

State of Delaware  
Department of Health and Social Services

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*Health Benefits Exchange Planning  
Stakeholder Report*

September 12, 2011

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## Version History

Version	Date	Comments
Version 1.0 – A. Holmes	August 31,2011	Initial draft
Version 1.1 –A. Holmes	September 12, 2011	Final Report

## 1 Executive Summary

### Introduction and Purpose

Media coverage surrounding the Patient Protection and Affordable Care Act (ACA) and, specifically, the health insurance exchanges (Exchanges), has been extensive, overwhelming, and at times misinformed. Thus engaging stakeholders in a meaningful and factual conversation regarding the requirements imposed on the states and the public at large is crucial to successful implementation. As affirmed by the Department of Health and Social Services (DHSS) and reinforced by PCG throughout this process, the State aims to develop an Exchange that, while leveraging the experiences and lessons learned from other states, is tailored to serve the unique needs of Delawareans. This goal cannot be accomplished without continuous input from Delawareans to ensure that the State understands their needs and how to reach them effectively.

This report presents the results of Delaware's initial outreach to support the foundational Exchange planning efforts that are underway. As stated above, the State plans to continually involve stakeholders in each stage of planning and implementation; therefore, this report represents only the first in a series of Exchange stakeholder analyses that the State expects to conduct over the next several years.

### Methodology

PCG built on DHSS's previous stakeholder engagement activities to compile a comprehensive list of stakeholder contacts and added to this list throughout the process as more organizations and individuals were identified. PCG's approach to stakeholder outreach involved three key components:

1. Educate stakeholders, dispel misinformation, and collect initial comments and feedback through topic-specific public forums.
2. Provide easily understandable background materials and make available those materials to the public.
3. Collect and analyze in-depth feedback and recommendations from stakeholders through small, roundtable focus group discussions.

PCG conducted seven public forums throughout the state covering topics including general Exchange requirements, changes to the commercial market, the effect on small businesses, the interplay between Medicaid and the Exchange, and issues related to consumer outreach and enrollment. In advance of each meeting, PCG drafted issue briefs that provided background information and a discussion of key decision points for each topic. Prior to the small business forum, PCG distributed an online survey to small business owners through the local chambers of commerce. Responses to the survey informed the small business discussion, tailoring the presentation to the unique needs of Delaware's small business community. During the public forum, PCG subject matter experts gave a presentation on the topic, followed by an open comment period. Stakeholders were also encouraged to ask questions and interject

comments and concerns throughout the meeting. PCG recorded minutes during each forum and later compiled feedback from all meetings for analysis.

During the next phase of outreach, PCG conducted three focus groups consisting of less than 10 stakeholders each. These sessions provided the opportunity for stakeholders to contribute detailed, in-depth feedback and recommendations to guide the planning process. The agenda for the focus groups was framed by broad discussion questions; however, the stakeholders led each discussion and posed new questions for comment as desired.

All data collected during the public forums and focus groups was compiled, analyzed, and organized into topic specific areas that could be readily incorporated into the Exchange planning process.

### **Stakeholder Input**

Analysis of stakeholder input revealed five broad topic areas under which the input could be organized and summarized. Highlights in each topic area are included below, and a thorough description of the input received is provided in **Section 4** of this document.

#### *Governance and Administration*

- Ensuring that the right people are in charge of the Exchange will be critical to its success. Board members should be appointed based on a broad range of expertise, and voting and attendance requirements should be mandatory conditions of board membership.
- Guaranteeing Exchange sustainability, given Delaware's small population will always be a concern. Stakeholders are seeking assurances that the cost of administering the Exchange can be effectively distributed without deterring individuals from enrolling or insurers from entering the market.
- Opinion was split among stakeholders as to whether the individual and small group markets should be merged. Some feel that merging the two markets would simplify the system and improve ratings for individuals. Others worry that a merger is not feasible given the many differences between the two markets and would lead to rate hikes for small employers. PCG reiterated that two separate markets may still be administered under one Exchange; however, some stakeholders suggested that the small group may be more effectively served by removing it entirely from the individual Exchange and administering under a private entity.

#### *Consumer Outreach and Education*

- When developing the message to send out to consumers, the State must break ties connecting health care to political debates and the national debt. For individuals, the cost argument will be less convincing than a moral argument, i.e. focus on the burden that an uninsured individual would leave parents and loved ones if critically injured or diagnosed with a chronic condition.
- Television advertising is not an option as there are no Delaware-based television stations; however, local newspapers, radio stations, and pamphlets are all options to consider. Community leaders should also be armed with simple, easily readable background materials so that they may

personally convey the message to their communities. Any materials prepared for this purpose, however, should be made in a plain and simple manner, so as not to give the appearance that money was wasted on glossy marketing tools.

- Community meetings and “Health Days” should be used to reach individuals in their own neighborhoods. Health Days may include free health screenings to further incentivize enrollment. Most importantly, these meetings should be led by trusted members of the community and include childcare services if offered during the evenings and weekends.
- Community leaders and organizations recommended for inclusion in this process include faith based organizations, housing authorities, the Department of Labor, the Department of Corrections, domestic violence organizations, and programs for English as a second language education.

#### *Certification of Qualified Health Plans and Benefit Packages*

- Recommendations for certification standards include:
  - Agreement to a collective credentialing process, i.e. a provider who has been credentialed by the Exchange will be accepted by all plans
  - Demonstrated interest in pilot programs to develop new methods of care delivery and focus on primary care
  - Demonstrated overall financial solvency
- Stakeholders support the inclusion of preventive and women’s health, pharmaceutical, and mental health services, and expressed concern over the apparent exclusion of dental, vision, and transportation benefits for adults.
- A thorough review of both comparative effectiveness research and prior authorization review processes should be conducted when designing benefits packages and limitations to ensure that the right services are included and unsafe or financially unreasonable services are excluded.

#### *Network Adequacy*

- Most of Delaware is underserved and the situation has been exacerbated by the economic downturn. The influx of retirees into the state has also contributed to scarce provider availability.
- Low provider wages and reimbursement, a lack of job opportunities for provider spouses, and the mediocre reputation of the public school system have always caused problems for provider recruitment. The inclusion of nurse practitioners as billable primary care providers, however, may alleviate some of these issues as nurses have been more likely to stay in the state when jobs are available.
- A focus on care coordination, coupled with appropriate reimbursement for care coordination services, will help providers and consumers use the services that are available more efficiently. The issue of coordination is particularly critical to the provision of mental health services as the referral process and tracking of patient progress is more complex in that context.

#### *The SHOP Exchange*

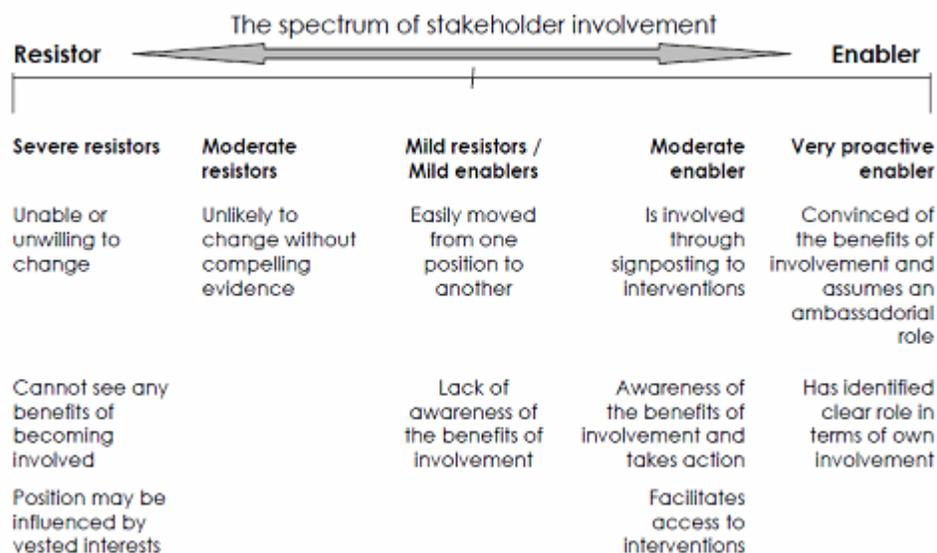
- Cost is, and will always be, the key concern for small businesses.

- Health underwriting has traditionally been the biggest cost driver for the small group market. Additionally, since health underwriting is less common in small group markets nationally, this practice may have been a barrier to entry for some carriers. Elimination of health underwriting may therefore improve the coverage environment for small businesses from multiple angles.
- Despite the small number of carriers, the market has succeeded in offering a wide variety of plan options for the small group consumer. Stakeholders expressed concern that standardization will substantially limit consumer options within the Exchange, but acknowledged that simplification may allow small employers to act more independently and gain confidence in their decision making.
- Stakeholders support the use of the Exchange as a premium aggregator for small employers to alleviate the administrative burden of handling multiple bills.
- Some of the current online enrollment options in the state are not set up in a consumer friendly way and should be reviewed for lessons learned when setting up the Exchange website.

## 2 Introduction and Purpose

Section 1311d (6) of the Patient Protection and Affordable Care Act (ACA) requires states to confer with various stakeholder groups throughout the planning, implementation, and operational phases of the Exchange. The ACA originally specified consultation with health care consumers, entities with experience facilitating insurance enrollment, advocates for enrolling underserved populations, small businesses, and State Medicaid and CHIP agencies. The recent notice of newly proposed rulemaking (NPRM) on the Establishment of Exchanges and Qualified Health Plans expanded this list to include federally recognized tribes, public health experts, health care providers, large employers, health insurance issuers, and agents and brokers.

In 2007 the World Health Organization (WHO) published a paper that included a four-step “model of stakeholder involvement.”<sup>1</sup> WHO suggests that, in general, stakeholders can be analyzed along a continuum of support to resistance and thinking about stakeholders along this continuum leads to a better understanding of the various stakeholder positions that the State will likely encounter during the Exchange planning process. It is important not to place value or imply that resisters are “bad” and enablers are “good.” Rather, the WHO model focuses attention on the fact that stakeholders will naturally vary in their support for a new program and it is useful to be aware of this and understand why.



<sup>1</sup> World Health Organization, (2007), *Stakeholder Involvement*, Background paper prepared for the WHO/WEF Joint Event on Preventing Non-communicable Diseases in the Workplace, Dalian, China. Retrieved on 6-30-2011 from <http://www.who.int/dietphysicalactivity/griffiths-stakeholder-involvement.pdf>

During this phase of stakeholder outreach, most resisters cited reasons that were largely based on misinformation. The extensive media coverage that has been devoted to the ACA, in general, and health insurance exchanges, in particular, has exacerbated the problem of misinformation nationally. Thus a critical and ongoing component to stakeholder engagement will be dispelling rumors and educating the public so that they may distinguish fact from myth.

This report will describe the methodology and results of the first phase of Delaware's stakeholder involvement. The State plans to continue actively engaging stakeholders throughout the planning, implementation, and operational phases of the Exchange and will develop and revise planning activities based on stakeholder input during each phase.

### **3 Methodology for Initial Outreach**

Since the outset of Delaware’s Health Insurance Exchange planning efforts, the Department of Health and Social Services (DHSS) has actively engaged stakeholders throughout the state, seeking feedback through meetings with individual organizations and through the Delaware Health Care Commission’s public meetings. Prior to PCG’s involvement, DHSS had reached out to representatives within all of the above described stakeholder groups to varying degrees, focusing primarily on basic governance and administrative decisions, as well as issues related to the SHOP Exchange.

DHSS transitioned stakeholder outreach activities to PCG in May of 2011. PCG and DHSS reached out to all previously engaged stakeholders and actively reached out to a number of additional organizations, including United Way of Delaware, the Delaware Nurses Association, the League of Women Voters, and the Ecumenical Council. All communications from PCG were approved and officially authorized by Secretary Landgraf’s office prior to distribution.

#### **3.1 Educating Stakeholders and Dispelling Misinformation**

PCG conducted seven public forums throughout Delaware to further educate Delawareans about health reform and the potential role of the Exchange. Each forum focused on a specific issue, from the relatively general (e.g., what is an Exchange) to the more specific (e.g., what is the most effective way to inform consumers of their health plan options; how can the Exchange best serve small employers). To help focus the discussions at the public forums, PCG prepared issue briefs, which the State made available in advance of the meetings through direct email and the Delaware Health Care Commission’s website. These issue briefs provided attendees with background information and an overview of the topics to be discussed at the forums, as well as the key issues to be considered.

The public forums began with a presentation by PCG subject matter experts explaining the topics and discussion points that were addressed in the issue brief, followed by an open question and comment period. PCG paid particular attention to topics where there has been considerable misinformation within the media and public opinion in order to present an accurate, objective, and comprehensive view of the issues at hand. Representatives from DHSS provided a brief introduction at the beginning of each forum to ensure that forum participants recognize this engagement as a State initiative. Below is a summary of the topics presented by PCG during this time period.

1. The Small Business Exchange
  - Overview of SHOP Exchange
  - Options for Delaware
    - One Exchange Serving Both Individuals and Small Employers
    - Separate Exchange for Small Employers and Individuals
    - Merging the Markets – Small Groups and Individuals
  - Premium Subsidies for Eligible Small Employers
  - Expanding the Small Group Market to Groups of 100

- Role of Brokers  
→Key Question -- How Can the Exchange Best Serve Small Employers?
- 2. General Overview of the Health Insurance Exchange
  - What is a Health Insurance Exchange
  - Key Features and Services
  - Options for Delaware in Structuring an Exchange
    - Governance and Administration
    - Availability of Plans/Carriers
    - Financing
  - Key Question -- What Will Make an Exchange Successful for Delawareans?
- 3. The Exchange and the Commercial Market
  - Changes Coming in 2014
    - Elimination of Medical Underwriting
    - Limits on Cost Sharing
    - “Essential Health Benefits” Requirements
  - Premium Subsidies for Small Groups through the Exchange
  - Key Question -- How Does the Exchange Fit into the Existing Market?
- 4. Consumer Information/Engagement
  - What Types of Information do Consumers Need/Want
  - Should Benefits be Standardized
    - Platinum, Gold, Silver, Bronze
  - Role of Customer Service to Facilitate Enrollment
  - Outreach to the Uninsured and the Role of Navigators
  - The Role of Brokers
  - Key Question -- How Can the Exchange Best Serve Delaware Consumers?
- 5. The Exchange and Medicaid/CHIP
  - Single Point of Access to All Health Coverage Programs
  - Medicaid Eligibility Expansion up to 133% FPL in 2014
  - Premium Subsidies and Reduced Cost Sharing Through the Exchange
  - Key Question -- How Can the State Establish a “Continuum of Coverage” Across Various Medical Assistance Programs?

Prior to the Small Business Exchange forum, PCG prepared and distributed a small business survey through the local chambers of commerce. The survey aimed to gain insight into current purchasing behavior within the small group market and understand questions and concerns regarding Exchange requirements prior to the forum. The survey collected responses from over 80 participants using Survey Monkey. Responses were used to shape the forum presentation, focusing on areas where small business

owners had indicated confusion or concern. The results of this survey are included in the discussion in *Section 4.5. SHOP Exchange*.

### **3.2 Collecting Stakeholder Feedback**

Following the presentation at each public forum, PCG facilitated an open question and comment period for the stakeholders present. PCG subject matter experts, DHSS representatives, and Division of Medicaid and Medical Assistance (DMMA) representatives were on hand to answer questions and respond to concerns as needed. PCG and DHSS recorded meeting minutes and distributed internally for review following each forum.

Following the public forums, PCG facilitated three targeted focus groups to provide the State with more detailed feedback on Exchange planning activities through small, intensive, and constructive group work sessions. Each focus group consisted of less than 10 individuals. A key difference between the public forum and focus group processes is that the latter leveraged the educational component that was established during the public forums. As such, focus group participants were expected to have attended the public forums, or at least have read the supporting material, in order to contribute meaningful input to the process.

PCG facilitated the focus group meetings. However, unlike the public forums, State representatives did not directly participate, allowing for an unencumbered exchange of information. The agenda for each group focused on discussion questions that are specific to the expertise of the participants. PCG notified each prospective focus group participant to gauge their willingness and availability to participate in this process and determined a feasible meeting schedule based on collective participant availability. Two PCG representatives recorded meeting minutes during the focus groups. The data collected was compared, compiled, and organized by topic area. A summary of major topics for stakeholder input is presented in the following section.

## 4 Stakeholder Input

The data collected during both the public forum comment periods and focus groups was compiled, analyzed, and organized into major topic areas. Stakeholder feedback, recommendations, and concerns are summarized under those topic areas below.

### 4.1 Governance and Administration

The stakeholders expressed three main concerns with respect to governance and general administration of the Exchange: ensuring appropriate board composition, sustaining an Exchange with Delaware's small population, and the possibility of merging the small group and individual markets and/or Exchanges.

#### *Board Composition*

A number of stakeholders pointed to board composition as the key to ensuring successful implementation in Delaware. They noted that, on other State boards, issues arise when there are not enough members in attendance to form a quorum. Therefore, they recommend that the Exchange impose attendance and voting requirements as a condition of board membership. They also strongly recommend that board members meet certain credentials and represent a broad range of expertise and public interests. The current draft Executive Order appropriately satisfies the latter recommendation.

#### *Exchange Sustainability*

Concerns surrounding Exchange sustainability, given the small Delaware population, were voiced at nearly every stakeholder meeting. Some groups focused on the concern that insurance carriers would not want to participate in a Delaware Exchange because the population, and therefore the total risk pool in the state was too small. However, the four major insurance carriers in the state have all expressed a strong interest in participating in the Delaware Exchange despite its small size.

Brokers have commented that the recent medical loss ratio (MLR) restrictions have immediately impacted their compensation rates. If the Exchange were to impose a fee on insurance carriers that would also count against the MLR calculation, brokers fear that their compensation rates would drop further or that other administrative cuts would lead to diminished service. Supporting this concern, providers noted that no one within their community wants to restrict access to care or restrict provider reimbursements.

#### *One Exchange or Two*

Stakeholders expressed support on both sides of this issue. Again, given Delaware's small size, providers and consumer advocates, among others, support merging the individual and small group markets and operating under one Exchange. Some of these stakeholders expressed a distrust of actuarial guidance for this type of policy decision. Others are merely looking to simplify the process as much as possible.

Other stakeholders are staunchly opposed to merging the individual and small group markets, although we heard very little opposition to governing the SHOP and individual Exchanges under one umbrella

administration. One stakeholder did suggest outsourcing the SHOP Exchange entirely to a private entity if it meant more efficient administration for small businesses. Reasons cited for keeping the individual and small group markets separate included the many current differences between how the two markets are regulated and administered and the potential increase in small group market rates caused by the introduction of high risk individuals.

## 4.2 Consumer Outreach and Education

Stakeholders in all groups focused on the importance of effective public outreach and enrollment. Their feedback can be broadly classified as answers to three questions:

1. What message should the State send?
2. What media and other tools should be used to send the message?
3. Who are best conduits in the community to reinforce the message?

### *What message should the State send?*

Stakeholders universally expressed concern regarding public acceptance of and participation in the Exchange. They noted that there must first be a focus on the importance of insurance coverage for the individual and the community, but that the message would be very different when addressing uninsured individuals versus small employers. For small employers, the mantra that the cost of prevention is much lower than the cost of crisis was identified as a key point (“deal with it now, or pay for it later”). For uninsured individuals, the overall cost savings of preventive healthcare was viewed as less persuasive. Consumer advocates suggested focusing on the potential burden that an uninsured individual will leave their parents or loved ones if they were severely injured or diagnosed with a chronic condition. In this manner, health care coverage becomes a moral issue rather than a political or economic concern.

For both audiences, however, there must be a clear shift away from politics and media coverage on the economic burden of health care reform. Advocates suggested publicizing a “Fact vs. Myth” pamphlet on health care reform that is written in plain English, and possibly includes an economic analysis to show how the State’s costs may be reshuffled rather than augmented to provide healthcare to all. For example, a graphical representation of the difference between primary care and emergency room costs may be encouraging to this population. Stakeholders expressed that the importance of breaking ties binding health care to the national debt and bipartisan debates cannot be overstated.

The message also needs to be very clear as to who is eligible for what type of coverage starting in 2014. Again, individuals are concerned about imposing a burden on tax payers by participating in the Exchange, especially since many uninsured individuals have likely not been eligible or otherwise never applied for any other form of public assistance. Individuals do not want to be seen as a burden to the State and their neighbors in Delaware by participating in the Exchange.

*What media and other tools should be used to send the message?*

Stakeholders proposed a number of different advertising options that have worked well for other programs and would be viewed by a cross section of individuals. Overwhelmingly, stakeholders stressed that while many components of Exchange operations and implementation will be web-based, there is a critical need to focus outreach efforts offline in order to reach the disenfranchised.

As there are no major television stations operating within Delaware, one major form of mass communication is eliminated from consideration. This limitation has two main implications. First, the State will need to focus their attention heavily on other forms of media available in the State. Second, the State will need to monitor advertising and other Exchange-related information that is being transmitted from neighboring television stations (Philadelphia and Baltimore were noted as two main sources of television programming).

One form of advertising that stakeholders suggest has yielded results for past consumer advocacy and political campaigns is public bus advertisements. Buses are widely used within the State and provide a large canvas to convey the State's message. Other tools that were discussed included the use of brochures in grocery stores, or convenience stores/gas stations in areas where grocery stores are not available, and advertisements in the local newspapers, including Brandywine Community News, Cape Gazette, etc. Free text cell phone ads were also suggested as a potential advertising outlet.

In addition to materials that are created for public distribution, stakeholders also stressed the importance of tools and materials that will be provided to community leaders and Navigators. For instance, a basic glossary of definitions and acronyms that is written in plain English would be helpful in assisting consumers and further educating the public. All materials should be tested by individuals who are healthcare or computer literate for efficacy. Additionally, any materials for public distribution or use by the program must not look too glossy or expensive to support the message that the State is not augmenting the economic burden on tax payers through this program.

Community meetings will likely be the most effective form of outreach that the State can provide. Stakeholders suggested that the State work with community organizations to establish "Health Days," in which individuals can receive information, participate in health screenings, such as blood pressure testing, and enter to win giveaways. The inclusion of health screenings may also incentivize individuals to enroll in insurance if an issue is revealed during that process. One stakeholder also recommended beginning outreach efforts by focusing on the parents of CHIP eligible children. It was noted, however, that any meetings or events that occur in the evenings or on weekends should include a nursery service for individuals with small children, such that the cost of hiring a babysitter does not prevent parents from attending.

*Who are best conduits in the community to reinforce the message?*

Stakeholders stressed the importance of community within Delaware. Therefore the most important element of the community outreach strategy will be heavily involving key community figures and

organizations. Faith based organizations have arguably the broadest reach within the state and are highly regarded within many communities. LaVaida Owens White, a parish nurse in Delaware, and Pastor Figueroa were mentioned by name as important resources for the state going forward. One stakeholder noted that although some members of the targeted population may not be directly involved in the faith community, their family members and particularly their elders likely will be. Therefore, it will be important to emphasize spreading the message through older members of the community even though they themselves may not be the target population.

Other existing organizations that may be leveraged for outreach purposes include public libraries, community centers, the Department of Labor, the Department of Corrections, housing authorities, and the Domestic Violence Coordinating Council. The Department of Labor will be critical to connect with individuals who are unemployed and therefore likely uninsured. For the CHAP program, an individual was stationed at an information booth within the Department of Labor once every two weeks to sign up individuals as they applied for unemployment benefits or checked in with their case worker. CHAP also worked with the Department of Corrections to set up informational sessions during days of peaceable surrender.

In addition, the Delaware Community Reinvestment Advisory Coalition and Earned Income Tax Credit Program (EITC) were noted as two additional sources for reaching lower income individuals within the state. United Way is also currently working with Stand By Me, a program that promotes financial literacy as part of English as a second language education. By connecting health care with other major milestones in the lives of younger adults, such as applying for a mortgage or increasing one's financial independence, the state can encourage the public to view obtaining health care coverage as another rite of passage.

### 4.3 Certification of Qualified Health Plans and Benefit Packages

Throughout the public forums, considerable attention was paid to the development of Exchange policies that would effectively govern the plans offered and offer the most value to Delawareans. The conversations revolved around two main concerns: certification standards for qualified health plans, and the identification and administration of appropriate benefit packages.

#### *Recommendations for Certification Standards*

The stakeholders offered a number of specific considerations when developing certification standards for qualified health plans, as listed below. However, above all of other criteria every group stressed a need to keep the options and plans simple, in order to avoid overwhelming consumers or creating an undo administrative burden, while not sacrificing competition.

- The actuarial value of plans should be calculated based on Delaware's population if it is materially different from the national standard.

- Plans participating in the Exchange should adhere to a collective credentialing agreement. In other words, if a provider is credentialed with the Exchange, he or she is covered for all plans offered through the Exchange.
- The Exchange should consider imposing a specific time table for enrolling individuals.
- Carriers should demonstrate a commitment to the value of services and focus on primary care providers, including recognition of nurse practitioners as primary care.
- Carriers should demonstrate an interest in pilot projects and developing new ways of delivering and paying for primary care services, including telephone and web-based appointments.
- Carriers should demonstrate a commitment to modernizing the rate review process and making transparent to the public how risk is stratified and rate increases are justified.
- The carriers overall financial solvency should be a key factor to consider in certification, including their ability to meet Delaware's prompt pay laws for services.
- Carriers should demonstrate a focus on improving health outcomes, not just financial outcomes, through care management practices.

#### *Benefits and Benefit Administration*

Though the essential health benefits package is yet to be released, and the majority of Delaware's current insurance mandates are expected to fall within this package, stakeholders voiced their support for several of the expected required benefits, including preventive and women's health, pharmaceutical and mental health services and expressed concern over the potential exclusion of other benefits.

Transportation is a major concern for lower income individuals, especially given the limited public transportation options within the state. Stakeholders noted that the current Medicaid non-emergent transportation system in Delaware has inefficiencies that result in long wait times for clients.

Additionally, providers expressed that dental and vision, while generally covered for children, are also critical to the health of adults. Most individuals do not need vision services until they reach the age of 40, at which point eyeglasses or other corrective measures are necessary for daily living. More recent links between oral health and overall physical health also support the inclusion of a more comprehensive dental benefit, both in Medicaid and commercial insurance.

Providers also stressed that the importance of patient follow-ups cannot be overstated, and often the time devoted to conducting effective follow-up communication is not reimbursed. As part of a renewed focus on care management and the potential development of medical homes, this communication should be a legitimized benefit.

In addition to specific benefit inclusions and exclusions, several groups discussed the impact of broader issues related to benefit packages. With respect to impending benefit changes, consumer advocates strongly recommend a well developed communication plan to inform consumers of those changes. Citing issues that arose following a change in the State drug formulary, they cautioned that sending a notification letter to beneficiaries is never sufficient. The Exchange, Medicaid, and individual carriers should work with existing organizations and community leaders to ensure that benefit changes are fully understood by consumers.

Providers recommended that an analysis of comparative effectiveness should be undertaken prior to allowing coverage of certain services, pointing to coverage of certain high end diagnostic tools that are expensive but do not lead to better health outcomes for the patient. Additionally, carriers should be more discerning with respect to coverage of new procedures when the overall safety of those services is still unknown.

Additionally, providers recommended that the current prior authorization processes should be reviewed and simplified to expedite patient treatment. The current process is complex and the time requirement can often act as a barrier to patients receiving needed services. Providers added that the need for expedited review is especially important for major medical services, including cardiac care.

#### 4.4 Network Adequacy

##### *Understanding the Underserved*

When asked whether certain areas or demographic populations are underserved, stakeholders universally agreed that, in reality, most of Delaware is underserved and the problem worsens as one travels downstate. Even when providers across state lines are considered in-network, which is a rare circumstance, residents very rarely travel to neighboring states to receive care. In Wilmington and Newark areas, the federally qualified health centers (FQHCs) are over utilized to fill gaps in affordable care, particularly in serving the Hispanic and African American populations. The FQHCs noted that serving non-English speaking populations essentially doubles appointment times as most providers are not bilingual and therefore conversations need to happen twice.

Two population level events have also strained resources within the state. The economic downturn and increases in unemployment have changed the face of the underserved within the state and, therefore, demand for affordable prescription programs has increased dramatically. Also, an influx of retirees who are typically more medically needy have caused a overall burden on provider availability.

##### *Provider Recruitment*

Providers also pointed to continued difficulty in recruiting providers to the state. In comparison to neighboring areas, Delaware is not a high wage or high reimbursement state, particularly with respect to primary care. Also, a lack of employment options for providers' spouses and relatively poor public

education systems have historically been cited as recruitment issues. Recently, the length of time required for medical licensure boards to issue licenses has compounded recruitment problems. Providers stressed that the use of nurse practitioners in primary care presents more possibilities. The Nurses Association stated that nurses more often want to stay in the state if there are jobs that make it affordable for them to live there.

#### *The Need for Care Coordination*

However, while there are many reasons for the shortage of services in the state, stakeholders strongly expressed that a focus on care coordination would help them to use current services more efficiently. Currently, patients tend to get lost in the system when they go to specialists as staffing shortages at the primary care level make follow-up more difficult. However, care coordination is time consuming, requiring both staff hours and expertise to achieve effective results. Providers noted that Delaware Physicians Care attempted to organize care referrals last year, but it is still not an efficient system for obtaining an appointment. They suggested that insurers would maximize efficiency by reimbursing primary care providers for care coordination rather than introducing external systems.

With the provision of mental health services in the essential health benefits package, both the demand and the challenge of care coordination are heightened. Approximately 60 percent of patients present with comorbidities, underlying the need to provide continuous coordination between mental and physical health assessments and services. Providers also expressed that most primary care physicians do not understand how to navigate the roster of mental health services available given the large number of very small mental health practitioners in the state.

## **4.5 SHOP Exchange**

#### *Rates and Costs*

The stakeholders expressed that their main concerns involved rates and costs. Delaware does not have a wide array of health carriers to choose from, and as a result, rates are unaffordable for many already. One stakeholder noted that the employer does not currently know what percentage of costs goes toward premiums and this presents problems in shopping for the right insurance coverage (i.e. more expensive must be better).

Health underwriting was cited as the biggest challenge driving costs. Two major association groups, the Delaware Farm Bureau Association, and the New Castle Chamber of Commerce have struggled to maintain affordable rates as a result. Historically, associations were intended to unite small businesses in order to obtain advantages normally reserved for large businesses. Employers who shopped for insurance outside of these association plans were often assigned lower rates than those within the plans. Initially, the insurance carriers rated the association plans higher to protect against unknowns within those populations. However, the rates were renewed each year and therefore no substantial cost savings has been realized. The stakeholders recognized, however, that the elimination of health underwriting after 2014 would mitigate some of these discrepancies.

### *Benefit Plans*

Stakeholders noted that, despite the small number of carriers in Delaware, there is a lot of plan choice for the small group market. However, they expressed concern that plan choices could be more limited for employers under the Exchange. Currently, employers can pick multiple plans from one carrier. The plans must be dissimilar, or in separate platforms. For example, if one plan is deductible based, the other plan should be copayment based. It has been hard for agents to explain the differences between plans, especially those dissimilar from one another. One of the most time consuming tasks that brokers have now is explaining the differences among plans. To this end, stakeholders suggested that standardized benefit summaries would be beneficial both in and out of the Exchange, which then requires the insurance carrier to compete on price. However, they expressed concern that standardizing too much could remove choice from the consumer. They also cited the Medicare standardized benefit plan as a helpful resource.

### *Navigator Role*

Brokers expressed interest in learning about Navigators and how to become Navigators, given that the NPRM explicitly states that brokers are not precluded from acting as Navigators within the Exchange as long as they are not compensated for Exchange plan enrollment. They noted that when the reform first happened, the agents who did health as a sideline business stopped and focused on life insurance and annuities. However, brokers in general are still mainly interested in being brokers - meeting with clients, small businesses, and small employers and acting as the outsourced human resources arm when assistance is needed.

### *Broker Compensation*

Broker compensation fell this year in the Delaware market in comparison to what it was historically as a result of insurers adapting to the medical loss ratio. Delaware currently uses a percentage-based compensation and brokers would prefer to continue with this system. Brokers expressed that if compensation were standardized, the inherent biases from one carrier to another would be eliminated.

### *Outreach*

Stakeholders expressed the importance of developing outreach plans for the Exchange. Recommended outreach tactics included print ads, radio ads and mailings. However, the importance of face to face contact during enrollment was stressed by every group. With respect to the use of online communications, a full forty percent of all insurance enrollment business is still completed on paper in Delaware. Similar to the individual market, the Exchange will need to include extensive outreach and education that is not web-based in order to effectively reach this population. Stakeholder also noted that some of the current online enrollment options in the state are not set up in a consumer friendly way and should be reviewed for lessons learned when setting up the Exchange website.

### *Aggregate Billing*

Stakeholders expressed interest in the Exchange serving as the premium aggregator. They noted that employers like the simplicity of one bill. Because many small businesses do not have a human resources department, the employer will never be able to take on premium payments to multiple carriers solely as their responsibility. Additionally, employees will often approach their employer if they have an issue with their insurance coverage, in which case the employers either turn to the insurance carriers or the broker

for help. If a business is using multiple carriers, solving these types of problems may become more burdensome. A single centralized call center, however, may alleviate those problems if there are multiple ways to reach those representatives (e.g. telephone, live-web, email). Stakeholders anticipated that allowing a purchasing model in which one group can choose from multiple carriers would be a good option to increase competition and allow more choice for employees, but stated that the State may consider a sunset clause in case there are problems with risk distribution.

## **5 APPENDICES – Stakeholder Meeting Documentation**

Attached are documents including meeting summaries compiled for Public Forums and Focus Groups.

### **5.1 Public Forum – General Overview June 7, 2011**

#### **Delaware’s Health Benefit Exchange: General Overview**

**Delaware Department of Health and Social and Social Services**

**Doubletree Hotel, 4727 Concord Pike, Wilmington, DE**

**Tuesday, June 7, 2011 1:00 PM – 3:00 PM**

#### **Notes from Public Forum**

**Question:** What are the governance options for the Exchange? My understanding is that it can be a single state Exchange or a regional Exchange.

**Answer:** Yes, the last option is to let the Exchange be run by the Federal government.

- Regional exchange does not necessarily need to be with bordering states. Can partner with other states to share back-office capabilities, etc.

**Question:** How do children fit into the Exchange?

**Comment:** Need to make sure, when implementing the Exchange, that we consider the affect that it will have on children who are going back and forth between plans – need to make sure that they are not losing preventive care services.

**Answer:** Yes, this is very important. The essential health benefits will cover preventive care.

**Question:** Gearing up for 2014, what do you see as the biggest milestone?

**Answer:** 1. Eligibility

2. The governance structure and making sure that legislature has been passed and statutes are in place

**Question:** Are states limited to the actuarial values that were mentioned in the presentation (platinum, gold, silver, bronze, HDHP)?

**Answer:** Plans offered through the Exchange need to be qualified health plans, and yes, they need to fit the actuarial values of those tiers. Plans that do not fit these tiers will continue to be sold outside of the Exchange, but all plans sold in the state need to meet the requirements of the Department of Insurance. There will also be a dental plan.

**Question:** Are the actuarial values based on the population of the state of Delaware or on the national population?

**Answer:** Federal guidance has not been explicit on this guideline, however it makes sense that the value should be based on the state's population if that standard is materially different from the national standard.

**Question:** Will there be transparency in regards to the rating value? Will the information be available to consumers on the Exchange?

**Answer:** Yes, plan quality ratings will be available through the Exchange and the rates approved by DOI are also publicly available information.

**Comment:** Impressed by the Wisconsin website. Delaware should do something similar.

**Answer:** We do want to note that the WI website is not operational, only a prototype.

**Question:** Will the Exchange be reaching out to commercial insurers and getting them interested in providing plans through the Exchange? Do we know how many lives an insurance carrier needs to have in order to have incentive to participate in the Exchange?

**Answer:** Yes, we are currently in the process of setting up individual meetings with the commercial carriers and will be in communication with them throughout the process of implementing the Exchange.

**Comment:** Need to make sure that we are giving people enough information and guidance to help them enroll, as most of them have never purchased health insurance on their own. It is very difficult and confusing – they do not make the process easy for you.

**Answer:** Yes, an important observation. There will be navigators and brokers that will be responsible for outreach in the community as well as walking people through the process of enrollment. Also there will be the single eligibility form for all individuals to fill out, regardless if they qualify for subsidies through the Exchange, Medicaid, or CHIP for children.

**Question:** Will there still be coverage available for purchase outside of the Exchange?

**Answer:** Yes, and it is very importance that we make sure that coverage available through the Exchange and outside the Exchange are on a level playing field.

- Lesson learned in Massachusetts: can't have open enrollment throughout the year

**Question:** The high deductible plan that Delaware currently offers – are they going to get rid of the provision that states that a person must go 6 months without insurance before they can qualify?

**Answer:** Unclear as to how this provision will play out but the state is aware of the disincentives that it poses on the system.

## **5.2 Public Forum – HBE and the Commercial Market June 16, 2011**

### **Health Benefit Exchange and the Commercial Market**

#### **Delaware Division of Medicaid and Medical Assistance**

#### **Sheraton Dover Hotel, Dover, DE**

**Thursday June 16, 2011**

#### **Notes from Meeting: Q&A**

Question: If when DHHS releases the essential health benefits package a service is not available, will there be an appeals process in place?

Answer: Yes, it will be the same appeals process that is in place today. The essential health benefits package will be very heavily scrutinized. In the fall, we should expect to receive the more granular list of the essential health benefits. The reason why this list is so important is that if a benefit is not included in the list issued by the Secretary, the State will have to pick up the cost of those benefits for all plans that are sold through the Exchange.

- This does not mean that carriers are limited to the essential benefits. They can choose to offer non-mandated benefits as well. Again this will not affect the client's current appeal rights under their insurance coverage.

Question: There has been a heavy push in Delaware for community based care for elderly. Do you envision this being included in the essential health benefits list?

Answer: Community based care is more relevant to the Medicare and Medicaid, not the commercial market or plans sold through the Exchange.

Comment: The risk corridors program essentially insures the failure of the insurers. It allows them to run up there administrative costs.

Answer: The administrative portion of carriers' expenses is removed from the risk corridors calculation; it only calculated claims. Also, the risk corridor works both ways. If an insurance company's premiums fall below the threshold, they are required to pay into the pool.

Question: How often will these transitional risk mitigation programs be reviewed?

Answer: It depends on the program. The transitional reinsurance program, for example, would need to be reviewed fairly often, perhaps on a quarterly basis. The risk corridors program is more of a year-end calculation, so this will be done annually.

Question: Do these risk mitigation measures apply to the 65 and older population as well?

Answer: For the most part, the 65 and older population will be enrolled in Medicare, not the Exchange, so it would not apply

- The exception to that would be someone who is over 65 that continues to work and receives employer sponsored insurance purchased through the Exchange. In this case, they would be included in the population.

Question: If commercial insurers want to operate in the 50 plus market, do they also need to operate in the 50 and below market?

Answer: There is no requirement, but the idea is that carriers would want to operate in the 50 and below market as well. There are a lot of younger individuals in this group, a healthy population that would be a good opportunity for carriers.

Question: How has the Connector in Massachusetts changed from its initial start to how it is today?

Answer: In Massachusetts, all carriers with 5,000 lives or more were required to submit plans to the Connector. Of the carriers that submitted plans, 6 carriers were chosen to offer plans. There was also a young adult plan in addition to those plans. At first, benefits were not standardized in the plans offered, except for gold level plans. This led to a lot of variation. Over time as the Connector evolved, there was greater standardization of plan designs. The evolution of the Connector is well documented in reports available on their website: [mahealthconnector.org](http://mahealthconnector.org)

Question: Will there be information available on the Exchange regarding how many claims are being denied by carriers? Will you be able to see which carriers deny the most claims?

Answer: Yes. One of the ideas behind healthcare reform is greater transparency.

Question: What happens if you live in a different state than the state in which you work?

Answer: This situation exists in today's market. Delaware residents who do not have employer sponsored insurance will be able to purchase insurance through carriers that are licensed to sell insurance in Delaware.

- Coverage through the SHOP Exchange will be available for small businesses with principle place of business in Delaware, or with employees who work in an office in Delaware.

Comment: Clarification on a previous question. If you are over 65 and still working, theoretically you can have insurance through the Exchange.

Answer: Yes, if you are still employed and your employer purchases insurance through the SHOP Exchange.

Question: Will information about how much each carrier pays providers for specific services be displayed through the Exchange?

Answer: The contractual relationship between carriers and providers is generally considered proprietary. While there is more emphasis being placed on transparency, it's not clear whether this information will be provided.

Question: Are the provisions in the ACA going to apply to all plans, or just the plans sold through the Exchange?

Answer: The provisions in the ACA apply to plans sold inside as well as outside of the Exchange. Certain provisions in the ACA will not apply to grandfathered plans; however, overtime this population of plans will go away.

Comment: The penalty for not offering coverage is small in comparison to the cost of buying insurance, so people will drop coverage as a result.

Answer: Today we do not have a penalty and employers are still offering coverage. It does not seem logical to think that employers will all of a sudden drop coverage for their employees. Employers offer coverage today for a variety of reasons, including because it makes them more competitive in the market. It is unlikely that this will change and didn't change in Massachusetts.

Question: What happens if an employer does not pay for dependent coverage?

Answer: The spouse and children can then go through the Exchange to purchase insurance, or they could be eligible for Medicaid as well.

Question: Is there a scale for subsidies provided to individuals in the Exchange?

Answer: Yes, and this information will be posted on the DHSS website.

- Subsidies are based off of plans at the silver level. There will be a fixed federal contribution amount based on FPL (size of family, income), but individuals can choose to purchase plans at other actuarial levels as well and cover the additional costs if applicable.

Question: Why is the SHOP Exchange only for employers with 50 or fewer employees? Can this be increased to 100 or fewer employees?

Answer: Yes, this is an option for Delaware. Thus far, we have not heard of any reasons not to increase the limit; however we are limited to 100 or fewer employees until 2017. We will need to do some work to figure out which scenario will be more beneficial for the small businesses in the state.

Question: By what process will Delaware decide whether it will establish one Exchange for the individual and small group market or two separate Exchanges?

Answer: This will be a legislative decision taking into account PCG's analysis. Just to clarify, there will still be two separate risk pools regardless of whether there are separate Exchanges.

Question: What is the timeframe for deciding whether it will be one or two Exchanges?

Answer: This decision will be made next legislative session.

Question: Will associations be allowed to purchase insurance in the small group market?

Answer: No, association plans will not be sold through the Exchange.

Question: What will be the compensation for brokers through the Exchange?

Answer: This is to be determined. The bottom line is that the services of brokers will be needed, but their role will be different than it is today. For example, today brokers do a lot of work on medical underwriting, which is not allowed under the ACA.

Question: What is the fine for not purchasing insurance?

Answer: Two percent of income.

Question: Are there statistics out there for the shared premium between employer and employee?

Answer: It is 70/30, and this drops slightly for small companies; however, the employer must contribute at least 50%.

### **5.3 Public Forum – Medicaid/CHIP and the Exchange – June 29, 2011**

#### **Delaware’s Health Benefit Exchange: Medicaid/CHIP Forum**

**Delaware Department of Health and Social and Social Services**

**Doubletree Hotel, 4727 Concord Pike, Wilmington, DE**

**Wednesday, June 29, 2011 2:30– 4:30 PM**

#### **Notes from Public Forum**

**Question:** How is it determined if an individual is eligible to receive Long Term Care services?

**Answer:** DE currently has no asset test for non-long term care – only for long term care; have not heard of states challenging this. They do verify income.

**Comment:** Need to make this clear during outreach “no asset test”

**Question:** If eligibility comes from the Federal government, there is a tax return. During the year, peoples’ incomes change.

**Answer:** MAGI (Modified Adjusted Gross Income) - A lot of states are wondering how this will work. In actuality, we can’t go back to the previous year. It is the responsibility of the enrollee to let us know of a change (every 12 months). If not, it is considered fraudulent

**Question:** EPSDT- Early Periodic Screening, Diagnosis, and Treatment

**Answer:** Non-emergent transportation is a Medicaid stipulation

**Question:** Anything about maternity care?

**Answer:** Very closed mouth particularly about maternity care

- Analyses
- Careful not to give indication
- Opportunity to input into process

**Comment:** Fiscal note adult dental care. If you subtract emergency care

**Answer:** Outreach note. Need to get people to stop going to the ER – there are cheaper solutions

**Question:** Is preventative dental care included?

**Answer:** Yes, as well as prescription drugs, which are historically not covered

- Evidence found that preventative dental care linked to decrease in heart disease
- Preventative care
- Exchange will hopefully help with enrollment

**Question:** Where is the creativity in the actuarial value tiers?

**Answer:** We are still unsure of the standardization

- premium vs. out-of-pocket

**Question:** Can you expand on how children can be in Medicaid and adults in the Exchange?

**Answer:** 138-200 children eligible for CHIP, but the adults need to go through the Exchange for subsidies.

- Have not heard of employer sponsored and dependent care coverage

**Question:** How do you count family size if children are eligible for CHIP?

**Answer:** Family size is still considered. Income covers more than healthcare such as food and shelter, etc

**Comment:** Differentiation between basic Medicaid for women and children vs. Long Term Care. Need to talk about how those eligible for LTC fit into the Affordable Care Act.

**Answer:** LTC coverage is not part of the essential health benefits

- The exchange is focused on affordable coverage, which for the post part does not include Medicaid
- Subsidies in the exchange are related by streamlined eligibility system and coordination of care
- New center in CMS (focused on dual eligible, etc) – good things

**Question:** What is DE doing to pick up the extra expense costs?

**Answer:** FMAP (Federal Medical Assistance Percentages)

- Today, 90% of newly eligible is paid for by the feds, and 10% is paid for by the state. Around 2014-2016, 100% will be paid for by the feds
- DE's own expanded population will eventually get 90% funding
  - The fed will pick up costs that DE currently pays for expanded coverage

**Question:** Who monitors going back and forward, what you are eligible for?

**Answer:** In change - As something changes, one is obligated to report changes in income.

- It is important for us to educate partners in the community in order for health to get public assistance programs
- Medicaid customer assistance, client handbook
- Federal government is trying to simplify rules around eligibility – it can be very complicated

**Comment:** Exception of “no wrong door”

**Answer:** Yes, it is a huge coordination effort. Everyone knows what has to be going on

**Question:** Is anyone starting to compile a list of group to reach out to?

**Answer:** Yes:

- 1<sup>st</sup> step forums
- 2<sup>nd</sup> step groups 5-10 people

**Comment:** Boys and Girls club, Purchase of care

**Comment:** It is nice for people to have continuity. MC plans seamless

**Answer:** Need potential product

**Comment:** Parents of CHIP – Known adults that do not have insurance

**Answer:** Great idea

## **5.4 Public Forum – Medicaid/CHIP and the Exchange – July 25, 2011**

### **Delaware’s Health Benefit Exchange: Medicaid/CHIP Forum**

**Delaware Department of Health and Social and Social Services**

**Irish Eyes Pub & Restaurant. 213 Anglers Road, Lewes, DE**

**Monday, July 25, 2011 2– 4 PM**

**Notes from Public Forum**

**Question:** Prescription- DE passed a law legalizing marijuana with doctor’s prescription

**Answer:** Federal law – doesn’t preclude state’s law

**Question:** Family planning – abortion?

**Answer:** Abortion is not covered now unless the mother’s health is in danger

**Question:** DE cancer treatment program?

**Answer:** (HCC) Separate, federally funded and tobacco settlement \$

-based on FPL, but goes up to 600% FPL

-separate and distinct from Medicaid

**Comment:** Concern is that will go away

**Answer:** Nothing in ACA to abolish that kind of program

-If anything, just more streamlined

**Question:** Navigators – how are they funded?

**Answer:** Through health insurance exchange (HIX)

**Question:** Any discussion about state Medicaid workers do navigating?

**Answer:** They will be involved in training

**Comment:** Love to see written that as soon as someone no longer eligible, go directly to HIX

**Question:** Cannot see how it will be seamless if all not under one system

**Answer:** Requirement that Medicaid and CHIP both be under one eligibility system

**Comment:** Keep people from working. Small income makes them lose coverage

**Comment:** Mechanism to maintain treatment, but also work. Reason people stay on welfare is fear they will lose benefits

**Question:** Is there talk about...

**Answer:** No wrong door. Met with FQHC, MA Health

**Question:** States such as VT. How are they handling 2014 deadline?

**Answer:** Single streamline access to care now -> future single payer

-Long road. Blueprint.

**Question:** Reasons of ACA ensure coverage and reduce cost. What does this do to reduce cost?

**Answer:** HIE not aimed at cost: a tool to help people get coverage and purchase insurance

-Not intended to be cost containment

-ACO's just being developed. Encourage quality/efficiency/less duplication of services. Not sacrificing services

**Question:** Is there a tentative profile of person who will use HIX? Who are we expecting? In my mind, not Medicaid profile person?

**Answer:** Hopeful it will be young, healthy individual (for subsidized piece) also have unsubsidized piece

**Question:** Where do pre-existing conditions fit in?

**Answer:** Now – 2014 every state has pre-existing plan. 2014 plans have no medical underwriting

-State has option to continue

**Question:** Eligibility for pre-existing condition says 6 months

**Answer:** Yes. That is in Federal law. Everyone recognizes impediment of this

-changed that originally needed two regulations

-now just 6 months

-only until 2014

**Comment:** 5,000 kids in the Healthy Children program, but eligible to 10,000. Half have not signed up despite low premium. What is the lesson learned for the Exchange?

-people go to ER instead of seeing their physician

## **5.5 Focus Group – Provider**

### **Delaware’s Health Benefit Exchange: Provider Focus Group**

**Delaware Department of Health and Social and Social Services**

#### **Agenda and Meeting Notes**

**August 23, 2011**

#### **I. Introductions**

#### **II. Discussion Topics:**

- a. Are there geographic or demographic areas of the state where there is unmet need for services (e.g. specialty services that are only offered in certain areas, particular population segments that are underserved)?**
- Most of Delaware is underserved, problem gets worse as you go down state. That’s the case for most of the state.
    - Huge issue for FQHCs, serving a lot of Hispanic individuals in Wilmington and Newark, appointments are longer because you have to have the conversations twice.
    - African Americans also disproportionately underserved. (Wilmington)
  - Dental care is always left off the table, huge demand and Medicaid only covers up to age 21.
    - Essential benefits package does not cover dental
  - Behavioral health is overlooked
  - Mental health: roadblock is coordination between primary care doctors and specialists.
    - Most PCPs don’t know how to navigate the roster of services. Too many small practices to coordinate services appropriately
  - Individual practices are losing out on coordination services: time consuming, takes people, takes knowledge, expectation that primary care docs will do the coordination piece for free in their spare time.
    - Carriers should pay PCPs specifically to coordinate care for services in addition to their regular services.
  - 60% of patients present with mental health co-morbidities. Always a challenge to health service provision
  - Stigma still surrounds mental health services.
  - DE Physicians Care tried to organize care referrals a year ago, still not an efficient system for getting someone an appointment.

- ACA needs to realize that PCPs are spending a lot of time and expertise on coordinating care
- A lot of talk about ACO pilot programs but no action
- Economy and unemployment is causing the face of the underserved to change right now, prescription programs are in high demand.
- A lot of retirees moving into the state cause a burden on provider availability
- Recruiting is difficult in this area, not an attractive area to live/work.
- Longer time for board of medical licensure to issue licenses:
  - new found regulatory powers – insurance companies also take 60 to 90 days to complete credentialing
  - Especially an issue down in Sussex county
- Trying to recruit a doctor for 15 years, switched to a nurse practitioner – we are already training nurse practitioners in this state, need help hiring and retaining because there are road blocks there two.
  - Doctors keep leaving – hard to keep them unless you offer a lot of money
  - Health insurance for the providers is also important, benefits are key to recruitment
- Spouses were a real issue for recruiting, spouses can't find work in the area, public school systems are also perceived to be weak.
- Transportation is always an issue also. New Castle County has a better public transportation system than we do.
  - Para transit is being slashed
  - More heavily in Kent county
- Non emergent transportation handled by Logisticare – need to give 48 hrs notice for an appointment, a lot of issues with the broker. Transporting more than one patient at a time
- There is a shortage of services, but if providers had more support from insurers to coordinate care then we could use current services more effeciently. If they can up the rates from commercial insurance, they'd be able to staff more people.

**b. How long are appointment waitlists for primary care? specialty care?**

- People will stay in state and wait for an appointment rather than cross state lines.
  - Medicaid cannot cross over to another state
  - Lower income, lower socioeconomic status are more likely to stay within the state
  - Transportation issue
- People get lost in the system when they go to specialists – all goes back to coordination of care

**c. What benefits/services are most important to the quality of care for Delawareans?**

- Still do not know when the essential health benefits will be released
- Transportation is a big concern for the lower income
- Preventative services
- Dental, vision (most people don't need vision until they hit 40 but it's already run out)

- More about what should not be included:
  - certain high end diagnostic care should be proven to more effective before it's paid for (comparative effectiveness)
  - Many procedures recently have proven to not be safe after
- PA issues – one of the carriers put demands for prior authorizations on care (Med Solutions – contracting agent to administer prior auths) cardiac care and denying services
  - Also an issue of coordination of care, if I know something needs to be done, I know how to get it authorized but it takes time that sometimes they don't have
  - PA process is complex, barrier for patient to get needed services, can take a couple of days for the provider to get authorizations through
  - A lot of back and forth and sometimes ends with the patient refusing services
- What's the criteria under which the Exchange will be let in insurance carriers

**d. When developing standards for certification of qualified health plans, what criteria should the Exchange consider?**

- We might get that anyway with the carriers leaving to other more valuable states
  - Already very limited on the number of carriers we have in the State, so the harder we make it for them to enter the market, the fewer carriers we will get
- Demonstrated commitment to value of services and focus on primary care providers
  - NPs should be looked at in helping doctors hire nurse practitioners

Some issues have to be addressed in the board composition – need to start at the top

- Need the right people around the table to compose that board

Demonstrate an interest in pilot projects and new ways of delivering and paying for primary – including paying for telemedicine and web based appointments

- Patient follow ups are important too

Those follow ups are not being paid

Proven medical standards

Care management from the insurers point of view are cost managers rather than care managers – need improved health outcomes rather than improved financial outcomes

Need to keep things simple for people in the plans – people don't know what they're plans are

Demonstrated commitment to modernizing the rate review process and making transparent to the public how they stratify risk and justification for their rate hikes

How strong they are financially should be an issue to include

Ability to meet DE's prompt pay laws for services

**e. Should we limit the number of plans that are offered through the Exchange? Will an artificial limit impose certain restrictions?**

- Can we limit the number of plans for simplicity's sake without limiting the free market to directly
- Will there be more administrative cost than a benefit to adding more plans to the issues

Want physicians to have the ability to negotiate the best contracts that they possibly can

Difference between how many plans versus how many carriers – are they encouraged to introduce as many plans as possible are in the Exchange

- Are we going to restrict how many plans each individual carrier can offer

#### Brokers and Navigators

Role of the broker is going to be critical for the Exchange

Financial aid assistants at the FQHCs would be key to the navigator role

- Don't want to become just another service center type organization
- Where do the patients go afterward?

Provider neutral language – use of APNs to fill the need for primary care services

Training nurse practitioners at U of DE and Wilmington U

- Primary care providers that we're training in the state are nurse practitioners
- 14000 RNs and 1500 APNs (increasing year over year)
- Nurses like to stay here, just need to get jobs that makes it affordable for them to stay here
- Make more as an acute care nurse so why pay for an advanced degree

Just need help getting primary care providers

Hospitals are hiring NPs because they're trying to get into primary care

Needs to be a campaign to get individuals into primary care

DE is not a high reimbursement/high wage state

Residents very rarely travel down state

Exchange self-sustaining is a major concern (no one wants to restrict access to care or restrict provider reimbursements)

We should merge individual and small group markets in the state and show proof as to why that's not the case

Standards for certification: collective credentialing agreement

- Go to one place and the providers should be credentialed with all of them
- 20 insurance carriers that they only bill once or twice
- If you're credentialed with the exchange, your covered with everyone

What's the speed of enrollment? Can we put limits on the time table to ensure that participants can get enrolled quickly? Open enrollment periods – more would be an administrative burden.

### **III. Additional Issues/Concerns**

#### **IV. Wrap-Up**

## **5.6 Focus Group – Consumer Advocacy**

### **Delaware’s Health Benefit Exchange: Consumer Advocacy Focus Group**

**Delaware Department of Health and Social and Social Services**

#### **Agenda and Meeting Notes**

**August 22, 2011**

#### **I. Introductions**

#### **II. Discussion Topics:**

- a. What are the major obstacles in reaching the target population (uninsured, lower income adults)?**
  - Biggest question is how to get the message out.
    - Biggest concern for uninsured is are we including Medicaid
      - Eligibility flip form from Medicaid to Exchange
  - CHAP program advocacy led by faith based
  - Must be convinced of the importance of coverage (coverage counts campaign)
    - Past experience- young men don’t see need
  - Need to not rely on internet as source of information: people that have been disenfranchised are not going to go to the internet
  - There is a level of trust in the faith communities – need to go where the people are.
  - Targeted community may not be reachable through the faith based community, but they will have family members such as a grandmother to give them the message about access
  - Ministry of Caring – has shelters, soup kitchens, daily meals which is partnered with various churches
    - Outreach is about training the trainer – good church associations down state, funded through thrift shop setups, set up an automated laptop, did something similar with Medicare Part D
  - Should talk to public libraries and see what programs they have set up
    - At one point there were consumer librarians: people ask librarians- give them the contact info
  - Community meetings – provide babysitting during meetings so people can attend
  - CHAP Program– grassroots outreach: community centers, faith communities, partner with people who are trusted by the disenfranchised (faith based is key), “20 year old probably has a grandmother” (access through others), never underestimate the power of the wise elderly
    - A lot of training the trainer (give them trainings that they can credit)

- Then start passing out the information (pamphlets, brochures)
  - Health Day: giveaways, blood pressure screenings, parish nurses
  - Once every two weeks, table at Dept of Labor to sign up individuals
  - Dept of Corrections during days for peaceable surrender
- Should work with Prison Reentry programs
  - Shelters for women and Domestic Violence Coordinating Council (state group)– much easier to work with than the other DV (Bridget) groups in the state
  - Could check on Temp agencies with the Dept of Labor
  - Father Greg Poesch- works upstate with Catholic Community
  - Pastor Figaroa (12-15 congregations that are Latin American based), small population downstate that speak Creole.
  - American legacy foundation stopped producing materials in Spanish
  - Lared now has a facility in Seaford (Brian Olsen is the contact)- contact for western side of the state
  - Need someone to be working on a basic glossary for definitions in basic English
  - DE already has a navigator program set up
    - FQHC's- these people are the natural fit
    - Extra set is community outreach
    - Navigators do not necessarily need to be someone that is connected in the healthcare
      - Religious community will have more success
  - Safety and wellness are big issues to the lay people (what do I do if my kid finds a gun? Instead of how do I get my child vaccinated?) – more holistic approach to communication
  - Need to be very clear who is eligible to be covered
    - broader education program so that the program is not undermined by individuals thinking that they're paying for it with tax dollars and are opposed to it simply because they are misinformed
  - Difference between catering message to small businesses and the individuals
    - For small businesses, prevention is a lot cheaper than crisis
    - Uninsured individuals don't care about the cost of care through the emergency room versus the PCP
  - Use existing organizations that are particularly for groups with disabilities, mental health, or autism
    - Trusted by the people who needs those services
  - Targeting housing authorities and subsidized housing – CHAP had difficulty getting into those areas because of security issues, have to get buy in from those authorities earlier (section 8 and subsidized housing), Housing Opportunities of Northern Delaware, DE Housing Coalition (work with wider group who needs housing)
    - If you're taking on the burden of a mortgage, you need to take on health care also (DE Community Reinvestment Advisory Coalition, Rashmee Rangin)
  - Working with people to get earned income tax credits

- Earned income tax credit program- EITC (Niamia Gateway, United working with Stand By Me financial literacy program for English as a second language)

**b. What benefits are most important to consumers in the individual market?**

- Major medical will always be the most important
- Preventative services will most certainly be covered, but we are not sure to what extent
  - Encourage young people to maintain their health
- How do we get importance of health care to same level as safety of our children?
  - Get across importance that something major can wipe out a family, and that something major may not happen to you personally, but also to parents or spouse
- Delaware has very low marriage rate
  - Economic fear is main reason
  - Marriage penalty tax
- What happens to my loved ones if something happens to me? Will my parents' income be wiped out paying for debt?
- Pharmacy needs to be a benefit- things are priced under the assumption that everyone has coverage
- Birth control recommended as a tag on to womens health services by legislature many years ago
  - Institute of Medicine (IOM) just gave recommendation on this last month
  - Health risks of women having babies too close together
- State formulary – some behavioral drugs had a ladder tiering required. Sent letter to announce change but that's it. Pharmacists couldn't fill scripts. No information/explanation available to tell them why they couldn't get their meds.
  - Need to use existing organizations for disabilities or mental health to get message out about benefits changes

**c. What organizations/groups could serve as Navigators?**

- Strong navigator program already setup in the state through the hospitals and FQHCs, health ministers were trained for CHAP
- Track number of people who come through, number of people they make linkages to, navigators work for Rosa Rivera, stationed at facilities- FQHC (Betsy Wheeler) (working with Christiana, Brandywine counseling, community health workers and community outreach workers through United Way)
- Identify all churches and the groups of people
- **LaVaida Owens White** – parish nurses, recruiting LPNs, CNAs, and lay health person (retired from Christiana Care, full time parish nurse now)
- Sorority of nurses working in Del State
- Community health and outreach workers
- IMAC – largely African American interest group
- Everything is done at the state level, not local governments

**d. What forms and times of communication/media are most effective in reaching this population?**

- No local television available- practically all Philadelphia
- Recommended to hire a market research firm
- Brochures and face to face contact in markets / convenience stores
- Everybody has a cell phone
- Billboards, need to use bus advertising, “Coverage Counts” needs to be the focus
  - Worked on politics, use in healthcare
- Information that you need to give to Navigators and intermediaries – cut out the extra and give simple, basic language (can’t be glossy and look like it was expensive to make it)
  - Materials need to be tested on individuals who aren’t super healthcare or computer literate
- Could do better at enrolling kids in CHIPRA because ASSIST is a great program but hasn’t reached as many individuals
- Free community newspapers
  - Brandywine Community News, Cape Gazette (weekly newspapers in Sussex County as a potential cheap way to distribute information): State News tends to be more cooperative than the News Journal.
  - Talk to a reporter

**e. When developing standards for certification of qualified health plans, what criteria should the Exchange consider?**

- MA accepts any willing plan – they are also strict with the ratings
- Coventry- new person in charge is talking about getting involved in the Medicaid MCO market- looking to be more involved in DE
- Medicare Advantage plans: when they tried to set up themselves in Delaware, what did they look at for inclusion in that program?
- Could be useful to have commercial carriers have mirror packages to Medicaid MCO or participate in MCO
  - Bill introduced that if you want to work in the State Employees plan, you have to be a part of the high risk pool
  - Idea of trying to manage continuity of care with the population that is flipping on and off Medicaid
- Worth it for insurers to include state employees
- Tremendous number of three generation families in DE
  - For many, first introduction to health insurance is dealing with their parents
- Non-long term care
- Insurance Commissioner will be responsible for making sure that plans are stable
  - Exchange board will determine who will be responsible for policing the program
- Attendance requirement for executive board
- Problems when they don’t have a quorum

### **III. Additional Issues/Concerns & Wrap Up**

- Going to take **a lot** of outreach to break ties with the debt and all misinformation that has been spread (faith, reform, and healthcare) – importance cannot be overstated
  - High risk program had problems because there was no outreach
- Message has to be clear to move away from politics and focus on outcomes, reduce costs and create a healthier state – must identify the right conduits to set up program and empower those people with simple language
- Can do Fact vs. Myth on health care reform and health care coverage
- Deal with it now or pay for it later
- Economic analysis – reshuffling the state’s costs rather than completely augmenting, part of broader message, reasonable to prevent it rather than cure it
- We talk about the burden that the uninsured are putting on ERs, paramedic system has improved dramatically over the past few years so that a lot of patients who would have never made it to the hospital
- Health care is not a commodity to be bought and sold in the marketplace
- Make it a moral issue, minimize the impact of the community

## **5.7 Focus Group – Small Business/SHOP**

### **Delaware’s Health Benefit Exchange: Small Business Focus Group**

**Delaware Department of Health and Social and Social Services**

#### **Agenda and Meeting Notes**

**August 23, 2011**

#### **I. Introductions**

#### **II. Discussion Topics**

##### **a. Are there any major concerns with the current small group insurance market?**

- For Delaware – right now there is health underwriting included in the rating
  - National health carriers are not used to that in other states
- Not a lot of health carriers to choose from
  - Rates tend to be high
- Positive – there is a lot of plan design choice. Concerned that there will be less plan choice for employers to give to their employees
  - Ie. Blue Cross currently has 39 plans in the small group market
    - Choices are in cost sharing.
- Employer now doesn’t know what percentage of costs goes toward premium – you never know where the cost is
- 2 levels of distinguishers in current plans with Blue Cross in the marketplace
  - IPA – HMO
  - EPO - hybrid
  - PPOs
- All run off these traditional plans, deductibles for some
- HAS or HRA eligible
- Employer can pick multiple plans from one carrier
  - Rule is that they have to be dissimilar plans, not on the same platform. So if one is a deductible, the other has to be a co-pay
- Rates are the concern – they are becoming unaffordable for a lot of folks already
- Contribution and participation requirements – some of the rules out there are not necessarily DE regulations, but rules that the insurance companies make themselves
- Won’t allow waiver for young healthy person to buy individual plan – needs to pre-exist before the group

##### **b. Any variations between benefit plans**

- Think that the current market does well with this
- The limited number of carriers provides a lot of plan choice.
- Issue is really cost

- Health underwriting has always been the biggest challenge driving the costs so high
- Worry about there not being strong enough incentive for new folks to go out and buy insurance.
  - Only the unhealthy people will be going out to purchase insurance right away

**c. Variation in age rating**

- Average age of employees, average health of employees, size of employer
  - Factors for small business
  - 60-65 is the final of the worse age rated categories
- Age band now is about 1-3, even in the individual market

**d. Are there any other features that we can offer through the Exchange**

- Standardized benefit summaries – if we get to that, both in and out of the Exchange, it will really help
  - One of the most time consuming things that brokers do right now
- Hard for agents to explain those differences, especially when dealing with dissimilar plans
- Medicare has standardized benefit plan – something like that will be helpful
  - Leaves it up to the insurance carrier to compete on price
  - Don't want to standardize so much that it removes choice from the consumer
- Exchange as premium aggregator?
  - Yes, see this as a benefit. Employers like one bill.
  - Then employers can charge employees the right amount
  - Concern: small businesses do not have an HR department. This is something that the employer will never be able to take on this responsibility by themselves.
    - They will either turn to the insurance carriers or the broker for help
- Do you see there being a market from brokers in DE to get into the role of the navigator inside the Exchange?
  - When reform first happened, agents that did health as a sideline business stopped and focus on life insurance or annuities
  - The other agencies that do health as their main thing – goal is to adapt as their main thing
    - Interest in learning about navigators and how to become navigators
- Now the interest in being a broker and maintaining that position
  - Interest is meeting with clients, small business and small employers and then acting as the outsourced HR arm for when they need assistance
- If compensation became more standardized, that would take away inherent biases from one carrier to another
  - Compensation in DE market fell this year in comparison to what it historically was
  - This is a result of insurers adapting to the medical loss ration

- Concern is that even larger brokers will not be able to survive another round of cuts
- Want compensation to be comparable to what exists outside of the Exchange given
- Include brokers, include compensation make it comparable to outside
- Per employee per month compensation exists in other states
- Delaware is a commission percentage based state – what the community is used to, and can lead to brokers leaving the community if it changes
  - Make it based off of what it is right now, which is the percentage of premium method
- Two major association based groups with insurance struggles: Delaware Farm Bureau Association, Chamber of Commerce
  - Historically idea was to unite small business to get advantage of large business
  - Competitors who service the chamber insurance policy. Premiums are higher for non-chamber members than they are for chamber members
  - Initially insurance carriers did this because they did not know what kind of population they were going to get
  - Every year when they renewed it created more separation
- Some association plans don't know to shop
  - Blindly go into the association plans assuming that they are the best thing
  - Exchange will come with publicity and everyone is going to thing to shop
  - Can envision the association plans disappearing
- Actuarial data from Blue Cross – won't show benefit connection rates, will most likely only give up external rates
- All insurance brokers can sell through the state Chamber. Most of the time regular Blue Cross is the best value
  - State Chambers don't deal with health underwriting
- When Delaware allowed one person business to exist
  - One of the reasons small employer rates are so high
  - If people were denied in the individual market, they could purchase in small group

**e. What kind of publicity should we use to reach out to small businesses?**

- Need a lot of delivery methods to small businesses
  - The one newspaper
  - Have the brokers be excited about this and talking about it with their clients
    - They are spending time marketing to their clients
  - Print ads, radio ads, mailings
  - Don't think that television based ads make much sense
  - Public health events

**f. Preference in purchasing models**

- Don't really like the separation of individual and SHOP Exchange
- Within shopping experience, like aggregate premium in the group functions. Good administrative function piece of the Exchange
- Whether or not to allow aggregate billing and multiple carriers for one employer
  - Something we should be willing to try
    - Anticipate it being a good thing, but may want to have a sunset clause just in case no one uses it – run it like a pilot program
- Will need some kind of potential for face to face enrollment
  - Large segment of the population that hasn't embraced technology
- People should be able to enroll my mail, phone, online, broker can enter it online for client
- 1/3 individual, 1/3 groups, 1/3 Medicare
  - 40% of all work is still on paper
  - A lot of that is because of consumer choice
  - Some insurance carriers that have online enrollment are not set up in a consumer friendly way
  - DE to look to other states – technology piece doesn't have to be unique built from the group up

### **III. Additional Issues/Concerns**

#### **IV. Wrap-Up**

- Do we want to continue to allow a market place outside of the Exchange – could set up adverse selection if they are not the same
- Need to do it carefully so that the state is not picking up the tab for additional benefits
- Concern group clients – excited about the individual client so that they can allow their employees to go to the individual market
  - What we don't want to see
  - Give more choice to the employee