Delaware Health Care Commission

Interim Report to the
HRSA State Planning Grant Program
September 30, 2004

Executive Summary

Through the continued discharge of its ***Uninsured Action Plan (UAP)***, the Delaware Health Care Commission (DHCC) remains focused on completing planning and service activities that demonstrate commitment to expanding access to health coverage and healthcare to uninsured Delawareans. The UAP has received funding support for the completion of these activities through the federal Health Resources and Services Administration (HRSA) and through designated proceeds to the State of Delaware reached under the Attorney General's Master Settlement Agreement.

The HRSA State Planning Grant program has provided the financial means by which to complete thorough and comprehensive research needed for planning and policy direction. In the project period reflected in this report the following State Planning activities were completed and/or are now in progress:

- Analysis of Delaware's Safety Net- this comprehensive assessment was commissioned to study the existing and potential capacity of safety net providers. A byproduct of this work was identification of lesser-known elements of the safety net and an assessment of pervasive service delivery issues affecting uninsured consumers and their providers of care.

- Demographic Analysis of the Total Uninsured Population- this survey research was completed by the University of Delaware and integrates the findings of three data sets. The report was issued in 2003 and assesses the three - year period of 2000-2001 and 2002. A first time appendix includes a qualitative assessment of uninsured consumers' perception of the quality of their health care.

- The Total Cost of Health Care- this research too is completed by the University of Delaware and contains a comparison of Delaware specific data and national trends.

- Coordination with the Delaware State Chamber of Commerce to produce an informational website *www.healthinsurancechecklist.com* for small businesses that need assistance in making coverage purchasing decisions.

- A "Small Business Task Force" was created by House Resolution 82, and its members appointed by the Governor to study the specific impacts of the limited availability and high

costs of private sector coverage options. The Task Force was chaired by the Lieutenant Governor of Delaware (the Chairman of the Delaware Health Care Commission). Ultimately this Task Force issued a report of findings and continued its work through two committees and a separate Task Force on Chronic Illnesses also created by a House joint resolution. These resolutions represent the General Assembly's support for State Planning activities.

- Research on the health disparities of the uninsured was completed during this period. A final report is now in draft format.

- Continued analysis of enrollment impacts and costs of options/models most feasible for expanding coverage in Delaware.

Over two-thirds (64%) of Delaware's uninsured work[1] and have incomes over the federal poverty line, but are uninsured either because insurance isn't offered as a benefit of employment or it is too expensive to be affordable. Lack of access to coverage and/or affordable health care prevents the uninsured from maintaining good health. Good health is an essential ingredient to economic growth in Delaware. Towards that end, the Commission has maintained focus on this fact despite a less than desirable economic environment both within the State and nationally. Supporting safety net providers who will provide care to the uninsured irrespective of an individual's insurance status, and identifying pathways and partnerships for making affordable health insurance coverage more widely available to employers and individuals who must make difficult financial tradeoffs to maintain coverage, remain central to health policy deliberations. The HRSA Community Access Program financially enabled the initial design and implementation of a statewide enrollment based program that, now with 100% State funding, continues to provide eligible uninsured enrollees with linkage to a volunteer or discounted primary care health home, medical subspecialties, diagnostic lab and xray, and pharmaceutical access. That program is the Delaware Community Healthcare Access Program (CHAP) and is discussed later in this report.

This is an Interim Report on activities completed under the State Planning Grant Program between April 2003 and August 2004. It provides explanation of continuation planning activities completed subsequent to the submission of a Final Report to HRSA in October 2001, and Addendum Reports in March 2002 and March 2003. To the degree that the environment has changed during, this report provides that update.

[1]Center for Applied Demography and Survey Research, University of Delaware, May 2003

Section 1. Uninsured Individuals and Families

Uninsured individuals represent less than 10% of the total Delaware population- a percentage that has gone down from 14% in the 2000 Current Population Survey. Delaware continues to do better than the region or nation. According to US Census Bureau reports in September 2003, Delaware was fairing better than the region and the nation who respectively had uninsured rates of 12.9% and 15.2%. According to that same US Census Bureau report, Delaware had the seventh lowest uninsured rate in the nation. In February 2004, *Governing* magazine reported Delaware as having the second lowest percentage of uninsured *adults* in the nation. Efforts to reduce that number have been multifaceted and focused on public coverage expansions, market reforms, and other health policy. The most recent survey research completed in Delaware states that approximately 77,000 Delawareans are uninsured. This research has drawn on a series of survey research data sets collected in Delaware to produce the findings that are included in Appendix A. There are three principal sources; 1) the Census Bureau's March Current Population survey with a sample of between 600 and 700 households in Delaware analyzed between 1982 and 2000 when health insurance questions were asked, 2) the Behavioral Risk Factor Surveillance System has been conducted monthly since 1989 in Delaware with sample sizes increasing from approximately 1800 adults to 3500 adults today, and 3) the Consumer Assessment of Health Plans Survey or CAHPS, which in Delaware is a sample of 1800 adults that has addressed these issues since 1996.

Since October 2001, the annual Current Population Survey has been re-administered with the addition of validation data. New nationwide CPS weights were issued in December, 2001 and subsequently were utilized to re-analyze uninsured statistics. Also, since the October, 2001 report, the Behavioral Risk Factor Survey System (BRFSS) was re- administered to a larger sample size and with more confirmation questions around being uninsured. An updated "Delawareans without Health Insurance" report using this new data was presented to the Delaware HealthCare Commission in September 2004 and will be appended to the Final Report to HRSA at the end of the grant period. (A no-cost extension through September 30,2005 to conclude work in progress was submitted to HRSA during the summer 2004.) The updated demographic analysis has facilitated a more concise breakdown of the uninsured by age and poverty level. This quantitative breakdown is used as a critical baseline for determining the impact of coverage programs, particularly in light of continued review of incremental reforms and methodologies given the newly recovering State economy and the outstanding November 2004 presidential election.

The Commission's continued planning and policy analysis activities have had two foci during this phase of the project period. As discussed in section four of this report, one systemic approach to reducing the uninsured continues to utilize data to segment the uninsured and design programs that respond uniquely to such characteristics. Community input has been achieved through policy forums and continues through a variety of sub-committee activities. This input demonstrates continued support for incremental strategies that build from the bottom up- ensuring that those who are at the lowest levels of poverty have access to coverage and services. Semantics for this incremental approach have been replaced with the title "building blocks" and are discussed in section four. This does ***not*** suggest that a need for a more comprehensive strategy targeting those who are above poverty levels and employed does not exist. Towards that end, policy research has been completed on models that would be more universal in nature and perhaps, through single or multiple payers, move Delaware in a direction of more wholesale change in the healthcare

coverage environment in contrast to some of the more incremental approaches under consideration. These options too are discussed in section four of this report.

Among the 77,000 uninsured, 83% are above the poverty line, 64% are employed, and some 34% live in households with incomes exceeding $50,000. Approximately 24% of the uninsured (18648 individuals) are adults and children who are believed to be eligible for but un-enrolled in public coverage. Another 19% of the uninsured (14623 individuals) are adults between 100-200%of the federal poverty level. Exhibit 1 is a chart that depicts the breakdown of the uninsured by poverty level.

Exhibit 1

POVERTY LEVELS	Uninsured Age 0-18	Uninsured Age 19+	TOTAL #
<100FPL	3831	9919	13750
100-199%FPL	4898	14623	19521
200-249%FPL	1366	6771	8137
250-299%FPL	1577	4947	6524
300-399%FPL	1168	10933	12101
400-499%FPL	1522	4708	6230
500+ FPL	1740	8297	10037
TOTAL	16102	60198	**76300**

These data suggest several things:

a) There is an opportunity to cover more people utilizing existing public coverage programs; Medicaid and/or SCHIP,

b) We do not fully understand the reasons that impede this population from accessing a program for which they are likely eligible; however, the Delaware Covering Kids and Families Program has begun this qualitative exploration (discussed below),

c) It is not uncommon in dual wage-earning families for there to be no offer of employer health coverage to either spouse and/or a combined inability to take coverage due to cost. This combination could produce family income greater than $50,000

Qualitative information gathering through surveys and focus groups was a critical aspect of the research completed during 2000-2002. This research continues to guide our work. During the project period reflected in this report, this initial information has been supplemented through the Commission's partnership with the Delaware Covering Kids and Families (CKF) Program, a national initiative funded by the Robert Wood Johnson Foundation and led by the Medical Society of Delaware. CKF findings during the past 18 months (January 2003 to June 2004) suggest that the most prevalent reason for an eligible person's lack of participation in coverage programs is lack of awareness, followed closely by lack of client follow-up in the provision of income documentation. Dis-enrollment from public programs is reportedly linked to consumer difficulty with forms. In response to this finding, the CKF Steering Committee led an exercise to gather and

incorporate consumer feedback on the forms and to make applicable modifications. The revised single page form, with a Spanish version of the flipside of the form, was introduced for consumer use in September 2004. Enrollment results will be monitored over the next months.

Delaware's safety net consists primarily of five community health centers (a combination of federally and privately funded operations), and a formally organized network of volunteer physicians managed by the Medical Society of Delaware. This safety net of "health homes" has been convened and integrated to the extent possible by the Delaware Health Care Commission in its discharge of the Delaware Community Healthcare Access Program (CHAP). At present this safety net serves an estimated 9000 members, or 11.6%, of Delaware's total uninsured population, though point in time CHAP enrollment does not equate to that number because the CHAP is an elective program. John Snow Inc. assessed the penetration rate of low-income uninsured in the safety net in August 2003 and reported that the Delaware safety net conservatively serves 14% of the state's total low-income uninsured population[2], a penetration rate that is comparatively high to the safety net penetration of other states. This seeming predisposition of Delaware's uninsured population to utilize safety net providers and their sliding fee programs as opposed to securing health coverage is an integral consideration to the Commission's Uninsured Action Plan. As indicated at onset the UAP maintains a dual priority of expanding coverage and supporting the safety net.

Section 2. Employer-Based Coverage

State Planning activities from 2000-2002 included both quantitative and qualitative research conducted on statewide small businesses and their employees. This research consisted of focus groups of both employers and employees, and a mailed survey to employers. Since a large proportion (29.4%) of the uninsured in the state of Delaware are employed in companies with less than 100 employees[3] and since these companies represent the largest growing segment of Delaware's economy, efforts were concentrated here. The highest rates of un-insurance are among construction workers (24.3%) and those in the trade industry (retail and wholesale) (15.2%).[4] The 2000 Small Employer benefits survey by Blue Cross Blue Shield, Employee Benefits Research Institute and Consumer Health Education Council was used as a basis for the design of a survey instrument administered to employers of these individuals. The survey was developed to find out the reasons why small employers in Delaware with less than 100 employees do not offer health insurance. The sample size of the Small Employer Health Insurance survey was 1598 providing appropriate representation by county. The response rate for the survey was nearly 50 percent. The data gathered was weighted to appropriately represent the population of small businesses in the state of Delaware.

This research clearly indicated that cost, or the perception of cost, is the single determinant of a business's decision to offer or not offer health insurance benefits. This is despite the majority of employers stating that they do feel a significant obligation to provide coverage and recognize that

[2] Final Report, Analysis of Delaware's Safety Net, John Snow Inc. August 2003
[3] Delawareans Without Health Insurance 2003, Center for Applied Demography and Survey Research, University of Delaware
[4] Delawareans Without Health Insurance 2003, Center for Applied Demography and Survey Research, University of Delaware

lack of this benefit dramatically impacts ability to recruit and retain employees. Employers who do not offer coverage, over sixty percent of the time, believed actual costs of insuring an employee to be nearly double that of actual costs. Many employers indicated confusion and difficulty in gathering information, making informed purchasing decisions, or tax treatment of the cost of providing health insurance benefits. This strikingly high level of misunderstanding and confusion that exists in small businesses about the topic of health insurance, gave way to the Commission's continued planning for the dissemination of helpful information to the employer community. As a result early DHCC discussion to address issues of employer education centered on:

1. Messages to inform employers about the true cost of insurance and the tax advantages of purchasing insurance
2. Methods to help small employers understand how to purchase health insurance.

To facilitate thinking on this topic a representative of the Consumer Health Education Council completed a site visit to Delaware to discuss the possible collaborative development of an informational "tool kit". This workshop prompted discussion about gathering more information from employers to precede the development of "tools". Because survey and research activities and anecdotal evidence suggested that employers do not view offering health insurance in terms of a larger social benefit that improves the health of the workforce, but, rather, as another cost of doing business, the DHCC concluded that the creation of an expanded dialogue strategy needed to take place as a precursor to "tool" development. That dialogue was furthered and ultimately the DHCC contracted with the Delaware State Chamber of Commerce with the use of State Planning funds to create a website to address the unique informational needs of small employers. That site, www.healthinsurancechecklist.com was launched on August 23, 2004. The website provides free, simple, and easy-to-follow descriptions in the form of a checklist for employers considering a health insurance benefit. The marketing plan for the website targets small business with less than 15 employees who most likely do not have a human resources department. The publicity campaign kicked off on August 23, 2004 and is scheduled to be active through February 2005. This campaign includes the use of media and has already resulted in newspaper and local television coverage.

To place employer-sponsored insurance in a larger social and policy context, and/or an economic development context, could result in more collaborative coverage expansion strategies. Employers are important to successful expansion whether they increase their offerings and take up, affect the marketplace, or support public coverage and safety nets. Through the UAP and its State Planning component, the Health Care Commission initiated exploration with employers about fundamental solutions through government, the private sector, and the market. The General Assembly endorsed this Commission work through House Resolution 82 that in 2002 created the Small Business Task Force. The Task Force was comprised of individuals representing business, insurance, government, and consumers and was chaired by the Lt. Governor, also the Chairman of the Delaware Health Care Commission. The Task Force met throughout 2002 and 2003 and in its final report to the Speaker of the House put forward 4 goals and a call for immediate bipartisan action. The DHCC was reauthorized as the appropriate oversight agency for these activities and to maintain momentum and a collaborative public-private process towards the 4 goals. The DHCC in turn formed two committees; the Small Business Health Insurance Committee, and the Single Payer Committee to advance work towards realizing three of the four goals (a separate Task Force was created by a House Joint resolution to explore the 4th goal. This is discussed elsewhere in this report). Each of those committees remains active and each has engaged, or is in the process of

engaging professional services to assist in fulfilling their objectives. The Small Business Committee developed and issued a request for professional services to complete a variety of work related to the small group market (discussed in section 3). Vendors are being interviewed on September 28, 2004. The Single Payer Committee engaged the use of policy consultants to fully understand the investment and financing implications for the State, businesses, and the federal government of implementing a Single Payer system. Through the course of this work, the policy consultants also revisited an incremental approach towards universal coverage that took into consideration the earlier models/options identified as most feasible/supported during the State Planning process. These are discussed more thoroughly in section 4 of this report.

Section 3. Summary of Findings: Health Care Marketplace

Delaware's economy experienced dramatic change during the course of the State Planning process and continues to have decided impact on consensus building activities and general strategy development. Prior to this change in fiscal climate, a general level of reception could be anticipated to broad conversation about the uninsured and coverage expansion possibilities. The cost and general availability of insurance products are more pressing issues within dialogue at this time, but concepts and strategies rooted in social equity have gained renewed vigor particularly as national trends and statistics about the uninsured have become more prolific in the media. This creates an even more pressing need to create and communicate a multi-pronged and incremental strategy that speaks to the needs and interests of many constituencies. Immediate State Planning focus remains on the lower-income uninsured and the employed, low-wage earning, uninsured. Fear that the small group marketplace is in such disarray that new segments of the uninsured will propagate has reaffirmed that employer education/engagement and a strong safety net are cornerstone to continuing policy deliberation.

Delaware has a limited amount of significantly sized small group insurers. Small group coverage in Delaware is defined as no more than 50 lives. Following is an overview of overall issues affecting the small group market:

- Insurance mandates tend to contribute to increased costs of carriers doing business; thus increasing rates consumers have to pay. The Patient Bill of Rights legislation created additional mandates to add to the overall costs insurance carriers already experience. HIPAA has also increased the administrative costs for health plans to do business.
- Brokers' commissions are being cut, making it hard to encourage brokers to sell products – brokers feel they cannot make a living selling health products and more are focusing on other product lines.
- Increasing national health care costs; particularly in advanced medical technology, compound the issue.
- An average of 6 carriers have withdrawn from the small employer market annually since 1998 – typically managed care products.
- The Office of the Insurance Commissioner provides basic information about small group carriers, and frequently asked questions, to employers who may be adversely affected by health plans' departure.
- The only recourse for some individuals will be to purchase policy(s) through the individual market.
- Any carrier who files in Delaware must submit two (2) plans and rates (basic and standard). The Office of the Insurance Commission reviews these filings for adequacy.

- Delaware law requires that carriers meet specific criteria in terms of experience rating vs. community rating. Carriers "experience" rate, staying within certain guidelines…. within a given class of business, the highest rates which may be offered cannot exceed the lowest rate offered by more than a specific percentage that is outlined in the law.
- Within the past 5-7 years, the State of Delaware has enacted legislation requiring small group insurers to provide guaranteed issue products.

Despite these considerable efforts, the availability and affordability of health insurance in the small group market remains a challenge. Since the Commission's inception and initial work on implementing reforms in the small group market, the private insurance market has changed. The rise and "fall" of managed care and the experiments in vertical integration of health systems are just two examples of phenomena that have produced a different landscape from that in the early 90's. In addition changes in federal law, including HIPAA, the S-CHIP program and most recently the changes in the Medicare program, including the creation of Health Savings Accounts will create a different environment in the future. The Commission is seeking to update its work on this area by analyzing the impacts of these changes effected over the past decade, and renew its analysis of the models developed in 2001 based on new federal laws and updated thinking about coverage. Specifically, through the State Planning process, the Commission will carry forward the following recommendations of the House Resolution 82 Small Business Health Insurance Task Force:

- Review and analyze the effects of Chapter 72, which regulates the small business health insurance market.
- Analysis of today's insurance market both in large and small groups
- Identification of current trends in the insurance market both in Delaware and elsewhere in the United States.
- Investigate further the feasibility of creating a pool of small businesses.
- Investigate further the feasibility and impact of creating a high- risk pool for Delaware.
- Aid in concept development of a small business health insurance program incorporating Health Savings Accounts.
- Aid in developing a small business health insurance program based on a disease management and/or total health management model.*

*An attempt to develop an affordable health insurance plan for the small group market has emerged during this State Planning period. "Delaware First Healthy Choices" is a 501c3 nonprofit organization that was created by a group of small business people in southern Delaware, with the assistance of local independent agents, and local chambers of commerce. Through contracts with actuaries and a health benefits consulting firm, the organization has drafted a coverage product. The product utilizes a disease management model and is based upon identification of health risks, and administration of consumer directed care plans based on age, gender, and health status. Through the State Planning process, the Commission has provided support to First Healthy Choices to complete market analysis of the prevalence of chronic conditions within specified and target populations. State employee data will be used as a benchmark. Subsequent to this work, the organization will complete a more detailed analysis, including rates, that would enable their filing of a plan with the State Department of Insurance. Matching financial support for this project has been secured by First Healthy Choices from the three downstate Delaware hospital systems.

Delaware made significant strides during the decade of 1990 to expand public programs. The Diamond State Health Plan (the State's Medicaid managed care program) provides coverage for adults up to 100%FPL and pregnant women and infants to one year up to 200%FPL. The Delaware Healthy Children Program (the State's S-CHIP) provides coverage to children in families up to 200%FPL. Though not an insurance product, Delaware's Community Healthcare Access Program provides income-based primary care and medical specialty services to adults between 100-200%FPL and undocumented citizens up to 200%FPL.

In the spirit of preventing erosion to the public coverage programs, the Delaware Division of Social Services (DSS) submitted a HIFA waiver application in mid-March 2002. The Commission's Uninsured Action Plan workgroup received an overview of the State's intended use of HIFA waiver flexibility to capitalize on opportunity to continue serving a population(s) that might otherwise be subjected to restrictions/loss of coverage. Using the HIFA waiver process, the DSS proposed, unsuccessfully, to transition some of the present expanded enrollment Medicaid population from their existing status as Medicaid enrollees to the SCHIP. This diversion tactic was to negate what might otherwise have been a limitation/reduction of Medicaid benefits to expanded benefit enrollees including pregnant women, adults, and select waiver groups. Despite the unsuccessful waiver process, the DSS fortunately did not subsequently scale back any eligibility levels but has curtailed outreach.

Scholarly review of journal and newsletters articles describing the experience of other States is an ongoing activity. Policy briefs from the State Coverage Initiative program provide helpful insights and creative ideas for exploration. Other States' experience in terms of public coverage expansion, public private partnerships, and other approaches are always relevant.

"Strengthening the Safety Net" remains a central theme of research activities that will inform policy decisions and coverage expansion models. The Delaware Community Healthcare Access Program (CHAP) integrates safety net providers in an enrollment- based system in which eligible patients are assigned to a volunteer or low cost medical home. CHAP also provides access to a statewide network of volunteer or discounted medical subspecialty services via a network of private volunteer physicians orchestrated by the Medical Society of Delaware. Private sector organizations provide discounted lab and radiology services to CHAP enrollees, and dialogue continues with community hospitals for the same provision of services. CHAP eligibility requires completion of a universal financial and health status screening process, income between 100-200FPL, and ineligibility for a public insurance program. According to the Delawareans without Health Insurance 2003 report, there are approximately 14623 uninsured individuals in this bracket of eligibility.

Since the CHAP "went live" in June 2001 nearly 10000 individuals have been assisted, approximately 2000 enrolled in Medicaid, and over 5000 at some point enrolled in CHAP. As part of the State Planning process, the need for a comprehensive assessment of safety net capacity and financial viability was identified. John Snow Inc completed this analysis and presented a final report of findings in August 2003. That product included a detailed assessment of the capacity and financial viability of Delaware's four community health center programs which are integral to CHAP and a broader environmental scan of resources that at that time had not been aligned in what we have traditionally considered the "safety net". This report purports the expanded capacity

of the safety net, given resources, and continues to serve as a blueprint for State level health service expansion planning. Moreover, CHAP and its infrastructural assets may serve as a foundation for building a reimbursement strategy/subsidy system for safety net providers who continue to absorb these "working poor" individuals who do not have access to employer sponsored coverage, or for whom the concept of insurance has little to no value. Ideas that will be explored during a HRSA Pilot Planning Program effective September 1, 2004 include development of a limited benefit coverage program for individuals enrolled in the CHAP, providing a direct, service-linked, subsidy to the CHAP network of safety net providers, or exploring community based systems development initiatives such as expansion of the federally qualified health center model. {Three of Delaware's four community health centers are United States Public Health Service (USPS) classified federally qualified health centers. The fourth health center received designation as a federally qualified health center "look-alike" in April 2004 and is currently waiting on award announcements from the June 2004 submission of a federally qualified health center "New Start" application.

Section 4. Options for Expanding Coverage

The Delaware path forward continues to consist of several types of strategies; strengthening the safety net, forging public/private partnerships, and building on existing resources and programs. Inherent to each of these activities is continued outreach to individuals who may currently be eligible for participation in public programs. During this reporting period, the Medical Society of Delaware was awarded a four year grant to lead the Delaware Covering Kids and Families program, a Robert Wood Johnson Foundation funded program to complete outreach to and health policy analysis related to the "eligible but un-enrolled".

During this Planning period, options have largely been categorized into two approaches; single payer and building blocks. This has transpired as a result of the work of the Single Payer Committee referenced earlier and chaired by the Lieutenant Governor of Delaware (also the Commission's Chairman). A variety of political developments, including the introduction of House Resolution 82, which formed the Small Business Task Force, and ultimately the continuation of committees to further the Task Force's recommendations, indicated a returned interest and growing public support and debate over the feasibility of a single payer system in Delaware. The State bid process was utilized to solicit vendors to complete this analysis. The Economic and Social Research Institute (ESRI) was the selected vendor. This is meaningful because ESRI also completed health policy consulting services in the development of the original options for consideration, and has provided a great deal of technical assistance throughout the Planning program's public-private consensus building processes. With that in mind, ESRI has been able to complete a preliminary Single Payer analysis with the benefit of understanding the larger context of State and stakeholder interests and perspectives. The evolution of the Single Payer discussion and ultimately its report of findings, was strengthened by a using the policy consultants history within the state to comparatively explore strategies/options that earned stakeholder support in earlier periods of the State Planning process and that in aggregate within a "Building Blocks" approach, can assist Delaware in achieving more universal coverage. Original cost and population impact statements for the "Building Blocks" models were based upon detailed actuarial work utilizing year 2000 dollars/rates. These models will be updated for cost and enrollment impact as a component of the new HRSA Pilot Planning award (Sept 1, 2004-August 31, 2005). The

econometric modeling activities for the Single and Multi-payer systems will be completed during a requested no-cost extension period on this original State Planning award.

SINGLE PAYER APPROACH

Summary of Elements

• All non-elderly legal residents would automatically be eligible and automatically enrolled (in the single state plan, in the case of single payer, and in one of several private insurance plans offering coverage through the state pool, in the case of multiple payer).
• Benefits for people with incomes under 150% of the poverty level would be equal to current Medicaid benefits.
• Everyone else would be covered by the standard benefit package, which would be based on the most popular current small-group coverage. Anyone could buy supplemental benefit coverage from insurers.
• Under the single payer approach, people pay premiums, with subsidies graduated by income for people between 150% of the poverty level and the state median income and no subsidies thereafter. Subsidies are financed with general revenues.
• Under the multiple payer approach, financing comes from an 8% payroll tax on employers and 2% on employees, with similar taxes for non-employed people. However, earnings below $10,000 and above $200,000 are exempt.
• Premiums would be community rated.
• The single State entity would administer the program, be responsible for cost control, and negotiate with providers under the single payer approach and with insurers under the multiple payer approach.

Summary of Assessment

• Everyone would be covered automatically—universal coverage with adequate benefits.
• Everyone would have full portability of coverage regardless of change in life circumstances.
• Real resource costs would be substantially higher because all who are now uninsured are covered and will use more health care; the additional costs will be partially offset by elimination of much duplication of administrative functions and reduction of many insurer administrative costs.
• State budget costs would be substantially higher; the state would need to raise additional general revenues, though only to subsidize those newly in Medicaid and with those with incomes up to median; others pay the full premium.
• The potential for cost and quality control would be substantially enhanced because government has access to all encounter data and great leverage as the only buyer and could set global budgets.
• Equity would be substantially increased: equal treatment of equals and financing based on ability to pay.
• Risk sharing would be very broad.
• People would have no choice of health plan but very broad choice of providers.
• Compulsion and disruption of the status quo (especially for insurers) would be high; everyone is required to have and pay for coverage; greater government control would be substantially strengthened.

Multiple Payer

• Everyone would be covered automatically—universal coverage with adequate benefits.
• Everyone would have full portability of coverage regardless of change in life circumstances.

• Real resource costs would be substantially higher because all who are now uninsured are covered and will use more health care.
• Administrative savings would be less than for the single payer approach, since insurance companies continue to offer coverage.
• The state budgetary costs are very high because state dollars substitute for private dollars, since everyone can choose a no-premium plan (though note other funding variations are possible).
• Cost control is achieved through bargaining between state pool and insurers and as result of competition among insurers offering identical coverage in the pool and competing for individual enrollees every year.
• Risk sharing would be very broad.
• Compulsion is substantially increased: coverage is required, insurers flexibility is limited, and government regulation is broadened, but disruption of the state quo is less than under the single payer option because private insurers retain a major role in the new system.

BUILDING BLOCKS APPROACH

Summary of Plan Elements

• Make Medicaid and SCHIP a single program, covering everyone up to 200% of the poverty level, and wherever possible, making enrollment automatic.
• Establish a state purchasing pool for small employers and individuals that offers multiple insurers.
• Put greater restrictions on insurers' ability to set premiums based on risk in both small-group and individual markets.
• Allow young adults to continue coverage under their parents' health plan.
• Offer tax credits, graduated by income, to subsidize cost of coverage for high-risk individuals and for people with incomes between 200% and 300% of the poverty level.
• Finance state subsidies from general revenues.

Summary of Assessment

• Substantially more people would be covered, but coverage sources would remain fragmented, though somewhat less than now.
• Portability would be somewhat better than currently for those now covered by Medicaid and SCHIP, which becomes one program with one set of eligibility requirements, and for those continuously covered through the state pool.
• Real resource costs would be significantly higher because many people now uninsured would be covered and would use more health care. There would be little reduction in system-wide administrative costs, and some new administrative functions for the state.
• Substantial new state government funding would be required to cover those newly eligible for the Medicaid replacement program and those receiving tax credits.
• Equity would be improved because more nearly equal treatment of people in equal circumstances. New financing comes from general revenues and is thus modestly progressive.
• No new cost containment tools would be introduced, although if the state purchasing pool were to enroll large numbers of people, it would have some bargaining power with health plans.
• Risk sharing would be somewhat broadened because of more limitations on insurers' ability to use risk rating in the small-group and individual markets.
• People in the state pool would have expanded choice of health plans.
• The approach involves very little government compulsion or new regulation.

Devising a targeted plan that leverages state and federal dollars, and/or blends those dollars with private sector dollars to produce low cost products tailored to small employers who typically employ low wage workers remains central to Commission planning activity. These are not mutually exclusive strategies but rather possibilities that must be closely coordinated for incremental and evolutionary implementation. The terminology "Building Blocks" has emerged as a descriptor for these incremental strategies taken in whole, or in part, as a collective expansion strategy. It is important to note that key components of this new Building Blocks strategy have presented themselves in earlier Planning activities as models/options that unto themselves had elicited stakeholder support as viable and desirable expansion alternatives. Namely:

Public Coverage Expansion:
Expand public coverage. An earlier option of expanding the Delaware Healthy Children Program (DE SCHIP) to cover parents of enrolled children enjoyed a high level of stakeholder support. That same concept has evolved to include the exploration of combining Medicaid and SCHIP into one program covering individuals up to 200%FPL.

Cooperative Purchasing Strategies
Though national experience demonstrates that purchasing pools have not been very successful in lowering cost, they have delivered primary benefits of greater choice and administrative simplicities. Delaware individuals and businesses continue to have much interest in purchasing pools and a conceptual belief that they offer savings. Pooling strategies warrant further study with results that address actual impact on cost either included as a dispelling component of an employer education strategy or further acted upon. The small group market issues discussed in Section 3 have given accelerated rise to the subject of pooling.

A subsidized purchasing pool approach evolved from a preliminary discussion of an option that would permit certain target populations to buy into the state employees' plan. For a variety of compelling reasons, that buy-in option was rejected, but it was recognized that there is a group of uninsured people who have trouble finding affordable coverage but who are unlikely to be eligible for other subsidized programs—in general, employees of small employers and people whose incomes fall between 200 percent and 300 percent of the poverty level. This approach targets this population. It combines some of the elements that were considered when the state employee plan buy-in was still on the table with elements of a purchasing cooperative.

The basic idea is to establish an entity, under state auspices, that would act as a purchaser of health coverage, negotiating with carriers and health plans on behalf of the target populations and then offering a choice of all the selected health plans to eligible employers and individuals. The expectation is that the total purchasing power of the state (resulting from its contracts with health plans for Medicaid and the state employees' plan) could provide effective leverage to negotiate contracts that would include favorable terms, thus ensuring that people who enroll would get more affordable, high-quality coverage.

While this option deserves further consideration, even more than the other options detailed here it is an approach that has many implications and many unresolved issues that would need to be addressed before a plan for implementation could be developed. Continued community interest

around pooling, combined with an exceedingly limited ability to gain a critical mass for spreading risk, suggests that perhaps the only pooling strategy that would have a sufficient volume of enrollees is to in some manner leverage the State employees plan. Given the fiscal condition of the State and a mixed perception of the State's ability to effectively yield negotiating leverage, this strategy remains one that is premature to either advance or abandon. Further, the exploration of Single Payer systems described above continues to advance these concepts of utilizing the state pool in single and multi-payer variants.

Section 5. Consensus Building Strategies

The Delaware Health Care Commission (DHCC) serves as a steering committee to State Planning activities. Given the composition of the Commission, particularly the inclusion of the Cabinet Secretary of Health and Social Services, and the State Insurance Commissioner, these public meetings provide forum for discussion with appropriate key stakeholders on the Commission and in attendance at the meeting. Technical assistance from the University of Delaware is routinely provided to this process. Together, the Commission as an entity and the University as a data repository are leading authorities on the characteristics, demographics, and trends of Delaware's uninsured population as well as the purveyor of information on the overall health system as it relates to access, cost and quality for the care of the uninsured. Over the course of the planning period, other key public and private stakeholders, including the Governor's Office have been identified and their input sought on an ongoing basis. The DHCC is an independent public body that reports directly to the Governor and the General Assembly. Commission membership is comprised of five (5) government officials and six (6) private citizens. The Commission is chaired by the Lieutenant Governor. The enabling legislation used by the General Assembly in 1990 to create the Commission specifically charged the entity with creating a pathway to basic affordable health care for all Delawareans. The Commission has undertaken this charge through the systematic, comprehensive analyses of Delaware's health care market place structure, financing, and delivery mechanisms.

There is no agency or organization in the state better suited than the Delaware Health Care Commission (DHCC) to lead a planning process requiring critical input from government, public and private sectors. Systematic, comprehensive analyses of Delaware's health care market place structure, financing, and delivery mechanisms have been required to render any possible comprehensive and effective solution(s) to the problem of the uninsured. The DHCC has for over a decade tracked and investigated the issue of the uninsured through the compilation of research and the administration of pilot initiatives.

Interest in the State Planning Grant program was most strongly linked to the harmony between SPG purpose and legislated purpose of the DHCC. In addition, the DHCC is in a unique position to provide input to potential long term financing mechanisms such as the Delaware Health Fund Advisory Committee. The Commission is charged with providing research, guidance, and advice to the Committee. The Delaware Health Fund was created as the financial vehicle for the investment of Delaware proceeds reached under the Master Settlement Agreement between the nation's attorney generals and the tobacco industry. The Advisory Committee oversees the Fund. Success indicators for the expenditure of these proceeds have been established based on public input and include *"Strengthening the infrastructure, and expanding access to health insurance and services for all Delawareans."*

It is important to note that the Commission attends to the broader responsibility of overseeing the "Uninsured Action Plan" (UAP). The UAP has two components: planning and policy direction, and implementation of direct service delivery initiatives. As a recipient of proceeds of the state's Tobacco settlement, the Commission made commitment to pursue the thoughtful development of strategies to address the problem of the uninsured in Delaware. These Tobacco Settlement funds provided significant leverage to the Commission on two federal Health Services and Resources Administration grant awards: the State Planning Grant (SPG) and the Community Access Program (CAP). Receipt of federal funding under each of these programs (SPG and CAP) has enabled more thorough completion of activities, and perhaps more importantly the opportunity to safeguard the Tobacco Settlement funding for use in implementing strategies on which consensus has been reached as a result of the planning process. The Health Care Access Improvement Coalition was formed by the Commission as a public-private partnership to develop and monitor service delivery initiatives and safety net strengthening programs. The approximately 50 individuals involved in this coalition provide an additional forum for input and consensus building.

The consensus building process has provided repeated indication of the need for economic feasibility of implementing any strategy. The fiscal environment provides stimulus to continue research into such tangential items as provider capacity, safety net capacity, and alternative financing mechanisms in order that our ultimate implementation strategy stands poised to address political, fiscal, and philosophical viability tests.

Key stakeholders, including all members of the General Assembly, and members of the public have been involved throughout the planning process through the use of a consensus-building model adapted from a model termed the "Assembly Method". Use of this method requires that key stakeholders be pulled together at the onset of the process in order for issues to be framed. A core group then oversees the completion of research and information gathering activities, and reconvenes the larger group of stakeholders at such time that findings can be shared and input received. As the final leg in the process, the core group formulates a strategy based on input received from stakeholders to review and applicably modify. Delaware utilized a series of three policy conferences throughout 2001 to solicit this input. The conferences utilized technology to tabulate audience responses in the way of priority and general support. Results of those processes led to the consideration of methodologies and options described in the previous section of this report. Attendees of these conferences have remained key stakeholders in the appointment and formation of Task Forces and Committees discussed throughout this report. A 2005 policy conference that reunites stakeholders and congeals their respective activities into an integrated plan is being planned for early 2005. Aside from conducting policy forums (summaries of which are located in Appendix F), the Commission conducts regular discussion on the topic at Commission's monthly public meeting, and has completed presentation of the process and its continued path forward at a variety of community meetings on an ad hoc basis.

Section 6. Lessons Learned and Recommendations to States

A significant allocation of time and the commitment of key individuals to the planning process are mandatory. This activity requires a philosophical commitment in spirit and purpose and due to the chronic, unrelenting political and financial considerations associated with the topic of the uninsured can not be viewed as a standalone activity but conversely a systemic restructuring of

values, financing systems, and roles of public and private sectors. Work processes are completed by Commission staff, Committees, contractors, and leaders from the industry many of whom provide a variety of in-kind professional assistance.

In terms of the effectiveness of varying types of research conducted, we encourage other states to think carefully as to the target participants, locations, times of day, and recruitment strategy for focus groups and qualitative information gathering. We found the recruitment process to be inordinately difficult and the hardship experienced during that process in some ways diminished our enthusiasm for the results rendered. Though our current Planning activities do not include this type of activity, we would regard this as helpful information for new grantees.

Lastly, we strongly recommend careful consideration to the role played by the safety net as insurance expansion strategies are postulated. The safety net's capacity, financial viability, and ideological willingness to be a part of systemic state level change must be assessed and incorporated to the planning process. In addition to being significantly impacted by new patients and new health plans, the safety net will always treat patients for whom the term "insurance" has little to no meaning. This too is a critical concept to be regarded in planning activities.

Section 7. Recommendations to the Federal Government

Multi-faceted, targeted strategies that build on a strong safety net as well as employer sponsored insurance coverage are required as components of a general solution to expand access to coverage to more uninsured individuals. However, in order for Delaware to move toward more universal health insurance coverage for the uninsured, financial resources from the federal government are prerequisite. There was 5.04 billion dollars in total Delaware health care spending in 2003 (inclusive of all payers). This represents a 9.5% annual spending growth rate. Per capita spending in Delaware was $6166 in 2003 compared to $4949 per capita nationally. This may be at least partially attributable to the states low concentration of uninsured.

The federal government should view states as partners, and work collaboratively to find solutions to some of the more fundamental problems plaguing the health care system today. One such problem is the "disconnect" between the purchase and consumption of health care. Health care is one of the few commodities in which the purchaser is not the consumer. This creates a fundamental tension about what types of services should be delivered versus how those services are paid for. In short, we live in a culture in which everyone wants the best health care, but no one wants to pay for it. Unraveling this deep-rooted notion is difficult, but an effort that should be explored.

The federal government must also be mindful of the interplay of multiple aspects of health care on the entire system. Rising costs are driven by several factors, some of which cannot be changed, such as the aging population. In 2003, 1 in 8 Delawareans are seniors. It is projected that between 2010-2030, 1 in 4 Delawareans will be seniors. Shortages in several health professions impact access to health care, even for those who have health insurance. Federal financing strategies that may save dollars, but also impact the ability to deliver care all impact the entire health care eco-system. Expanding coverage, as essential as it is in order to maintain a healthy population, must be done with an eye to the other financing and capacity issues within the health care system. We continue to study and monitor federal trends including tax credits, consumer driven health care in part via health savings accounts, and the shift of functional medical management to health plans as a potential cost control measure.