article about hard work and all the pressure on state workers to apply for, receive and maximize any dollars that are available in the grant world.

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RESEARCH AND POLICY DEVELOPMENT

Presentation: Reforms Effective September 23 and Gaps in Regulatory Authority – Linda Nemes, Department of Insurance
(This presentation is available on the Delaware Health Care Commission's website at <http://dhss.delaware.gov/dhcc/> under "Presentations")

Ms. Roy reminded Commissioners that a series of insurance reforms were enacted in the Federal Affordable Care Act. These were reviewed at the October DHCC meeting. They became effective September 23, 2010 – six months after the Act was signed into law. States must now analyze their own laws to determine where they already have the authority to enforce the laws and where state legislation will be needed to give them the authority to do so.

Ms. Roy said Ms. Nemes will explain to the Commission where Delaware already has the authority to implement and enforce the new federal reforms, where the gaps are and what the legislative agenda will be in January 2011 in order to make Delaware's law mirror the federal requirements.

Linda Nemes told the Commission that many people are under the impression that the health care reforms actually begin on September 23 and all the carriers have to be in compliance.

The actual reform laws provide that they will go into effect for the next policy or plan year that begins after September 23. In many cases it will be January 1; for the State of Delaware Employee Benefit Program it will be July 1, 2011. For many of the larger employers it will be whenever their plan year happens to fall – that's when the reforms would actually take place.

The Department of Insurance (DOI) wants the State of Delaware to be able to regulate the insurance activities that take place in the state rather than have a federal agency regulate Delaware activity. DOI feels it can address the problems much better than someone who is not connected with the state environment.

After working with the National Association of Insurance Commissioners (NAIC) and its committees it is closing in on getting the model laws drafted and adopted and Delaware should be able to use those models.

All of the states and U.S. territories belong to the NAIC. The Association works to develop policies and procedures and works with the federal government on these issues. The National Association has been very active with the federal government throughout the reforms and many of the policies and procedures

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the government is putting in place were developed through collaboration with the NAIC.

Areas of gaps in regulatory authority

- *Allow young adults to stay on their parents' health care plan until age 26.*
 - *Applies to both grandfathered and non grandfathered plans and policies effective for plan years that begin after September 23.*
 - *Young adult does not have to be living with parents, does not have to be a student and does not have to be claimed on parents' tax return.*
 - *Applies to both married and unmarried children*
 - *Spouse and child are not included.*
 - *Transition for certain existing group plans that generally do not have to provide dependent coverage until 2014 if the adult child has another offer of employer-based coverage aside from coverage through the parent.*
- *Lifetime and Annual Limits*
 - *No lifetime limits*
 - *Grandfathered individual policies are exempt from this provision.*

Lifetime Limits

Right now, carriers cannot impose lifetime limits.

Grandfathered individual policies are exempt from this provision. Annual limits are permitted up until 2014. With annual limits, there are some requirements for those and the limits phase out.

Annual Limits

On September 23 there are no limits less than \$750,000 annually. In 2011, the limit goes up to \$1.25 million; in 2012 the limit raises to \$2 million and on January 1, 2013, there is a prohibition on annual limits.

- *Preventive Health Services*
 - *Grandfathered plans and policies are exempt*
 - *100% Coverage*

For services designated preventive services by the U.S. Preventive Care Task Force, plans must provide 100 percent coverage with no cost sharing or co-insurance charges. The Delaware Code does have some reference to some immunizations and some preventive services as mandate. While DOI does not have authority to regulate this, there are protections to some degree within the Code already. DOI will

be working to bring its authority up to match the federal government has put in place.

There are a few other gaps and one gap not included in the hand-out distributed is *Provider Choice for Females*, enabling women to choose their gynecologist as a primary care physician. Delaware Code does have that already and it closely mirrors the federal law so State legislation will not be necessary.

The ACA requires Departments of Insurance to provide for internal and external reviews. Ms. Nemes has been in contact with the U.S. Health and Human Services (HHS), Office of Consumer Information Insurance Oversight (OCIIO) on this. OCIIO is a new agency set up within HHS to help oversee the insurance reform aspects of the Affordable Care Act. Delaware Code is pretty strong and closely mirrors the federal law. Only small changes may be necessary. Ms. Nemes will participate in a conference call with that area after the Commission meeting to go over questions. It is her opinion that Delaware is in a good position on this provision.

In a departure from current practice, the federal government is looking to the states to assist self-funded plans in the appeals process on the external review. Self-funded plans are exempt from state insurance regulation under federal Employee Retirement Income Security Act (ERISA). The Federal government regulates ERISA plans.

Grandfathered Plans

The federal government promised people in this reform that they would be able to keep their coverage if they liked their plan. This grandfathering structure was put in place to enable those who like their current coverage and carriers to work with their employers to designate certain plans as grandfathered and will not be subject to the reforms – they will stay as is.

To remain grandfathered, there are certain criteria that have to be met: plans cannot make major increases in co-insurances and cannot change benefits. Employer's contribution levels cannot change to a large degree. Once changes are made, plans are no longer grandfathered and are subject to the reforms. Annual premium increases do not affect the grandfathered status.

The grandfathered plans will be a 'closed block of business' which means the cost of those plans go up at a faster rate than other plans. Projections are that by 2014 we will see those gradually disappear.

Office of Consumer Information Insurance Oversight (OCIIO) is a new agency set up within HHS to help oversee the insurance reform aspects of the Affordable Care Act.

The grandfathered plans will be a 'closed block of business' which means the cost of those plans go up at a faster rate than other plans. Projections are that by 2014 we will see those gradually disappear.

There are some tax implications for some employers with these reforms so there are reasons why an employer may choose to grandfather the plan, not just because they don't want to change.

- *Pre-existing condition Exclusion Prohibition*
 - *Grandfathered plans in the individual market are exempt*
- *Pre-existing Exclusion for Children under age 19.*

The main part of this will go into effect 2014, however for children under age 19 it is in effect as of September 23rd and applies to all plans. Delaware does not have a law that addresses this at all so DOI will be working to get something in place rather quickly on this particular area.

The individual market is the area that is most impacted by this at this point in time. The Delaware Code does not address children or dependents at all in the individual market or pre-existing conditions.

The group market is a little safer in this area because, generally, plans that bring families on board will cover the children and those children would be subject to the same pre-existing conditions that the parents would be.

In the small employer market the Delaware Code actually has protection built into it for people moving from plan to plan. Legislation will be required to be sure that DOI can regulate this provision and bring all of the carriers on board.

Ms. Riveros asked Ms. Nemes if she would share the legislation when it is ready. Ms. Nemes responded that there is an NAIC conference in a couple of weeks and there will be more work and modification done to the drafts so she expects it would be available for the January DHCC meeting.

Ms. Riveros said as we look forward to the work relative to the Affordable Care Act there will be a lot of collaborative work across the state with Secretary Landgraf's department, the Health Care Commission and the Insurance Commissioner's Office. One of the key, early jobs for us and action that we need to take is with respect to Health Benefit Exchanges. States are starting Exchange planning now. Roseanne Mahaney's Division of Medicaid and Medical Assistance applied for, and was awarded \$1,000,000 for Exchange planning. Through the Exchange planning process Delaware will determine if it wants to establish an Exchange and, if so, determine its

functions - where people can go, compare insurance programs for the individual market, the small employer market and to look at what is available, compare benefits, determine whether they are eligible for subsidies, determine how they can enroll through a web portal. The most fundamental decisions will be answering the questions, 'Does Delaware want to create an Exchange? Is there an opportunity for a Regional Exchange?' Are there benefits to falling into the federal Exchange? It is important to educate the Commission and the public on that arena.

Secretary Landgraf added that all states are carefully considering their options with regard to the establishment of exchanges. States are looking for clarification and guidance from the U.S. Department of Health & Human Services (HHS) regarding the minimum and maximum activities that Exchanges must undertake. It is clear that exchanges will be expected to make information about Medicaid and S-CHIP eligibility available, and allow people to enroll in those public programs. This seamless feature will be important, as people generally flow in and out of Medicaid; hence the ability to access coverage through the exchange will be an important feature.

Exchanges will be expected to go live in 2014, but states must inform the U.S. Secretary of HHS in 2013 whether they will be able to operate an exchange.

Secretary Landgraf noted that many national organizations are playing supportive roles for states. The National Governor's Association (NGA) has been very instrumental in facilitating discussions with federal agencies. Harvard's Kennedy School of Government will be publishing a white paper on the subject and many national information technology organizations are analyzing the issue.

Finally Secretary Landgraf noted that it will be important to learn how HHS plans to define regional exchanges. It is possible that the definition may not necessarily be based on geography. For example, at a recent NGA meeting a group of states with populations of under one million people discussed the possibility of forming a regional exchange.

This will probably be the Commission's first major issue we need to plan for and what will that entity look like.

There is a wealth of information available that is very useful.

Presentation: Affordable Care Act: American Health Benefit Exchanges – Paula Roy, Executive Director, Delaware Health Care Commission

(This presentation is available on the Delaware Health Care Commission's website at <http://dhss.delaware.gov/dhcc/> under "Presentations")

Ms. Roy said that since state based American Health Benefit Exchanges will be so central in implementation of the Affordable Care Act, it is important for Commissioners to review some Exchange basics.

Exchanges will become a place where people can find and compare coverage options. Exchanges become active and operational January 1, 2014 and along with it is the requirement that everyone have health care coverage – the individual mandate.

The initial targets for the exchanges are individuals and employees of small businesses and their employees.

There will actually be two different Exchanges: one is for Individuals and the other for Small Business Health Options Program (SHOP), which will offer options for small businesses. States may form one exchange to serve both populations.

Many aspects of health reforms enacted in Massachusetts in 2006 were borrowed from in crafting the Affordable Care Act. Massachusetts made a policy decision to merge the non-group and small group markets. States can choose to either merge the markets or make both options available through one Exchange.

The Affordable Care Act sets forth activities which Exchanges must do. Beyond the minimum, states will have leeway in how they structure Exchanges.

Plans offered in the Exchange must be certified as 'qualified' health plans. These plans must offer 'essential benefits' as defined in the Affordable Care Act.

Exchanges must:

- Certify 'Qualified Health Plans' that offer plans through the Exchange
- Provide a toll-free telephone number to respond to requests
- Maintain a web site that provides standardized, comparative information about plan options.
- Provide employees a choice of plans within the Exchange
- Provide an electronic calculator to allow consumers to determine actual cost of coverage and determine amount of any premium tax credit

Exchanges become active and operational January 1, 2014 and along with it is the requirement that everyone have health care coverage – the individual mandate.

- Provide for initial open enrollment periods, annual enrollment periods and, if applicable, special enrollment periods (Native Americans)
- Assign ratings to plans based on relative quality and price
- Use a uniform enrollment form
- Inform consumers of eligibility for Medicaid, Children's Health Insurance Program or other state or local program *and* enroll them if eligible
- Certify any exemptions from the individual mandate in ACA
- Notify US Department of Treasury of those exempt from the individual mandate and those receiving subsidies
- Provide information to employers on employees who cease coverage in a qualified health plan
- Publish on its Web site, costs of licensing, regulatory fees, administrative costs and money lost to waste, fraud and abuse
- Establish a Navigator program to educate consumers, facilitate enrollment in plans and provide referrals to consumer assistance programs
- Consult with stakeholders, including:
 - ✓ Educated health care consumers
 - ✓ Individuals and entities with experience in facilitating enrollment in qualified health plans
 - ✓ Representatives of small businesses and self-employed individuals
 - ✓ Medicaid
 - ✓ Advocates for enrolling hard to reach populations

State Flexibility (States Decide)

States may choose to establish its own exchange, establish a regional exchange with other states or allow the US Department of Health & Human Services to operate an exchange in that state.

- How to manage insurance markets
States can decide how they want to regulate and manage their insurance markets. Examples of decisions to be made include:
 - Merge non-group and small group markets?
 - Determine plan conduct inside and outside the Exchange
- Whether to operate one or two Exchanges – one for individuals and one for employees of small businesses or combine them into one Exchange

States choose or determine where the Exchange resides

- Within existing state agency
- New separate state agency
- Quasi-state agency
- Private non-profit

States can also choose to allow the federal government to operate a state-based Exchange.

Secretary Landgraf added when Delaware was required to decide whether to operate a temporary high risk pool last summer, it was decided to let the Federal government operate the pool in Delaware. Since the pools have become operational, states have been trying to access information on how many residents have purchased coverage. It is hoped HHS will share with Delaware how many Delawareans enrolled in our high risk pool as this information may help us decide what is in the best interest of Delawareans.

States choose how Exchanges are governed:

- Are employees State employees of existing or new state agency (Utah)?
- Is the Exchange overseen by Independent Board (Massachusetts)?
- Who appoints board members and how do they get appointed?
- Should there be any relevant board member experience?
- How is transparency of activities assured?
- What is the relationship and applicability of state administrative processes?

States need to consider the roles of various state agencies in the Exchange. For example, in Delaware these issues would include:

- IT needs and DTI
- Medicaid and CHIP eligibility and DMMA
- Insurance information and Department of Insurance

States will decide how goods and services will be procured

- Do we want to be an active purchaser or a market organizer?

States must determine how intersection between Exchange products and public programs operate

IT Needs

IT needs are considerable, depending on how active we want the Exchange to be. Examples include:

- Interface with Medicaid/CHIP
- Ability to enroll those eligible into Medicaid/CHIP
- Identify subsidies for consumers who qualify
- Web portal design
- Standard format to allow consumers to compare price and quality
- Data reporting to federal government

- Data transfer to IRS

Secretary Landgraf pointed out that the IRS doesn't necessarily have real time income information on individuals. In order to determine eligibility for Medicaid, DHSS will need to have real time income information. If individual income information is obtained through the IRS, will it be on a lag basis, which would be a year old? Does that mean we will be providing benefits on income from a year ago? What does that do to costs? What does that do to portability? Americans are a mobile population so if all states are creating something different how do benefits become portable?

Scope and Financing –states must determine and project:

- How many lives are expected to enroll in the Exchange?
- How many plans are offered in the Exchange?
- What is the real nature of the small group and non-group markets in DE?
- Should Medicaid MCO's be required to offer a plan in the Exchange?
- How should the Exchange finance itself? It must be self-sufficient by Jan 1, 2015.

Key Dates

September 2010 Award of state planning grants

Spring 2011 Notice of implementation grants

January 1, 2013 States inform and US Secretary of HHS decides in state Exchanges will be ready for implementation Jan. 1, 2014

January 1, 2014 State Exchanges become operational

Ms. Roy noted that Delaware has been awarded an Exchange Planning grant which can be used to explore all these options and bring findings to the Commission. The Division of Medicaid and Medical Assistance was the lead agency in the grant application. Roseanne Mahaney, Division Director, will review planning grant activities with Commissioners.

Presentation: Health Benefit Exchange Planning Activities

Roseanne Mahaney, Director, Division of Medicaid and Medical Assistance (DMMA)

(This presentation is available on the Delaware Health Care Commission's website at <http://dhss.delaware.gov/dhcc/> under "Presentations")

Roseanne Mahaney provided an overview of the Exchange planning activities for the next year.

Obtain Funding for Planning Activities - August - September 2010

On August 30, 2010 DHSS applied for a federal Exchange Planning grant and received notification on September 30, 2010 that it was awarded \$1 million grant. These funds do not require a state match.

Exchange Planning Consultant Procurement - October 2010 - February 2011

DHSS is publishing a Request for Proposal (RFP) in October 2010 for project management services. Contract is anticipated to be finalized in February 2011.

Conduct Current State - Environment Scan - Fall 2010

The Health Care Reform Steering Committee is analyzing the potential impact of the Exchange on the Delaware insurance coverage, market drivers, and possible impacts to Medicaid services. The Steering Committee is also establishing a potential legislative agenda outline that will be refined as the project moves forward.

Document Exchange Options - December 2010

After the Environmental Scan is complete, the Health Care Reform Steering Committee will begin to debate and document Exchange options.

Work Group Activities - Ongoing

1. Governance and Policy

The Governance and Policy work group will focus on detailed analysis of legislative mandates, HIPAA concerns, and future policies that will need to be enforced to properly govern the activities of the Exchange and ensure the public trust.

2. Business Operations & Technology

This work group is focusing on defining the viable Exchange options for the state of Delaware as well as framework to effectively manage the Exchange once it is online. Responsibilities of this group include defining the required interactions with other agencies for determination of eligibility, plan procurement, and other critical business workflows. It will then move to define the technical requirements for security, privacy, and integration with other systems.

Initial Recommendations on Exchange Implementation - Spring 2011.

All recommendations regarding governance, policy, operations and technology of the Health Care Reform Steering Committee workgroups will be brought before the Commission for decision-making.

Phase 2 - Summer 2011

More in-depth research will be conducted to explore policy, operational, technological, and financial requirements. These activities will be coordinated with the second funding announcement for implementation grants. Specific focus will be placed on defining options available to the state with regard to the detailed design and function of the Exchange and its interaction with government-administered programs such as Medicaid and CHIP.

Phase 2 Activities Include:

- Analysis of financial models in other states;
- Identification and cost estimates of technological infrastructure needs;
- Review of eligibility requirements and recommendations for streamlining and co-aligning program eligibility requirements; and
- Development of a regulatory agenda.

Final Recommendations Presented to the Health Care Commission - Fall 2011

Discussion

Dennis Rochford asked since DMMA needs a preliminary recommendation in the Spring 2011 and the consultant comes on in February or March, the planning process will not have the benefit of a consultant. Given all of the time pressure, is it possible to turn the Request for Proposals (RFP) around in 30 days? If we're looking for a health care consultant why does it take so long?

Secretary Cook said it can take that long and the key is to make sure there is solid RFP planning in place and make sure the responses are as exact as possible. Secretary Landgraf replied the other frustration is the guidance from HHS is very, very gray and DMMA does not want to invest in a consultant until we have firm guidance from HHS on what is expected of Exchanges. It is hoped that after the elections in November, more information will start to flow. HHS is definitely getting pressure from many organizations to supply more information.

Ms. Mahaney said the grant application was general in wording so there should be flexibility in using those funds. Furthermore, an amendment to the grant application can be done, should there be a need to significantly shift funds around.

As an FYI, Ms. Roy said last week California enacted legislation establishing its Exchange.

Delaware Funding Opportunities Under the Affordable Care Act
Paula Roy provided an update on the many grants that were applied for and received.

Title 1 Quality, Affordable Health Care

Health Insurance Consumer Information (93.519)
Department of Insurance
Establish or strengthen consumer assistance
Estimated \$120,000 - \$3.4 million

Health Insurance Exchange Planning (93.525)
Delaware Health and Social Services/Division of Medicaid and Medical Assistance (collaborating with Department of Insurance, Delaware Health Care Commission and Department of Finance
Planning to determine feasibility of operating state Exchange, governance finance and operations
Awarded \$1,000,000

Health Insurance Implementation
TBD
Funds to implement Exchanges according to plan established under Planning Grant
Grant not yet announced

Premium Review Grant (93.791)
Department of Insurance
Improve oversight of premium increases
Awarded \$1,000,000

Title II – Role of Public Programs

Money Follows the Person (93.791)
Rebalancing
DMMA
Extend existing program from 2012 to 2016
TBD

Aging and Disability Resource Centers (93.791)
DMMA and DSAAPD
Extend existing program. Supports development of resource centers; linked to Money Follows the Person
Awarded \$400,000

Maternal, Infant & Early Childhood Visitation Program (93.505)

Division of Public Health

Home visiting for at risk families. Social workers, nurses or other professionals evaluate and connect families to needed services

Awarded \$1,280,893

Personal Responsibility Education (93.092)

Division of Public Health (collaborating with Department of Education, FQHCs, DSCYF, Nemours, Children and Families First)

Personal responsibility education to change behavior leading to delays in sexual activity, reducing pregnancy and develop adolescent state health plan

Awarded \$250,000

Title III – Improving the Quality and Efficiency of Health Care

Medicare Prescription Drug Program (93.071)

More funding for outreach and assistance for low income programs (existing)

Awarded \$84,240

Title IV – Prevention of Chronic Disease and Improving Public Health

Non-competitive public health infrastructure #1 (93.505)

Division of Public Health

Increase performance and management capability of public health departments to assure public health goals are effectively met

Awarded \$100,000

Supplemental Funding for Behavioral Risk Factor Surveillance System (93.520)

Division of Public Health

Enhance and expand BRFSS. Financial support for data collection for evaluation of effectiveness of activities funded under ACA and enhance surveillance infrastructure

Awarded \$37,860

Title IV – Prevention of Chronic Disease and Improving Public Health

Strengthen epidemiology, laboratory and health information system capacity (93.521)

Division of Public Health

Strengthen and integrate capacity to detect and respond to infectious disease and other public health threats

Awarded \$429,055

Healthy Communities, tobacco cessation

Division of Public Health

Enhance tobacco cessation programs

Awarded \$54,554

HIV Surveillance-Enhanced Lab Reporting (93.523)
Division of Public Health
Improve HIV planning
Awarded \$51,218

Title VI – Transparency and Program Integrity

National and state background checks on direct access employees of long term care facilities (93.506)
Division of Long Term Care Residents Protection
Upgrade systems of employee background checks for long term care facilities
Estimated amount \$3,000,000

Other

Early Retiree Re-Insurance
Office of Management and Budget
Encourage employers to maintain health benefits for retirees
Estimated amount \$1,600,000 through 6/30/10 to \$19,200,000 year two

Ms. Roy reported that the Workforce Development Planning Grant that the Commission applied for in collaboration with the Workforce Investment Board and the Division of Public Health was not funded. This is very disappointing. It is hoped there will be future opportunities. It was hoped the Commission would be able to plan for Delaware's workforce needs in parallel with the implementation of the Affordable Care Act.

The Office of Management and Budget (State Personnel) was awarded money to help fund the Early Retiree Coverage, that supplements benefits paid to retirees that have not yet reached the age to be eligible for Medicare. The purpose of the provision was to encourage employers to maintain coverage for those who had retired but had not reached Medicare eligibility. The program reimburses employers for a portion of the expenses they incur to pay for claims submitted.

Secretary Landgraf noted there were quite a few Delaware employers awarded the Early Retiree Coverage grant, including Astra Zeneca. Health Care Commission staff will provide an update on all Delaware awards.

Since the Affordable Care Act applies to everyone, it will be important to capture information for all in Delaware, and not be confined to State government.

To that point, Ms. Roy mentioned there are other aspects of the Affordable Care Act and some grant opportunities to partner with the private sector to help drive delivery system reform, if

that is a desired policy goal. Examples include: workforce development, residency training programs, a pilot program in Medicaid for bundling payments for one episode of care, hospital value-based purchasing programs, grants and contracts for quality measurement, and one the Commission has espoused for some time under Dr. Nevin's leadership – the Patient Centered Medical Home.

Presentation: Delaware Patient Centered Medical Home Initiative

Dr. Karryl Rattay, Director, Division of Public Health (DPH)
(This presentation is available on the Delaware Health Care Commission's website at <http://dhss.delaware.gov/dhcc/> under "Presentations")

Dr. Rattay said DPH was awarded \$100,000 to help support building a performance management system. The much needed \$1,000,000 IT infrastructure grant was not awarded to DPH.

Dr. Rattay reminded Commissioners that Dr. James Gill had addressed the Commission earlier in the year about the Patient Centered Medical Home initiative. As is often reported, the United States spends more on health care than other developed nations, but our outcomes are worse. The current system rewards specialty care over primary care and this is a barrier to improving health outcomes. On a positive note, there are a lot of great efforts going on across the country with Patient Centered Medical Homes pilot projects aimed at returning focus to primary care delivered in a manner that focuses on the needs of the patient.

Rationale for Patient Centered Medical Home (PCMH)

- Better health quality and outcomes
- Lower health care costs
- Increased patient satisfaction
- Increased provider satisfaction

The Dartmouth Atlas, which measures variations on how health care is delivered across the country, has consistently demonstrated unacceptable variations in cost and health care utilization, much of which is associated with the ineffective use of primary care.

Timely, acuity-stratified care delivered via a health care team's coordinated efforts could save 100,000 lives yearly and control costs, according to a Geisinger study published in the September *Annals of Surgery*.

What is a Patient Centered Medical Home

- The PCMH concept aims to provide continuous, comprehensive, coordinated care through a partnership

between patients and their personal healthcare team.

- PCMH practices provide care through:
 - Evidence-based medicine;
 - Expanded access and communication;
 - Wellness and prevention;
 - Care coordination and integration; and,
 - Culturally and linguistically sensitive care.
- Practices are incentivized through payment reform to be a PCMH.

A useful example from the Maryland Payment Incentive Model for Providers

- Carriers would use their traditional fee structure, plus-
- A fixed per patient per month (PPPM) payment for enhanced care coordination and practice transformation.
- PPPM plus possible additional incentives based on shared savings and quality improvements/performance

Phases of planning for a Patient Centered Medical Home pilot in Delaware

- Pre-planning – Planting the Seeds
Having initial conversations with key stakeholders to determine levels of interest.
- Planning – Building the Foundation
Bringing stakeholders together in a more concrete way to identify a plan
- Implementation

Pre-Planning – Planting the Seeds

Activities have included:

- Participation in a Medical Society of Delaware Task Force
- Bringing together a number of existing related efforts
- Great momentum is being established
- A common set of principles must be established
 - Multi-payer – in order to be successful, many payers must agree to participate
 - All individuals regardless of age or chronic condition should be included
 - Payment reform – promoting and rewarding primary care services is key
 - Defined primary care as family practice, general internal medicine and general pediatric practices

Planning – Building the Foundation

Among activities that must occur include:

- Governance and operating structure, roles and

- responsibilities;
- Agreement on vision, goals, objectives, scope, patient and practice level outcomes;
- Partnership building (including written agreements);
- Identification of needs, including acquisition of funds, IT and policy needs
- Plans for payment reform
- Practice engagement
- Family/patient engagement
- Evaluation plan

Implementation - Pilot

- Optimistic goal to begin in the Fall of 2011
- Details yet to be worked out – (e.g. duration, number of practices)
- Building systems of care for after the pilot

Governance

- Co-leadership of the Medical Society of Delaware (MSD) and DHSS/DPH
- MSD –
 - Provider engagement and advocacy
 - Leadership and previous experience
 - Dr. Gill – expertise and experience
- State of Delaware/DHSS/DPH
 - Safe Harbor

State government can provide a 'safe harbor' environment that will allow different health plans to discuss reimbursement methodologies. Current anti-trust laws prohibit insurance companies from discussing these types of business practices.

- Funding streams
- Existing infrastructure
- Prevention-focused
- Integration of public health and primary care
- Dr Rattay – expertise and experience

Discussion

Dr. Janice Nevin noted there are groups which are noticeably absent on the list of leadership or governance on the initiative: one is the Federally Qualified Health Centers (FQHCs). FQHCs almost function as Patient Centered Medical Homes. Hospitals are visibly missing. Dr. Nevin said the involvement of these organizations is absolutely essential, particularly if there is a desire to scale and leverage.

Management Services to Support Pilot Planning

- Secured Wheeler and Associates Management Services
- Professional expertise:

- Design, implementation and management of health service delivery programs
 - Ambulatory care operations management
 - Planning and staffing multi-stakeholder initiatives and consortium; e.g. the Delaware Cancer Consortium, CHAP, VIP, the Delaware Covering Kids & Families Program
 - Physician education and residency training programs
- Wheeler and Associates project deliverables include:
 - Assistance with stakeholder engagement
 - Communication and meeting support
 - Written Materials and Research
 - Pilot Project Plan and Timeline

Stakeholder involvement includes

- Executive Team – small and nimble
- Steering Group – varied representation, advisory
- Sub-committees – focused on topical/operational issues (e.g. payment reform, evaluation, practice improvements, policy)

Learning from Others

- Collaboration is key to success
 - Example - Involvement of the employer community is critical
 - A collaborative learning approach works well
- In order for whole-practice transformation to occur, the project must be:
 - Multi-payer
 - All ages and diseases
 - Prevention-focused
- Adequate practice incentives and technical assistance is Important
- HIT – HIE and EHR/EMR is a huge advantage

Timeline, Deliverables and Cost: Quarter 1

- Bring stakeholders together as a Steering Committee as well as defining functional subcommittees
- ID the goals and objectives
- Assess whether legislation is needed to create a 'safe harbor' for payment reform discussions to occur.
- Technical Assistance from the Patient-Centered Primary Care Collaborative (PCPCC)

Timeline, Deliverables and Cost: Quarter 2

- Form workgroups to address key operational and strategic considerations for the pilot.
- Draft an operating structure and budget
- Define the roles of government and other partners

- Prepare written proposal and other materials needed to elicit support from partners (e.g. funders and payers).
- Promote legislation if needed
- Begin funding recruitment

Timeline, Deliverable and Cost: Quarter 3 and 4

- Agreements in place (e.g. MOU's)
- Finalize payment reform methodology
- Secure funding commitments
- Recruit practices
- Finalize evaluation plan
- Support personnel capacity (e.g hiring of care coordinators)

Dr. Nevin would love to have a discussion about what the role of the Health Care Commission is in this initiative. This issue really is a question of policy and state involvement. The Patient Centered Medical Home has the potential to create the actual health care infrastructure that is going to make health care reform work for the people of the State of Delaware and is very important. There has been no real discussion about moving forward with the Commission, including the decision to hire a consultant. Dr. Nevin asked for clarification as to whether there was an expectation of merely reacting or is the Commission going to be part of a group that is going to be more pro-active in terms of creation? Some of the specialty groups are going to try to create their own version of a Patient Centered Medical Home. What will be the impact of that?

Insurance Commissioner Stewart said there is another issue that doesn't get a lot of treatment - *ERISA. Commissioner Stewart attended a meeting on ratings a couple of weeks ago which included a number of other Insurance Commissioners, HHS Secretary Kathleen Sebelius, President Obama and Secretary of Labor, Hilda Solis. Several Insurance Commissioners, including Ms. Stewart, were very upset over the fact that ERISA precludes states from regulating a large portion of health plan activity.

Approximately 80 percent of Delawareans receive health coverage through ERISA plans and the Insurance Commissioner has no jurisdiction over them, nor do they have to abide by mandates that are passed in the state. Ms. Stewart speculated that a door might be opening since the Secretary of Labor attended the meeting in Washington. The DOI gets many telephone calls from consumers about their coverage through ERISA plans. The DOI has hired a law firm on retainer to which people are referred to even though it is not a function of her department. Many people who work for large employers who self-insure do not realize that their coverage is actually paid for

Many people who work for large employers who self-insure do not realize that their coverage is actually paid for by their employers and that 'insurance companies' such as Blue Cross or Aetna only function as third party administrators (TPAs).

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**an ERISA group insurance plan is federally regulated self-funded health insurance offered by employers to their employees. Regulations for this type of insurance were put in place by the Employee Retirement Income Security Act (ERISA) in 1974.*

***TPA is Third Party Administrator. The duty of the TPA is to serve as the liaison between the insured person or company and the health insurance provider. This TPA company will typically file claims for the insured, but will also certify insurability for the insurance company.*

PUBLIC COMMENT

Dr. JoAnn Fields asked the Insurance Commissioner when we can expect more rigorous rate review so the citizens of Delaware have some confidence that when insurance rates go up the Insurance Commissioner's office is questioning that and auditing that and challenging those increases? That information, at this point, is not available.

Commissioner Stewart responded that on the DOI web site rate reviews are listed there. On health insurance, the Delaware statute needs to be changed and that is something that something DOI is pursuing. A number of other states have already changed their statute.

The Department of Insurance recently provided The News Journal with a list of companies that have applied for health rates, what they applied for, what was allowed and what is still pending. That can make available if people would like to e-mail the DOI.

There is a lot of confidentiality in health that most states are not allowed to give information out on the details.

Dr. Fields asked the Commissioner if they are *considering* the legislation in January, not *definitely* going to ask for a more rigorous rate review?

Ms. Stewart answered that the law that was originally passed made rate filings private. She wants to go back to the history and find out why very learned people made that particular piece of information confidential at that time. She then wants to talk to some of the other states and get an overall sense of whether rate filing information should be made public or is there good reasons it needs to still be private and what are the ramifications if it is made public versus not.

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Dr. Fields thinks at this point that the citizens of Delaware are not assured that when their health insurance premiums go up it is being reviewed with their interests in mind and thinks it should be an open forum and transparent and hopes there is legislation in the coming session to make that happen.

Commissioner Stewart assured Dr. Fields that her department works very hard.

Dr. Fields felt that it should be transparent and the public should have a chance to review those details and know why increases happened and be able to challenge whether they are accurate.

Ms. Roy added that, before Commissioner Stewart joined the meeting, a couple of points were made and wanted to re-emphasize them. The first is that Linda Nemes reported on was on insurance reforms mandated by the Affordable Care Act and the analysis DOI has done on the authority it has to enforce the new Federal laws and the gaps. DOI is working on legislation to close those gaps. DOI is working very closely with National Association of Insurance Commissioners that is developing model legislation that all states can use for a guide. The second point was the award of rate review grants that were made available to all 50 states to help them 'beef up' the rate review process. Those are specific steps that are being taken and had already been discussed earlier in this meeting.

Commissioner Stewart said most states don't have the authority to review health insurance rates; only 50 percent do and Delaware is one of them. It is hoped that the NAIC model will help in this area. Delaware statute specifically does not give Commissioner Stewart the authority to make certain information public.

Jon Kirch served as Committee staff in the Legislature and feels he remembers former Insurance Commissioner Matt Denn presenting bills to give the Insurance Commissioner the authority to even look at health insurance rates. He feels he also needs clarification and asked what is the Commissioner's level of authority in the health insurance market?

Ms. Stewart answered that legislation was passed last year; however, the negotiation between actuaries in DOI and health insurance carriers is confidential by statute and has always been.

Lolita Lopez of Westside Family Healthcare thanked the DIMER Board and the Commission for the State Loan Repayment Program award to Dr. Patrice Moore and liked the idea of private match. Ms. Lopez did want to point out that to recruit her, Westside paid a recruiter \$23,000 and gave her some relocation support. That is something to consider into the future.

Ted Becker said as we go forward with the State Loan Repayment Program and we look at private funding it is important that even recruiters are made aware that this is an option that's out there and could result in the physician ending up with much stronger monies available for them and might offset some of the expenses sites are looking at otherwise.

Barb DiBastiani who represents the Mid-Atlantic Association of Community Health Centers, totally agrees with Dr. Nevin that the Federally Qualified Health Centers are very well positioned to be Patient Centered Medical Homes. Ms. DiBastiani also wanted to introduce Greg Williams, who is the new CEO of Delmarva Rural Ministries.

Mr. Williams is looking forward to working with the Commission and rebuild and reinvent Delmarva Rural Ministries to serve the community it was intended to serve. He has 35 years experience working with community health centers.

Ms. Roy said Greg Williams is one of the original members of the Delaware Health Care Commission when it was formed in 1990.

NEXT MEETING

The next meeting of the Delaware Health Care Commission will be held on Thursday, November 4, 2010 at 9:00 a.m. at the DeIDOT Administration Building in the Farmington/Felton Conference Room, 800 Bay Road, Dover.

ADJOURN

The meeting adjourned at 11:30 a.m.

NEXT MEETING

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GUESTS

Janet Bailey	Hewlett Packard
Judith Chaconas	DHSS/Division of Public Health/Bureau of Health Planning Management
Anthony Brazen, D.O.	Division of Medicaid and Medical Assistance
Barbara DeBastiani	Wheeler and Associates
Mark DiMaio	Astra Zeneca
Dr. JoAnn Fields	Family Practice Physician
Robert Frelich	Medical Society of Delaware
Barbara Jackson	Hewlett Packard
Jon Kirch	American Heart Association & American Stroke Association
James Lafferty	Mental Health Association of Delaware
Lolita Lopez	Westside Family Healthcare
Roseanne Mahaney	Director, Division of Medicaid and Medical Assistance
Chris Manning	Delaware Health Information Network
Anne McGhee	Health Resources Services Administration
Linda Nemes	Department of Insurance
Sheila Nutter	Hewlett Packard
Brian Olson	LaRed Health Center
Karyl Rattay	Division of Public Health
Rosa Rivera	Henrietta Johnson Medical Center
Lillian Ronneberg	Hewlett Packard
Christine Schultz	Parkowski, Guerke and Swayze
Betsy Wheeler	Wheeler and Associates
Rob White	Delaware Physicians Care
Gregory Williams	Delmarva Rural Ministries