

SMALL BUSINESS HEALTH INSURANCE TASK FORCE

FINAL REPORT

June 30, 2003

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LETTER FROM THE CHAIRMAN

June 30, 2003

The Honorable Terry Spence
Speaker of the House
Legislative Hall
Dover, DE 19901

Dear Mr. Speaker,

In compliance with House Resolution 82, a report of the Small Business Health Insurance Task Force follows. This report includes a summary of the work done by the Task Force as well as a series of recommendations that resulted from that work.

These recommendations, while not identifying one solution to address the problem of affordable insurance premiums for small business, outline several issues and alternatives the Task Force believes merit further study and examination. They range from a review of Chapter 72 – the regulations enacted in the early 1990s intended to reform the small group market – to a more extensive analysis of a single payer universal plan.

It is clear to the Task Force that many small businesses are having problems finding affordable health insurance. Although it is difficult to determine average premiums and health care costs because of the proprietary nature of the pertinent financial information, the Task Force heard and received many stories from small business owners and employees detailing escalating and unaffordable health insurance premiums.

Based on that testimony, the Task Force did conclude that there is a real need for more affordable options for health insurance for the small business community. While there is much more work to be done, the Task Force is enthusiastic about the potential of the alternatives it identified and believes work must continue.

Thank you for the opportunity to do this work and please don't hesitate to contact me with any questions or concerns you may have.

Sincerely,

John C. Carney, Jr.
Lt. Governor and Task Force Chair

TASK FORCE MEMBERS

Lt. Gov. John C. Carney, Jr., Chair

Rep. Timothy Boulden

Former Rep. John Schroeder

Rich Heffron
Delaware State Chamber of Commerce

Brad Allen
New Castle County Chamber of Commerce

Michael Harrington Sr.
Central Delaware Chamber of Commerce

Jim Rasa
Rehoboth Beach-Dewey Beach Chamber of Commerce

Donna Lee Williams
State Insurance Commissioner

Bernard Ableman
New Castle County resident

Cathy Castiglione
Kent County resident

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Sussex County resident

EXECUTIVE SUMMARY

The Small Business Health Insurance Task Force met for nine months and considered a number of health insurance alternatives for the small business community. The Task Force was made up of individuals representing government, the business community, the Delaware Insurance Department and the Delaware citizenry.

In order to make the most of its allotted time, the Task Force created two subcommittees to pursue two different approaches: conventional and unconventional.

The subcommittee looking at conventional solutions looked at creating a pool of small businesses with the idea of bidding that entire book of business to one or a limited number of carriers. When the effects of such an approach proved inconclusive after an actuarial analysis, the subcommittee considered adding disease management.

The subcommittee investigating unconventional – or out-of-the-box – alternatives went through a lengthy scoring process to narrow a large group of alternatives before eventually settling on a universal single-payer system.

The methodology of both subcommittees as well as the work of the entire Task Force is detailed later in this report. There are five recommendations included that the Task Force believes are important to the overall goal of providing affordable health care insurance to Delaware's small business community.

This is an important issue in Delaware as well as across the country. It is a complex, difficult subject that takes time to study, analyze and understand. Finding a solution will require more work and more time than this Task Force was given, but the members are enthusiastic about the potential of the ideas outlined in this report. It is a problem not unique to Delaware and every state is working to find a solution.

While the Task Force's recommendations are examined in more detail later in this document, they are highlighted below.

1. **Review and analyze the effects of Chapter 72, which regulates the small business health insurance market.** There was extensive testimony, much of it anecdotal, that raised several questions about the regulations created in Chapter 72 when it was enacted in 1992. Among the most concerning questions are: Are the regulations in Chapter 72 being followed? Have they had an effect on insurance rates in the small group market? Should they be kept, changed or replaced? Are the mandates in the standard plan in Chapter 72 driving up premiums? This analysis should also involve an in-depth study of the rates charged by carriers within the small group market and the loss experience of carriers in the small group market compared to other plans within Delaware.

2. **Conduct an in-depth update on a 1995 study on a single-payer system should be done.** A subcommittee of the Task Force charged with studying “out-of-the-box” ideas identified a single-payer system as the most promising long-term health care alternative for the small business community. The Task Force is recommending an update of a 1995 study that concluded a single-payer plan could cover every citizen, while controlling utilization and offering substantial health care savings for Delaware. An update of that study should be done by an objective, reputable consulting firm. The first universal health plan in the nation was recently enacted in Maine.
3. **Investigate further the feasibility of creating a pool of small businesses.** The Task Force did examine the concept of creating a small business pool that would include sole-proprietors and businesses with one to nine employees. An actuarial study proved inconclusive, but it is recommended that further consideration be given to different variations of this idea, including examination of a high-risk pool.
4. **Study the potential of using medical management to better control costs and improve patient health status.** While the Task Force looked at a number of ideas for the small business health insurance market, one of the most provocative concepts involved establishing a plan that would use a medical manager as a tool to provide better care and to reduce costs. A task force was recently created by House Joint Resolution 10 to study the concept of disease management. The resolution was sponsored by Rep. Bethany A. Hall-Long. This task force could be an appropriate forum for carrying on the work done on medical management detailed in this report.
5. **Create a forum or discussion that brings together the many stakeholders with an interest in health insurance.** It was clear to the Task Force that before it could be determined that any solution was viable, insurance carriers, hospitals, doctors, insurance agents and all others with a stake in this issue must be brought together and given an opportunity to comment and contribute.

The Delaware Health Care Commission could be the logical agency to implement recommendations 1,2,3 and 5. The Commission was involved in the last attempt to reform the small business health insurance market and its Uninsured Action Plan is dedicated to preserving and expanding access to affordable health coverage to Delawareans. The Commission has identified a particular interest in small firms and their employees and looked to the Small Business Task Force for guidance on how to address these unique issues.

The Task Force did come to one unanimous conclusion: Small business owners and employees in Delaware have experienced a rise in health care insurance premiums and all indications are those premiums will continue to increase.

The Task Force believes more time and work is required understand this issue and to find an alternative plan to provide affordable health care insurance for the small business community.

INTRODUCTION

The Small Business Health Insurance Task Force, created by House Resolution 82, was asked “to study and make findings and recommendations regarding making available an affordable, comprehensive health care plan for small businesses, their employees and the self-employed, subject to the following:

1. This health care plan should cover physician and hospital services as well as prescription drugs and medically necessary equipment;
2. Dental and mental health coverage should be considered for inclusion in the basic plan;
3. While State agencies may partake in establishing and organizing the plan, once the plan is fully operational, it should not be subsidized by public funds.”

The resolution also called for the 11-member task force to include the following: The Secretary of Health and Social Services or his designee; two members of the House of Representatives, one each appointed by the Speaker of the House and the Minority Leader of the House; the President of the Delaware State Chamber of Commerce or designee; the President of each of New Castle, Kent and Sussex county chambers of commerce; the Insurance Commissioner or designee; and three members of the public, one from each county, each appointed by the Governor.

The Task Force, which was chaired by Lt. Governor John C. Carney, Jr., the designee of Secretary of Health and Social Services Vincent P. Meconi, met nine times over nine months, beginning in October, in an effort to meet the charge of House Resolution 82.

Assessing the Current Situation

It was clear from the start of this process that health insurance is quickly becoming unaffordable for small businesses in Delaware. Task Force members, interested members of the public, small business owners and employees shared many personal stories about rapidly escalating health insurance premiums. At an informational meeting for the Sussex County small business community sponsored by the Rehoboth Beach-Dewey Beach Chamber of Commerce, a question-and-answer session included many stories of unaffordable premiums and pleas for help.

Those stories made it clear to the Task Force that there was a critical need for affordable health insurance in the small business community. In order to understand how to address that need, the Task Force needed to collect information about how the situation had reached its current critical status. As members would discover, collecting such information was not a simple process and was not possible in many instances, particularly under an expedited schedule.

It is the hope of the Task Force that work continues on this difficult and complex issue. The information in this report will be critical to that process and the Task Force

believes the ideas referenced here are promising. A better understanding of the cost of medical care, the associated charges and how the costs are shifted from one group to another are just a few of the issues that must be understood on the way to identifying a viable solution.

Research and data from various sources, including the Delaware Health Care Commission and the Kaiser Family Foundation, did indicate several trends: Small businesses are less likely than larger companies to offer their employees health insurance; health insurance is more expensive for small businesses; and, like all health insurance, small business health insurance, which has escalated greatly in recent years, is expected to increase by a double-digit percentage yet again next year.

If any or all of those trends were true in Delaware, the Task Force needed to identify exactly who they would affect. In other words, if health care insurance premiums were becoming unaffordable for small businesses and their employees and small businesses were less likely than larger businesses to even offer insurance, how many people was that affecting in Delaware?

Based on information from the Center for Applied Demography and Survey Research (CADSR) at the University of Delaware, it was determined that there are approximately 131,000 people employed in Delaware by businesses with between two and 50 employees and of that group, 67,000 are employed by businesses with two to nine employees and 43,000 are employed by businesses with 10 to 24 employees. Further, it was determined that there are about 22,000 sole proprietors in Delaware.

It is important to note a few caveats to those numbers. A number of the sole proprietors are covered under their spouses plan and would not be aided by any policy intervention aimed at the small group market. Also, sole proprietors frequently enter and leave the market, further making the number of those who would be helped unclear. Additionally, sole proprietors are eligible in Delaware for small group insurance and are able to move from that market to the individual market in search of the most affordable policy. That movement or “gaming” of the market is generally done by younger, healthier people, which drives up premiums.

What the statistics do make clear is that there are a substantial number of small business owners and employees who would be affected – hopefully helped – by any policy changes or programs that would result in lower premiums.

There was a previous effort to address the health care insurance needs of the small business community. In 1992, Title 18, Chapter 72 of the Delaware Code was enacted to address several issues.

The Statement of Purpose in Chapter 72 – which is still in place today – states that “the regulations are to provide for the availability of health insurance coverage to small employers, regardless of their health status or claims experience; to regulate insurer rating practices and establish limits on differences in rates between health benefit plans; to ensure renewability of coverage; to establish limitations on underwriting practices,

eligibility requirements and the use of preexisting condition exclusions; to provide for development of “basic” and “standard” health insurance plans to be offered to all small employers; to provide for establishment of a reinsurance program; to direct the basis of market competition away from risk selection and toward the efficient management of health care; and to improve the overall fairness and efficiency of the small group health insurance market.”

It became apparent early in the Task Force’s work that there is widespread belief among the Task Force and others that the regulations of Chapter 72 are not being followed or are not working. Although it appears the “basic” and “standard” plans referenced in the regulations are available to any small business owner or employee regardless of their health status or claims experience, it also appears that Chapter 72 has done little to keep the accompanying premiums affordable, particularly for low income workers. The Task Force also heard testimony that the carriers who do offer the “basic” or “standard” plan do not price them affordably, in part, because they are not interested in selling those plans.

Time constraints prevented the Task Force from determining in any precise way whether Chapter 72 regulations are being followed or if they are simply ineffective. But from those unanswered questions came the first recommendation of this report.

Recommendation No. 1: Require a full review and analysis of Title 18, Chapter 72 of the Delaware Code to determine if the regulations are having the intended effect on the small business health insurance market. It is the Task Force’s belief that Chapter 72 is not having the intended effect on the small business health insurance market. The Delaware Health Care Commission could be the appropriate agency to carry out this recommendation in view of current activities associated with its Uninsured Action Plan.

The Task Force, which started its work by looking at Chapter 72, believes an assessment of the current small business environment cannot be complete without a full examination of Chapter 72 and its effects. In short, Chapter 72 was enacted to address the very issues this Task Force was created to investigate. The question remains: If Chapter 72 isn’t doing what it was created to do – reform the small business health insurance market – what went wrong?

The idea of pooling

One assumption the Task Force did make with regard to the small business market involved the size of these businesses with regard to creating a profitable product for insurance carriers. Although various factors have created this difficult environment in Delaware and in the nation, the basic challenge within the current health care system can be summed up as such: Insurance carriers need a certain number of policyholders over which they can spread risk to make issuing health insurance profitable for themselves and affordable for each policy holder.

It follows that businesses with fewer than 50 employees and certainly those with fewer than 10 don’t provide a pool large enough to meet those goals. When any adverse

selection is included, i.e. an employee with ongoing or serious health problems, premiums rise sharply.

In fact, according to Delaware's Deputy Insurance Commissioner, claims in no greater number or percentage necessarily occur under small business plans, although factors such as adverse selection and young people failing to enroll may push the figures somewhat in that direction in comparison to large business plans. The main contributor to higher premiums within the small business health insurance market remains the effect of small numbers. There are too few lives to actuarially spread the risk sufficiently to compete with larger employer plans.

One potential answer to reducing the rate of premium increases in the small business market could be a State run reinsurance or pool to cover comparatively catastrophic claims of, perhaps, \$50,000 or \$100,000, so that the insurers' larger risks are otherwise covered. However, such a recommendation is outside the scope of this Task Force as is stated in the House resolution that created it – "... once the plan is fully operational, it should not be subsidized by public funds."

Still, the effect of pool size seems to be clear when examining the basic and standard plans created by Chapter 72. Although they, like other plans, were affordable at first and still must be offered by each carrier licensed in Delaware, testimony from insurance agents and small business owners indicates rates for both plans have increased dramatically in recent years and months. Monthly premiums provided by agents across Delaware were largely in excess of \$1,000 for family coverage.

Taking Two Paths

Many ideas were offered and discussed from the start of this process. With the challenge of meeting a fast approaching deadline and finding answers to a bevy of questions, the decision was made to take two very different paths at the same time. Two subcommittees were formed to focus on these different approaches.

The first, which followed what was dubbed the "conventional" path, was charged with creating a plan that followed the design of the "basic" and "standard" plans laid out in Chapter 72. The second, called the "out-of-the-box" subcommittee, was asked to sort through the long list of unconventional ideas.

Both subcommittees presented plans to the full Task Force, which had lengthy discussions about each. Eventually, the Task Force chose to focus on finding a conventional alternative, while concluding that further work on the out-of-the-box approach was needed, but beyond its scope.

Recommendation No. 2: An objective consultant should be engaged to update a 1995 study done by Philadelphia-based Solutions for Progress that estimated a single-payer system would reduce statewide costs by 8 percent, while effectively covering 100 percent of the population. The Delaware Health Care Commission could be the appropriate agency to carry out this recommendation in view of current activities associated with its Uninsured Action Plan.

Although many Task Force members have serious concerns about a single-payer system, the Task Force does believe the concept should be fully studied and considered a viable option for the future. Within the realm of unconventional ideas, the Task Force concluded that a single-payer system holds the most promise for the future.

It should be noted that early this month (June 2003) Maine became the first state to enact a universal health care plan. The plan, called the Dirigo Health Insurance Plan, creates a new public-private agency that will join with private insurance carriers to offer health care coverage to about 180,000 uninsured Maine residents by 2009. The plan will provide an insurance option for businesses of 50 and fewer employees, the self-employed, unemployed individuals and individuals working less than 15 hours a week in any size business. Premiums will be on a sliding scale

The plan will be financed with \$52 million of Maine's share of state aid packaged with recent federal tax cuts, a 4 percent fee on gross revenues received by insurance companies in the state, premiums paid by employers and the self-employed and Medicaid benefits. An attempt has been made to contain costs by setting voluntary price caps for providers, hospitals and insurers, and a state-run group will track health care costs and quality. Complete details of the plan can be found at the Maine Senate's website: www.mainesenate.org.

The out-of-the-box subcommittee pointed out that the viability the universal care approach was supported by a recent study undertaken for the State of Maine by Mathematica Policy Research, Inc. Quoting from the final report, "A preliminary analysis of alternative benefit designs suggests that a single-payer system could generate a minimum 5 percent savings in 2004 using a benefit package that covers 85 percent of all health plan expenditures for individual above 200 percent FPL [Federal Poverty Level]. Such a benefit package would be similar to conventional health plan designs currently offered in the employer-provided health insurance market." The full report can be found by searching "Publications" on Mathematica's website: www.mathematica-mpr.com/.

In continuing down the conventional path, the Task Force decided to focus on the existing plans created by Title 18, Chapter 72 of the Delaware Code. The group considered 18 discussion points that would affect the plan design. These discussion points are listed in the "Conventional Approach" section later in this report. The resulting indemnity plan was presented to Palmer & Cay Consulting Group, which was contracted using resources made available by the Delaware Health Care Commission to report on the effects those principals might have on the current plans and to produce and actuarial study on what the resulting premiums might be.

The Task Force also asked Palmer & Cay to comment on the 18 discussion points and the concept of accepting bids for the plan and giving the entire pool to one carrier. The Palmer & Cay report is included in the appendix.

The Task Force concluded that the different rates approximated by Palmer & Cay did not represent a significant savings compared to current rates available in the market place. Further, the Task Force concluded that it would not be worth the required investments to create such a plan for small business.

However, the Task Force did determine that more work was needed to analyze the idea of creating a large pool of small businesses in order to try and achieve the critical mass necessary to make it a profitable risk for insurance carriers and to produce affordable premiums for consumers. That determination led to the third recommendation of this report.

Recommendation No. 3: Continue the examination and analysis of a pooling concept. The Task Force believes there is promise in the concept and continued investigation could produce more reasonable premiums. The Delaware Health Care Commission could be the appropriate agency to carry out this recommendation in view of current activities associated with its Uninsured Action Plan.

The subcommittee charged with looking at the conventional path moved on to the concept of medical management. Within this concept a medical manager is used to focus on better medical outcomes, hopefully lowering costs by making patients healthier.

Although there was significant discussion about this concept within the full Task Force, including a presentation by one company, the idea was not put through the same kind of analysis as the pooling concept. That led to a fourth recommendation.

Recommendation No. 4: Investigate the concept of disease management and medical management, and consider creating a pilot program to test the concept. The task force created by House Joint Resolution 10 could be the appropriate group to carry out this recommendation.

The subcommittee argued that a pilot program using the small business community, even one restricted to Kent and Sussex counties, would be the best way to prove the concept in Delaware.

Although Task Force discussions did not progress far enough to determine the best way to implement such a pilot program, the idea of testing this or any other concept through such a method was widely endorsed by members.

There was one caveat, however. While the Task Force's membership included a mix of people from across Delaware, it did not include many of the stakeholders key to implementing any new health care insurance alternative for the small business community.

Recognizing the need for all of those groups to comment on all of the previously mentioned plans and any others, the Task Force strongly makes the following recommendation:

Recommendation No. 5: Create a forum that brings together all the various stakeholders with an interest in health care insurance should be arranged. The Delaware Health Care Commission could be the appropriate agency to carry out this recommendation.

Such a meeting should include representatives from the Medical Society of Delaware, the state's hospitals, insurance carriers licensed to do business in Delaware, disease management third-party administrators, health and human services representatives, chamber of commerce representatives, insurance agents and any other interested parties.

Finally, it was clear throughout the Task Force's work that every member agreed that small businesses are facing a crisis in health care insurance. It also is clear that every member believes work should continue in an effort to better understand this issue.

And while a full and proper analysis and examination must be done on each and every idea, the process should be expedited in any way possible. Otherwise the Delawareans who are already stretched to the limit financially by health care insurance will find all options out of their reach.

That would not only have a tremendously adverse effect on their lifestyle, but would push another group into State sponsored programs, such as CHIP and Medicaid. All in all, an unacceptable result that the Task Force believes can be avoided with continued work.

CONVENTIONAL APPROACH

The Task Force subcommittee charged with looking for a conventional solution began by looking at the indemnity plans that are already available for small businesses. These basic and standard plans were created through Title 18 Chapter 72 of the Delaware Code.

The Task Force concluded that one way to address the affordability issue was to create a pool large enough that a carrier could offer a plan that was profitable for it and affordable for policyholders.

Agreeing that the quickest way to identify a workable plan for that pool could potentially come by slightly adjusting the plans already in existence, the subcommittee outlined 18 points for discussion among the full Task Force. The goal was to determine if the Task Force could agree on which areas were best to adjust within the existing plans to obtain some savings for policyholders. The discussion centered on the following points:

1. Size of Group
2. Medicare Fee Schedule at 100% for provider payments
3. Bid Process
4. Two- or three-year retention for carrier awarded bid.
5. Small business regulation enforced when not in conflict with HIPAA Regulations.
6. HIPAA regulations must be followed.
7. 63 days = 12 months back, 18 months forward.
8. Drug formulary and/or percentage
9. Mandatory enrollment. All new hires 18 and above are required to enroll.
10. Banded rates – 18 to 29 and 30 to 64 ?
11. Extra premium for smokers?
12. Pre-tax deduction
13. In and out procedure for seasonal employees
14. Selling agents – All health agents in good standing with the state.

15. Commission – Minimum 5%

16. Establish a small group oversight commission under the supervision of the Insurance commission.

17. Any rate increase would have to be submitted to the small group oversight commission for approval.

18. Catastrophic Pool

With a consensus on each point (all of which are reflected in the Palmer & Cay Report on page 73 in the appendix of this report), the Task Force decided to have a consultant analyze the plan. The Task Force obtained data from the Center for Applied Demography and Survey Research (CADSR) at the University of Delaware that indicated there are approximately 131,000 people employed in Delaware by businesses with between two and 50 employees and of that group, 67,000 are employed by businesses with two to nine employees and 43,000 are employed by businesses with 10 to 24 employees. Further, it was determined that there are about 22,000 sole proprietors in Delaware.

The Task Force decided to have a consultant study whether a minimum potential pool of 67,000 bodies (the number of people employed by businesses with 2 to 9 employees) would be large enough to convince a carrier to bid on that book of business. Using planning grant money provided by the Delaware Health Care Commission, the Task Force contracted with Palmer & Cay Consulting Group.

Palmer & Cay was asked to use the existing standard indemnity plan – with the previously mentioned adjustments – and the minimum pool of 67,000 bodies to test what the effect on pricing would be if one carrier had the entire book of business.

Discussion points, pricing assumptions, cost development and age-banded rates are included in the Palmer & Cay report. Although some of those rates, particularly those for younger people, are lower than the rates indicated in testimony, the Task Force did not believe the savings would be substantial enough to make such a plan affordable to lower paid workers who are making minimum wage or slightly more. Additionally, some members, particularly those representing chambers of commerce, did not agree with some of the recommendations in the report, including that those in the 2 to 9 market should not be permitted to join other programs, such as associations, chambers of commerce or multiple employer health plans.

Still, the Palmer & Cay study provided the Task Force a tremendous amount of valuable information and gave the group a baseline from which to work. The subcommittee charged with taking the conventional path took this knowledge, redirected and returned with another alternative – medical management.

The subcommittee identified and contacted a New Jersey-based company, Health Network America, that has implemented health benefit plan management for more than

12 years. In the company's words, "the combination of improved medical care quality, patient and physician empowerment with useable information at the patient level, provider contracting based on accountability as well as price, high quality social service support, an administrative program free of financial conflicts of interest, advanced medical informatics and modern computer technologies, have resulted in lower subscriber costs and profitability for the carrier."

Health Network America is an example of a company that embraces the concept of managing patients' health and providing incentives to prompt them to get proper screenings and take preventative measures. In simple terms, companies like Health Network America believe an investment in early care and preventative measures saves substantial money through fewer claims in the long run. The Task Force was not able to research the concept to establish its frequency of success. Included on page 97 in the appendix is information on a proof of concept project Health Network America successfully employed for the federal government.

The Task Force heard a presentation by Health Network America, which drew an enthusiastic response. However, the Task Force was not able to continue its investigation into the concept and did not have the time to contact other carriers or physicians to collect more input.

The subcommittee did argue that a plan that centered on medical management, like that of Health Network America, held the most potential for helping the small business community with costs and better health.

According to the subcommittee, medical management, when void of conflicts of interest, can perform with the highest standards of patient care. The main merit of this concept is to allow the medical manager to operate outside of the traditional insurance company mode, whereby the insurance company doesn't control both the risk function and the medical management. Further, it allows attention to be focused on better medical outcomes, which also reduces costs.

The concept did add to the Task Force's interest in developing a pilot program or proof of concept within the small business community. Whether it involve a pooling concept, medical management, a blend of both or some other idea, the Task Force believes the current predicament small businesses find themselves in merits an attempt at developing a new plan.

The lingering question was exactly how would a pilot program be implemented? Also, because the resolution that created the Task Force specifically said that government subsidies could not be used, the group wondered how a pilot program would operate if funds were required.

The subcommittee did, however, offer a few suggestions with regard to a plan design for a pilot program. They are:

1. Risk and medical management would be separate in the pilot program.

2. Insurance companies would look at the plan design and structure and bid on the plan.
3. The medical manager would report first to a board that would oversee the plan.

It is the belief of the subcommittee that a plan with the proper triggers for health as well as consequences for bad health behavior will help the health care process. Included in the appendix are two presentations by the subcommittee – A plan for medical management (page 104) and a pilot proposal (page 111)

OUT-OF-THE-BOX APPROACH

In order to make the most of its allotted time, the Task Force empowered a subcommittee to investigate a number of unconventional ideas. This group took a different approach toward a solution, asserting that efforts to date have attempted to add patches to the existing employer-based health insurance system.

The subcommittee submitted that often these initiatives have consisted of taxpayer-funded, fill-in programs that try to bridge the gaps between the public safety net and private, work-based coverage. The group concluded that that approach has encountered increasing problems as the composition of the traditional workplace has changed. More and more workers (e.g. self-employed, modest wage, part-time, seasonal, contract) now find themselves outside the protection of the public/private coverage envelope. Moreover, the situation has only grown worse as the cost of coverage has pushed the problem further into the middle class. The group pointed out that extrapolating current trends produces a troubling picture of more of our citizens without insurance while a health care system continues to consume an ever-greater portion of our gross domestic product.

The subcommittee concluded that House Resolution 82 recognizes that fewer insurance carriers are now offering fewer policies with fewer benefits at a higher price to a small business community increasingly unable to afford their products. At the same time, because of both budgetary and regulatory restrictions, the public sector has been unable to step in to fill the void.

So this subcommittee took a different approach to fill the void, setting guidelines around benefits, participation and cost sharing that it applied to each of 15 options. After scoring each of these options, the subcommittee narrowed its focus to four: single-payer, DelaCare, Federal Employee Health Benefits Plan (FEHBP) expansion and individual mandate. After scoring and discussion, the group settled on a single-payer system as the top out-of-the-box option.

In establishing operating guidelines, the out-of-the-box group started by looking at anticipated cost trends and the role of cost containment and competition in today's marketplace. It became clear that given our aging population, the expansion of expensive medical technology, the increased reliance on costly pharmaceuticals and the rise of aggressive entrepreneurial medicine that health care costs would continue to far outstrip inflation for the foreseeable future.

As such, any lasting solution must first have a strong cost containment component. At the same time, there is a growing body of data to suggest that the present health care payment system results in over diagnosis, over prescription, over testing and over treatment. A recent study appearing in the American College of Physicians' Annals of Internal Medicine pointed out that we could save 30 percent of our Medicare outlay without harming quality if we simply eliminated unnecessary medical procedures. Further, any option based on premium subsidies without a cost containment mechanism

will simply commit taxpayers to support a care delivery system that is clearly out of financial control. As such, a lasting solution should address the issues of access and cost concurrently.

The group also questioned the effectiveness of the current form of marketplace competition in addressing the problem. The system's inherent asymmetry of information means that the health care consumer may never be equipped to make fully informed care decisions. Rather, patients will continue to rely on the advice of providers, who have a clear financial incentive to recommend treatment. Further, many health care decisions are made under emotional stress or while in pain, which precludes the kind of deliberative process that the average consumer would employ in making almost any other kind of purchase.

Finally, by creating a system whereby the consumer typically sends the bill off to a third party for payment, we have subverted the incentives needed to make competition work. The option selected must refocus competitive forces to produce better patient care and better outcomes while recognizing that our health care resources are finite.

In the course of informally surveying members of the small business community, a number of observations were frequently offered. First, for various reasons -- both social and economic -- there was a feeling that everyone should have an equitable stake in the system. This would assure that benefits, risks and costs were distributed fairly across the entire population. Also, to be considered as a possible solution, a plan option must contain enough benefit features to protect every citizen from financial ruin in the event of illness or accident.

It was felt that the non-participating young, healthy and wealthy must no longer be permitted a free ride. It was also frequently mentioned that there were numerous small business owners and their employees who were desperately seeking coverage and who could afford to make some sort of contribution, but were unable to afford 100 percent of today's high premiums. The fact is that these non-participants will sooner or later present themselves at the emergency room, receive care and the system's current participants will likely pay for it.

There seemed to be general agreement that all of these marginalized groups should be swept into the system. Further, options that were all-inclusive would be the first step towards ending the corrosive and destabilizing practice of risk avoidance and cost shifting. Finally, small employers seemed to be willing and anxious to get the issue off their desk. The current no-win situation often finds employers in the middle of a complex dynamic that they don't have the time, tools or understanding to deal with effectively.

In the final analysis, the group chose the following guidelines to arrive at a suitability index for each of the various out-of-the-box options:

1. Benefit – The option's coverage must not discriminate because of employment status, age, health history, employer size, income or net worth.

2. Participation – The option must provide coverage for the entire population.
3. Cost Sharing – The option must spread the costs fairly throughout the population.

Added weight was given to options that would facilitate cost containment, support global health care planning and ease the current financial burden on the public sector.

PROCESS

The following fifteen options were put on the table (See appendix for thumbnail descriptions of each option):

Play or pay	All-payer	Consumer-directed
Low limit policies	Tax credits	Alliance plans
Bare-bones policies	DelaCare	MSA's
Employer mandates	Medicare expansion	State plan buy-in
Individual mandate	Single-payer	FEHBP expansion

Each option was measured against the criteria with a Y awarded for satisfying the objective, an N of non-compliance and a ½Y if the option partially satisfied the requirement. At the beginning, the group agreed that any option would have to be awarded the equivalent of at least two Y's to be acceptable.

In addition, an arrow was assigned to each suitability index to predict the impact that the option would have on public funding. An up arrow would signal an anticipated increase in overall cost to the system, while a down arrow would indicate a projected savings. Only a suitability index with a down arrow(↓) attached would be considered for further consideration.

At the end of the first cull, four options emerged as worthy of more study.

Option	Suitability Index
Single-payer	3Y↓
DelaCare	3Y↓
FEHBP expansion	2Y↓
Individual mandate	2Y↓

(See appendix for the scoring tabulation)

The group then subjectively analyzed the four options by applying key elements derived, in part, from the Delaware Health Care Commission's criteria used in assessing coverage options. The screening process assessed whether the option would:

Have broad political support	Minimize disincentives to work
Utilize existing admin. structures	Lessen stigma & maximize dignity
Permit global resource planning	Reduce current public subsidies
Support equitable financing	Require few changes in Federal laws
Offer simplicity & transparency	Conserve costly medical resources

One to ten points were awarded for each condition met depending on the level of compliance. (See appendix for the scoring tabulation)

DISCUSSION

Though mindful of the limits of our mandate under HR 82, it nonetheless became increasingly clear that any sort of effective, permanent, cost-containing solution would have to involve not just Delaware's small business community, but would have to embrace the entire population.

Initially, there was a concern that the state did not possess the resources necessary to undertake this kind of fix within the current labyrinth of federal regulations. And while any sort of systemic fix may ultimately require "heavy lifting" at the national level, Delaware is ideally positioned to serve as a countrywide laboratory for innovative ideas that demonstrate promise. This is consistent with the position that is currently being voiced in Washington.

The single-payer option scored highest in our analysis. It is our belief that a privately run, publicly financed single-payer program would be the most efficient and proven alternative available with the best chances of containing costs and facilitating system-wide health planning.

Single-payer is the only alternative that offers the potential to reduce total expenditures for health care for both the private and public sectors. Based on a study of the Delaware health system in 1995, Philadelphia-based Solutions for Progress estimated

that statewide costs would be reduced by 8 percent, while effectively covering 100 percent of the population. In today's terms this would translate into a net savings of over \$300 million in Delaware. No other alternative meets this test of universality of coverage with such a potential for cost reduction.

Because of the system's efficiency, most small businesses that now pay premiums may well see a reduction in out-of-pocket health expenses. One funding method would entail a health surtax, which in almost all cases would be less than premiums that the surtax would replace. There would be no price differentials based on the size of the business.

It is important to note that these savings stem from a true structural reform of the health care system. These savings are not the ephemeral "savings" we experienced through managed care as it exacted price breaks from providers. These are lasting changes as single-payer introduces the utilization controls necessary to insure the desired stability in both cost and quality.

A non-profit ASO carrier could administer the single-payer system, with legislation crafted to insure its permanence as a non-profit. Delaware is large enough to permit this approach, which because of its efficiency could provide all citizens with health care coverage equal to that now experienced by state employees and elected officials.

The remaining three options are built around or contain some sort premium subsidy mechanism, which raised a number of practical issues. The administrative difficulties in setting, adjusting, monitoring, policing and collecting/dispensing either prospective or retrospective subsidies makes the approach cumbersome and inefficient. The subsidy concept tacitly acknowledges the fact that many are unable to afford today's premiums. Conversely, this means, of course, that some are able to pay more for their health care security than others.

If we sign on to this idea, then it simply becomes a matter of determining the most efficient, effective and equitable way to raise the cash needed to fund the system. And complain as we might, there is no more efficient method of collecting large amounts of revenue than through the existing tax system, either in the form of a tax on income or on consumption. In fact, a recent study asserts that the taxpayer already funds 60 percent of the today's national health care costs. This compares to Canada's universal system that is 80 percent funded by taxes. We may well be closer than many think.

Small business has historically been reluctant to sign on to any health security option that requires tax funding. However, as the health insurance situation has continued to deteriorate, we have been hearing a different voice. Some question if there might not already be enough revenue in the present system to support a universal approach. The argument claims that any new tax would simply offset or replace contributions that we are currently making in other ways (e.g., through health insurance

premiums, deductibles, co-pays, non-covered medical procedures, portions of our car and workers' compensation insurance premiums, etc.).

When one considers the disjointed, multi-source way we now fund care, there may be some truth to this assessment. Further, some estimate that as little as 50 cents on the health care dollar actually finds its way down to the provider. The remainder is leaking from the system while providing no public benefit. In short, it appears that we are grossly inefficient at both collecting and spending our limited health care dollars. We simply no longer have this luxury.

There are added advantages to single-point financing that address two of the major shortcomings of our current system. Specifically, if you control the only source of reimbursement, you control the system. This opens up new avenues for aggressive cost containment. Further, centralized health data record keeping would facilitate comprehensive health planning and best-practice monitoring. Finally, and equally as important, tax funding finally breaks the long and increasingly impractical link between coverage and employment.

The remaining three options also all continue to rely on the involvement of an insurer. We are not at all sure that the expense of the traditional insurance model adds sufficient value to warrant continued inclusion in the health care equation.

Based on responses compiled to date, DelaCare was ranked next because of its generous standard benefit package and its recognition of the efficiency of the tax funding method. On the minus side is the fact that a DelaCare-model is unique, has never been attempted and, as such, carries the very real risk of failure.

The remaining two options both permit the participant to select from among a wide variety of benefit plans. While attractive from a marketing and public relations standpoint, multiple choices introduces a number of undesirable features.

First, there is the matter of adverse selection, which ultimately serves to defeat our fundamental goal of spreading risk and cost fairly across the population. Second, a certain degree of benefit apartheid is introduced, as the wealthy are able to opt for the rich plans, while the less fortunate would only be able to afford the less generous core plans. And, of course, the more choices offered, the more administratively complex and inefficient the overall system becomes.

The group's third choice was the FEHBP expansion option. This ranking was based on the assumption that a comprehensive, basic plan option would be fully tax funded. Benefit enhancements or buy-ups would be offered through plan options, which would require the participant to pay any cost differential. Not only would this approach greatly simplify today's convoluted administrative process, but also it is the only option that has much of the required program infrastructure already in place.

The Individual mandate option, though inherently much less efficient than FEHBP expansion, could fit the bill, but only if funded progressively using the tax option to cover a floor of coverage, as discussed above. The major drawback is that little structure is currently in place to facilitate a transition.

Since the collapse of a national health care initiative almost ten years ago, the emphasis has been on incremental reform. And while this approach has led to greater coverage for those with low incomes through SCHIP and Medicaid expansion, the commercial insurance marketplace remains in turmoil as escalating costs and heightened aversion to risk have made coverage increasingly unobtainable.

Granted, the least disruptive, easiest and most palatable solution would be through some sort of in-the-box, employment-based, traditional group insurance model. Sadly, we may have already squandered the opportunity to fix the situation within this delivery mode. If this is the case, then we must not be paralyzed by the task before us. We must agree that continued inaction given existing trends will only make the ultimate solution that much more difficult.

Finding an enduring solution will not be easy, but, in truth, we may be underestimating the public's grasp of the situation and its willingness to make sacrifices today in order to enjoy health care security tomorrow. It's time to start a candid public dialogue on the cost of continued inaction.

In the final analysis, the group firmly believes that any proposed solution that does not securely cover every citizen with a comprehensive set of health care benefits will ultimately fail and will only condemn policymakers to revisit this issue after we endure yet another cycle of failure. Of all the alternatives examined, we believe that the single-payer option is clearly superior and offers the best chance of long-term success.

PROPOSED ACTIONS

1. We suggest that the Task Force recommend that the issue of health care be elevated to a state priority by both the executive and legislative branches. The health care issue must be regarded as a growing emergency, with dire consequences looming for all Delawareans. We believe that immediate, bi-partisan action is called for.
2. We recommend that the Task Force consider engaging Solutions for Progress (or a suitable alternative) to update the 1995 single-payer study. If the results support the option's promise of better coverage for everyone at a lower cost, then we would recommend exploring possible paths to its implementation.
3. The Secretary of Health and Social Services has proposed using states as test beds for a wide variety of care options. Among them will certainly be an alternative designed to test the single-payer approach. Given our manageable size, proximity

to Washington, and clear need, Delaware should be first in line to apply for one of these study grants. In order to facilitate this, the state may wish to team with an academic health center like the Johns Hopkins School of Public Health, which has the necessary expertise in the design and analysis of health systems.

4. It is suspected that the worsening of the insurance situation may have increased acceptance of a single-point financed health care system. We propose that a survey be undertaken by the Task Force to determine the extent of this support.
5. While the stated mandate of the Task Force is limited to “findings and recommendations,” application should be made to the General Assembly to extend the jurisdiction of the Task Force to not only continue its study of this problem, but also to support the implementation of whatever plan is proposed and/or adopted.

Lastly, we commend the small business community for helping to focus the spotlight on this issue and for mobilizing Delawareans to address the worsening situation. It is our hope that they will continue to apply pressure until a lasting, secure solution is found.

STUDY DESIGN CONSIDERATIONS

With respect to studying design considerations for a universal health care system – proposed action No. 3 above – the out-of-the-box subcommittee proposed the following points:

General

- Project costs, prices and accessibility trends without system change
- Assess changes in the political, health consumer and health industry environment since the 1995 Delaware study
- Look at outcomes in other countries that have adopted a universal system since 1995
- Examine the Canadian system to determine if their current problems are caused by a flaw in the program design or a lack of funding or for some other reason
- Estimate the long term effect of shifting emphasis from curing illness to maintaining health
- Compile the pros and cons of a universal system as seen by the public and by the business community
- Consider the role of existing insurers
- Explore the feasibility of a federal pilot project
- Outline a path to implementation

Specific

- Benefit package (dental, prescription drugs, long term care?)
- Population covered
- Possible influx out-of-state patients
- Coverage of Delawareans working in other states

- Funding sources
- Revenue offsets
- Increased utilization
- ERISA considerations
- Integration with existing federal benefit programs
- Possible role of co-pays, deductibles, caps, etc. recognizing revenue vs. collection costs and possible barriers to care
- Retraining of displaced workers
- Cost containment effects of: coordinated wellness program, universal care protocols, standardized utilization review, other incentives
- Provider payment options (global budgets, negotiated schedules, capitation, salary, etc.)
- Modeling out 3, 5, 10 years

The subcommittee also forwarded a list of 17 reasons to consider a universal health care system. These reasons are:

1. Offers coverage that doesn't suddenly become unavailable or unaffordable because of changes in employment status, age, health history, employer size, income or net worth
2. Eliminates disruption in coverage that is caused when insurers leave the state or alter their business plan
3. Keeps health care decision-making in the hands of the professionals
4. Securely covers every Delawarean with everyone paying a fair share of the cost
5. Breaks the increasingly impractical link between coverage and employment in the traditional workplace
6. Removes employers from an issue that many don't have the time, tools or understanding to deal with effectively
7. Ends adverse selection and risk avoidance by insurers
8. Permits aggressive cost containment that's only possible in a single-source reimbursement system
9. Supports effective practice monitoring and quality management available through centralized record keeping
10. Facilitates the creation and implementation of standardized, evidence-based care protocols
11. Recognizes that resources invested in an effective preventive care program improves long term health and, in turn, lowers costs
12. Maximizes that portion of the health dollar that passes through to the provider by streamlining the reimbursement system and eliminating costs that don't offer any health benefit
13. Provides medical providers the assurance that every appropriate service will be paid and paid at a predictable, negotiated rate
14. Puts an end to benefit "apartheid" that finds many financially vulnerable Delawareans underinsured
15. Permits global resource planning

16. Aligns the delivery of medical care to personal medical need, not to financial or insurance resources
17. Comes with a proven track record

APPENDIX

SPONSOR: Rep. Schroeder;

Reps. Boulden, Price, Thornburg

HOUSE OF REPRESENTATIVES

141st GENERAL ASSEMBLY

HOUSE RESOLUTION NO. 82

ESTABLISHING A SMALL BUSINESS HEALTH INSURANCE TASK FORCE TO STUDY AND MAKE RECOMMENDATIONS REGARDING MAKING AVAILABLE AN AFFORDABLE, COMPREHENSIVE HEALTH CARE PLAN FOR SMALL BUSINESSES, THEIR EMPLOYEES AND THE SELF-EMPLOYED.

WHEREAS, the engine of growth in our economy is small business; and

WHEREAS, an increasing number of Delaware small businesses have dropped or diluted their health insurance coverage; and

WHEREAS, even successful small business owners are abandoning their enterprises for salaried positions that offer health coverage; and

WHEREAS, a number of Delaware Chambers of Commerce have defined the lack of health insurance coverage as the major business problem threatening the very viability of their member firms; and

WHEREAS, uncontrollable increases in health care premiums will doubtless lead to an increase in small business failures and bankruptcies; and

WHEREAS, this decline in coverage due to rapidly escalating rises in premiums for small business has been steadily worsening for over a decade; and

WHEREAS, initiatives within various communities have not provided any relief.

NOW, THEREFORE:

BE IT RESOLVED by the House of Representatives of the 141st General Assembly of the State of Delaware that there is hereby established a small business health insurance task force to study and make findings and recommendations regarding making available an affordable, comprehensive health care plan for small businesses, their employees and the self-employed, subject to the following:

1. This health care plan should cover physician and hospital services as well as prescription drugs and medically necessary equipment;

2. Dental and mental health coverage should be considered for inclusion in the basic plan;
3. While State agencies may partake in establishing and organizing the plan, once the plan is fully operational, it should not be subsidized by public funds.

BE IT FURTHER RESOLVED that the Task Force be composed of the following 11 members:

1. Cabinet Secretary of Health and Social Services or designee;
2. Two (2) members of the House of Representatives, one each appointed by the Speaker of the House and the Minority Leader of the House;
3. President of the Delaware State Chamber of Commerce or designee;
4. The President of each of New Castle, Kent and Sussex County Chambers of Commerce;
5. The Insurance Commissioner or designee; and
6. Three (3) members of the public, 1 from each county, each appointed by the Governor.

BE IT FURTHER RESOLVED that the Chairperson of the Task Force be the Cabinet Secretary of Health and Social Services or their designee on the Task Force.

BE IT FURTHER RESOLVED that the Task Force shall issue its written report to the Governor and the Speaker of the House by March 31, 2003.

BE IT FURTHER RESOLVED that the Chairperson of the Task Force be responsible for guiding the administration of the Task Force by, at a minimum:

1. Setting the date, time and place for the initial, organizational meeting;
2. Supervising the preparation and distribution of meeting notices, agendas, minutes, correspondence and reports of the Task Force; and
3. Ensuring that the final report of the Task Force is submitted to the Speaker of the House with a copy to the Governor.

BE IT FURTHER RESOLVED that the recommendations developed should call for having the Small Business Health Insurance Program operational within eighteen (18) months following passage of the legislative and executive approvals and provisions required for implementing the recommendations.

SYNOPSIS

This resolution establishes the Small Business Health Insurance Task Force to study and make recommendations regarding making available an affordable, comprehensive health care plan for small businesses, their employees and the self-employed.

CHAPTER 72 REGULATIONS

1.0 Statement of purpose

1.1 This Regulation is intended to implement the provisions of 18 Del.C. Ch. 72, Small Employer Health Insurance. The general purposes of 18 Del.C. Ch. 72 and this Regulation are to provide for the availability of health insurance coverage to small employers, regardless of their health status or claims experience; to regulate insurer rating practices and establish limits on differences in rates between health benefit plans; to ensure renewability of coverage; to establish limitations on underwriting practices, eligibility requirements and the use of preexisting condition exclusions; to provide for development of "basic" and "standard" health insurance plans to be offered to all small employers; to provide for establishment of a reinsurance program; to direct the basis of market competition away from risk selection and toward the efficient management of health care; and to improve the overall fairness and efficiency of the small group health insurance market.

1.2 18 Del.C. Ch. 72 and this Regulation are intended to promote broader spreading of risk in the small employer marketplace. 18 Del.C. Ch. 72 and this Regulation are intended to regulate all health benefit plans sold to small employers, whether sold directly or through associations or other groupings of small employers. Carriers that provide health benefit plans to small employers are intended to be subject to all of the provisions of 18 Del.C. Ch. 72 and this Regulation.

2.0 Definitions

2.1 As used in this Regulation:

2.1.1 "Risk characteristic" means the health status, claims experience, duration of coverage, or any similar characteristic related to the health status or experience of a small employer group or of any member of a small employer group.

2.1.2 "New entrant" means an eligible employee, or the dependent of an eligible employee, who becomes part of an employer group after the initial period for enrollment in a health benefit plan.

2.1.3 "Risk load" means the percentage above the applicable base premium rate that is charged by a small employer carrier to a small employer to reflect the risk characteristics of the small employer group.

2.1.4 "Associate member of an employee organization" means any individual who participates in an employee benefit plan (as defined in 29 U.S.C. Section 1002(1)) that is a multi-employer plan (as defined in 29 U.S.C. Section 1002(37A)), other than the following:

2.1.4.1 An individual (or the beneficiary of such individual) who is employed by a participating employer within a bargaining unit covered by at least one of the collective bargaining agreements under or pursuant to which the employee benefit plan is established or maintained; or

2.1.4.2 An individual who is a present or former employee (or a beneficiary of such employee) of the sponsoring employee organization, of an employer who is or was a party to at least one of the collective bargaining agreements under or pursuant to which the employee benefit plan is established or maintained, or of the employee benefit plan (or of a related plan).

3.0 Applicability and scope

3.1

3.1.1 Except as provided in sections 1.1 and 14.0, this Regulation shall apply to any health benefit plan, whether provided on a group or individual basis, which:

3.1.1.1 Meets the conditions set forth in 18 Del.C. §7203;

3.1.1.2 Provides coverage to one or more employees of a small employer located in this state, without regard to whether the policy or certificate was issued in this state; and

3.1.1.3 Is in effect on or after the effective date of 18 Del.C. Ch. 72.

3.1.2 The provisions of 18 Del.C. Ch.72 and this Regulation shall not apply to an individual health insurance policy issued prior to the effective date of 18 Del.C. Ch. 72.

3.2

3.2.1 A carrier that provides individual health insurance policies to one or more of the employees of a small employer shall be considered a small employer carrier and shall be subject to the provisions of 18 Del.C. Ch. 72 and this Regulation with respect to such policies if the small employer contributes directly or indirectly to the premiums for the policies and the carrier is aware or should have been aware of such contributions.

3.2.2 In the case of a carrier that provides individual health insurance policies to one or more employees of a small employer, the small employer shall be considered to be an eligible small employer as defined in 18 Del.C. §7207(a)(3) and the small employer carrier shall be subject to 18 Del.C. §7207(a)(2) (relating to guaranteed issue of coverage) if:

3.2.2.1 The small employer has at least two (2) employees, and

3.2.2.2 The small employer contributes directly or indirectly to the premiums charged by the carrier, including, but not limited to the following conditions:

3.2.2.2.1 any portion of the premium or benefits is paid by or on behalf of the employee;

3.2.2.2.2 the health benefit plan is administered by the small employer;

3.2.2.2.3 an eligible employee or dependent is reimbursed, whether through wage adjustments or otherwise, by or on behalf of the small employer for any portion of the premium;

3.2.2.2.4 the health benefit plan is treated by the employer or any of the eligible employees or dependents as part of a plan or program for the purposes of Section 162, Section 125, or Section 106 of the United States Internal Revenue Code.

3.3 The provisions of 18 Del.C. Ch. 72 and this Regulation shall apply to a health benefit plan provided to a small employer or the employees of a small employer without regard to whether the health benefit plan is offered under or provided through a group policy or trust arrangement of any size sponsored by an association of discretionary group.

3.4 An individual health insurance policy shall not be subject to the provisions of 18 Del.C. Ch. 72 and this Regulation solely because the policyholder elects a deduction under Section 162(1) of the Internal Revenue Code.

3.5

3.5.1 If a small employer is issued a health benefit plan under the terms of 18 Del.C. Ch. 72, the provisions of 18 Del.C. Ch. 72 and this Regulation shall continue to apply to the health benefit plan in the case that the small employer subsequently employs more than twenty-five (25) eligible employees. A carrier providing coverage to such an employer shall, within sixty (60) days of becoming aware that the employer has more than twenty-five (25) eligible employees but no later than the anniversary date of the employer's health benefit plan, notify such employer that the protections provided under 18 Del.C. Ch. 72 and this Regulation shall cease to apply to the employer if such employer fails to renew its current health benefit plan or elects to enroll in a different health benefit plan.

3.5.2

3.5.2.1 If a health benefit plan is issued to an employer that is not a small employer as defined in 18 Del.C. Chapter 72, but subsequently the employer becomes a small employer (due to the loss or change of work status of one or more employees), the terms of Chapter 72 shall not apply to the health benefit plan. The carrier providing a health benefit plan to such an employer shall not become a small employer carrier under the terms of 18 Del.C. Ch. 72 solely because such carrier continues to provide coverage under the health benefit plan to the employer.

3.5.2.2 A carrier providing coverage to an employer described in section 3.5.2.1 shall, within sixty (60) days of becoming aware that the employer has twenty-five (25) or fewer eligible employees, notify such employer of the options and protections available to the employer under 18 Del.C. Ch. 72, including the employer's option to purchase a small employer health benefit plan from any small employer carrier.

3.6

3.6.1

3.6.1.1 If a small employer has employees in more than one state, the provisions of 18 Del.C. Ch. 72 and this Regulation shall apply to a health benefit plan issued to the small employer if:

3.6.1.1.1 the majority of eligible employees of such small employer are employed in this state; or

3.6.1.1.2 if no state contains a majority of the eligible employees of such small employer, the primary business location of the small employer is in this state.

3.6.1.2 In determining whether the laws of this state or another state apply to a health benefit plan issued to a small employer described in section 3.6.1.1, the provisions of such paragraph shall be applied as of the date the health benefit plan was issued to the small employer for the period that such health benefit plan remains in effect.

3.6.2 If a health benefit plan is subject to 18 Del.C. Ch. 72 and this Regulation, the provisions of Chapter 72 and this Regulation shall apply to all individuals covered under such health benefit plan, whether they reside in this state or in another state.

3.7 A carrier that is not operating as a small employer carrier in this state shall not become subject to the provisions of 18 Del.C. Chapter 72 and this regulation solely because a small employer that was issued a health benefit plan in another state by such carrier moves to this state.

4.0 Establishment of classes of business

4.1 A small employer carrier that establishes more than one class of business pursuant to the provisions of 18 Del.C. §7204 shall maintain on file for inspection by the Commissioner the following information with respect to each class of business so established:

4.1.1 A description of each criterion employed by the carrier (or any of its agents) for determining membership in the class of business;

4.1.2 A statement describing the justification for establishing the class as a separate class of business and documentation that the establishment of the class of business is intended to reflect substantial differences in expected claims experience or administrative costs related to the reasons set forth in 18 Del.C. §7204; and

4.1.3 A statement disclosing which, if any, health benefit plans are currently available for purchase in the class and any significant limitations related to the purchase of such plans.

4.2 A carrier may not directly or indirectly use group size as a criterion for establishing eligibility for a health benefit plan or for a class of business.

5.0 Transition for assumptions of business from another carrier

5.1

5.1.1 A small employer carrier shall not transfer or assume the entire insurance obligation and/or risk of a health benefit plan covering a small employer in this state unless:

5.1.1.1 the transaction has been approved by the Commissioner of the state of domicile of the assuming carrier;

5.1.1.2 The transaction has been approved by the Commissioner of the state of domicile of the ceding carrier; and

5.1.1.3 The transaction otherwise meet the requirements of this section.

5.1.2 A carrier domiciled in this state that proposes to assume or cede the entire insurance obligation and/or risk of one or more small employer health benefit plan from another carrier shall make a filing for approval with the Commissioner at least sixty (60) days prior to the date of the proposed assumption. The Commissioner may approve the transaction if the Commissioner finds that the transaction is in the best interests of the individuals insured under the health benefit plan to be transferred and is consistent with the purposes of 18 Del.C., Ch. 72, and this Regulation. The Commissioner shall not approve the transaction until at least thirty (30) days after the date of the filing; except that, if the ceding carrier is in hazardous financial condition, the Commissioner may approve the transaction as soon as the Commissioner deems reasonable after the filing.

5.1.3

5.1.3.1 The filing required under section 5.1.2 shall:

5.1.3.1.1 Describe the class of business (including any eligibility requirements) of the ceding carrier from which the health benefit plans will be ceded;

5.1.3.1.2 Describe whether the assuming carrier will maintain the assumed health benefit plans as a separate class of business (pursuant to section 5.3 or will incorporate them into an existing class of business (pursuant to section 5.4. If the assumed health benefit plans will be incorporated into an existing class of business, the filing shall describe the class of business of the assuming carrier into which the health benefit plans will be incorporated;

5.1.3.1.3 Describe whether the health benefit plans being assumed are currently available for purchase by small employers;

5.1.3.1.4 Describe the potential effect of the assumption (if any) on the benefits provided by the health benefit plans to be assumed;

5.1.3.1.5 Describe the potential effect of the assumption (if any) on the premiums for the health benefit plans to be assumed; and

5.1.3.1.6 Describe any other potential material effects of the assumption on the coverage provided to the small employers covered by the health benefit plans to be assumed.

5.1.3.1.7 Include any other information required by the Commissioner.

5.1.3.2 A small employer carrier required to make the filing under section 5.1.2 shall also make an informational filing with the Commissioner of each state in which there are small employer health benefit plans that would be included in the transaction. The informational filing to each state shall be made concurrently with the filing made under section 5.1.2 and shall include at least the information specified in section 5.1.3.1 for the small employer health benefit plans in that state.

5.1.4 A small employer carrier shall not transfer or assume the entire insurance obligation and/or risk of a health benefit plan covering a small employer in this state unless it complies with the following:

5.1.4.1 The carrier has provided notice to the Commissioner at least sixty (6) days prior to the date of the proposed assumption. The notice shall contain the information specified in

section 5.1.3 for the health benefit plans covering small employers in this state.

5.1.4.2 If the assumption of the class of business would result in the assuming small employer carrier being out of compliance with the limitations related to premium rates contained in 18 Del.C. §7205(a)(1), the assuming carrier shall make a filing with the Commissioner seeking suspension of the application of 18 Del.C. §7205(a)(1).

5.1.4.3 An assuming carrier seeking suspension of the application of 18 Del.C. §7205(a)(1) shall not complete the assumption of the class of business unless the Commissioner grants the suspension requested pursuant to section 5.1.3.2.

5.1.4.4 Unless a different period is approved by the Commissioner, a suspension of the application of 18 Del.C. §7205(a)(1) shall, with respect to and assumed class of business, be for no more than fifteen (15) months and, with respect to each individual small employer, shall last only until the anniversary date of such employer's coverage (except that the period with respect to an individual small employer may be extended for a period of up to twelve (12) months if such small employer's anniversary date occurs within three (3) months of the date of assumption of the class of business).

5.2

5.2.1 Except as provided in section 5.1.2, a small employer carrier shall not cede or assume the entire insurance obligation and/or risk for a small employer health benefit plan unless the transaction includes the ceding to the assuming carrier of the entire class of business which includes such health benefit plan.

5.2.2 A small employer carrier may cede less than an entire class of business to an assuming carrier if:

5.2.2.1 One or more small employers in such class have exercised their right under contract or state law to reject (either directly or by implication) the ceding of their health benefit plans to another carrier. In such instance, the transaction shall include each health benefit plan in the class of business except those health benefit plans for which a small employer has rejected the proposed cession; or

5.2.2.2 After a written request from the transferring carrier, the Commissioner determines that the transfer of less than the entire class of business is in the best interests of the small employers insured in such class of business.

5.3 Except as provided in section 5.4, a small employer carrier that assumes one or more health benefit plans from another carrier shall maintain such health benefit plans as a separate class of business.

5.4 A small employer carrier that assumes one or more health benefit plans from another carrier may exceed the limitation contained in 18 Del.C. §7204(b) (relating to the maximum number of classes of business a carrier may establish) due solely to such assumption for up to a period of fifteen (15) months after the date of the assumption, provided that the carrier complies with the following provisions:

5.4.1 Upon assumption of the health benefit plans, such health benefit plans shall be maintained as a separate class of business. During the fifteen (15) month period following the assumption, each of the assumed small employer health benefit plans shall be transferred by the assuming small employer carrier into a single class of business operated by the assuming small employer carrier. The assuming small employer carrier shall select the class of business into which the assumed health benefit plans will be transferred in a manner such that the transfer results in the least possible change to the benefits and rating method of the assumed health benefit plans.

5.4.2 The transfers authorized in section 5.4.1 shall occur with respect to each small employer on the anniversary date of the employer's coverage, except that the period may be extended for a period that is no greater than twelve (12) months for small employers whose anniversary dates occur within three (3) months of the date of assumption of the class of business.

5.4.3 A small employer carrier making a transfer pursuant to section 5.4.1 may alter the benefits of the assumed health benefit plans to conform to the benefits currently offered by the carrier in the class of business into which the health benefits plans have been transferred.

5.4.4 The premium rate for an assumed small employer health benefit plan shall not be modified by the assuming small employer carrier until the health benefit plan is transferred

pursuant to section 5.4.1. Upon such transfer, the assuming small employer carrier shall calculate a new premium rate for the health benefit plan from the rate manual established for the class of business into which the health benefit plan is transferred. In making such calculation, the risk load applied to the health benefit plan shall be no higher than the risk load applicable to such health benefit plan prior to the assumption.

5.5 During the fifteen (15) month period provided in this subsection, the transfer of small employer health benefit plans from the assumed class of business in accordance with this subsection shall not be considered a violation of the first sentence of 18 Del.C. §7204(e).

5.6 An assuming carrier may not apply eligibility requirements (including minimum participation and contribution requirements) with respect to an assumed health benefit plan (or with respect to any health benefit plan subsequently offered to a small employer covered by such an assumed health benefit plan) that are more stringent than the requirements applicable to such health benefit plan prior to the assumption.

5.7 The Commissioner may approve a longer period of transition upon application of a small employer carrier. The application shall be made within sixty (60) days after the date of assumption of the class of business and shall clearly state the justification for a longer transition period.

5.8 Nothing in this Section or in 18 Del.C. Ch. 72 is intended to:

5.8.1 Reduce or diminish any legal or contractual obligation or requirement, including any obligation provided in 18 Del.C. Ch. 9, Reinsurance, of the ceding or assuming carrier related to the transaction;

5.8.2 Authorize a carrier that is not admitted to transact the business of insurance in this state to offer or insure health benefit plans in this state; or

5.8.3 Reduce or diminish the protections related to an assumption reinsurance transaction provided in 18 Del.C. Ch. 9, or otherwise provided by law.

6.0 Restrictions relating to premium rates

6.1

6.1.1 A small employer carrier shall develop a separate rate manual for each class of business. Base premium rates and new business premium rates charged to small employers by the small employer carrier shall be computed solely from the applicable rate manual developed pursuant to this subsection. To the extent that a portion of the premium rates charged by a small employer carrier is based on the carrier's discretion, the manual shall specify the criteria and factors considered by the carrier in exercising such discretion.

6.1.2

6.1.2.1 A small employer carrier shall not modify the rating method used in the rate manual for a class of business until the change has been approved as provided in this paragraph. The Commissioner may approve a change to a rating method if the Commissioner finds that the change is reasonable, actuarially appropriate, and consistent with the purposes of 18 Del.C. Ch. 72 and this Regulation.

6.1.2.2 A carrier may modify the rating method for a class of business only with prior approval of the Commissioner. A carrier requesting to change the rating method for a class of business shall make a filing with the Commissioner at least sixty (60) days prior to the proposed date of the change. The filing shall contain at least the following information:

6.1.2.2.1 The reasons the change in rating method is being requested;

6.1.2.2.2 A complete description of each of the proposed modifications to the rating method;

6.1.2.2.3 A description of how the change in rating method would affect the premium rates currently charged to small employers in the class of business, including an estimate from a qualified actuary of the number of groups or individuals (and a description of the types of groups or individuals) whose premium rates may change by more than ten percent (10%) due to proposed change in rating method (not including general increases in premium rates applicable to all small employers in a health benefit plan);

6.1.2.2.4 A certification from a qualified actuary that the new rating method would be based on objective and credible data and would be actuarially sound and appropriate; and

6.1.2.2.5 A certification from a qualified actuary that the proposed change in rating method would not produce premium rates for small employers that would be in violation 18 Del. C. §7205.

6.1.2.3 For the purpose of this section, a change in rating method shall mean:

6.1.2.3.1 A change in the number of case characteristics used by a small employer carrier to determine premium rates for health benefit plans in a class of business;

6.1.2.3.2 A change in the manner or procedures by which insureds are assigned into categories for the purpose of applying a case characteristic to determine premium rates for health benefit plans in a class of business;

6.1.2.3.3 A change in the method of allocating expenses among health benefit plans in a class of business; or

6.1.2.3.4 A change in a rating factor with respect to any case characteristic if the change would produce a change in premium for any small employer that exceeds ten percent (10%).

6.1.2.4 For the purpose of section 6.1.2.3.1, a change in a rating factor shall mean the cumulative change with respect to such factor considered over a twelve (12) month period. If a small employer carrier changes rating factors with respect to more than one case characteristic in a twelve (12) month period, the carrier shall consider the cumulative effect of all such changes in applying the ten percent (10%) test under section 6.1.2.3.1.

6.2

6.2.1 The rate manual developed pursuant to section 6.1.1 shall specify the case characteristics and rate factors to be applied by the small employer carrier in establishing premium rates for the class of business.

6.2.2 A small employer carrier may not use case characteristics other than those specified in 18 Del.C. §7202 (g) without the prior approval of the Commissioner. A small employer carrier seeking such an approval shall make a filing with the Commissioner for a change in rating method under section 6.1.2.1.

6.2.3 A small employer carrier shall use the same case characteristics in establishing premium rates for each health benefit plan in a class of business and shall apply them in the same manner in establishing premium rates for each such health benefit plan. Case characteristics shall be applied without regard to the risk characteristics of a small employer.

6.2.4 The rate manual developed pursuant to section 6.1.1 shall clearly illustrate the relationship among the base premium rates charged for each health benefit plan in the class of business. If the new business premium rate is different than the base premium rate for a health benefit plan, the rate manual shall illustrate such difference.

6.2.5 Differences among base premium rates for health benefit plans shall be based solely on the reasonable and objective differences in the design and benefits of the health benefit plans and shall not be based in any way on the actual or expected health status or claims experience of the small employer groups that choose or are expected to choose a particular health benefit plan. A small employer carrier shall apply case characteristics and rate factors within a class of business in a manner that assures that premium differences among health benefit plans for identical small employer groups vary only due to reasonable and objective differences in the design and benefits of the health benefit plans and are not due to the actual or expected health status or claims experience of the small employer groups that choose or are expected to choose a particular health benefit plan.

6.2.6 The rate manual developed pursuant to section 6.1.1 shall provide for premium rates to be developed in a two step process. In the first step, a base premium rate shall be developed for the small employer group without regard to any risk characteristics of the group. In the second step, the resulting base premium rate may be adjusted by a risk load, subject to the provisions of 18 Del.C. §7205 to reflect the risk characteristics of the group.

6.2.7

6.2.7.1 Except as provided in section 6.2.7.2, a premium charged to a small employer for a health benefit plan small employer carrier shall not include a separate application fee, underwriting fee, or any other separate fee or charge.

6.2.7.2 A carrier may charge a separate fee with respect to a health benefit plan (but only one fee with respect to such plan) provided the fee is no more than five dollars (\$5.00) per month per employee and is applied in a uniform manner to each health benefit plan in a class of business.

6.2.8 A small employer carrier shall allocate administrative expenses to the basic and standard health benefit plans on no less favorable a basis than expenses allocated to other health benefit plans in the class of business. The rate manual developed pursuant to section 6.1.1 shall describe the method of allocating administrative expenses to the health benefit plans in the class of business for which the manual was developed.

6.2.9 Each rate manual developed pursuant to section 6.1.1 shall be maintained by the carrier for a period of six (6) years. Updates and changes to the manual shall be maintained with the manual.

6.2.10 The rate manual and rating practices of a small employer carrier shall comply with any guidelines issued by the Commissioner.

6.3 If group size is used as a case characteristic by a small employer carrier, the highest rate factor associated with a group size classification shall not exceed the lowest rate factor associated with such a classification by more than twenty (20%) percent.

6.4 The restrictions related to changes in premium rates in 18 Del.C. §§7205 (a)(3) and 7205 (a)(7) shall be applied as follows:

6.4.1 A small employer carrier shall revise its rate manual each rating period to reflect changes in base premium rates and changes in new business premium rates.

6.4.2

6.4.2.1 If, for any health benefit plan with respect to any rating period, the percentage change in the new business premium rate is less than or the same as the percentage change in the base premium rate, the change in the new business

premium rate shall be deemed to be the change in the base premium rate for the purposes of 18 Del.C. §§7205 (a)(3)(c) and 7205 (a)(7)(a).

6.4.2.2 If, for any health benefit plan with respect to any rating period, the percentage change in the new business premium rate exceeds the percentage change in the base premium rate, the health benefit plan shall be considered a health benefit plan into which the small employer carrier is no longer enrolling new small employers for the purposes of 18 Del.C. §§7205 (a)(3) and 7205 (a)(7) of Chapter 72.

6.4.2.3 If, for any rating period, the change in the new business premium rate for a health benefit plan differs from the change in the new business premium rate for any other health benefit plan in the same class of business by more than twenty (20%) percent, the carrier shall make a filing with the Commissioner containing a complete explanation of how the respective changes in new business premium rates were established and the reason for the difference. Such filing shall be made within thirty (30) days of the beginning of such rating period.

6.4.2.4 A small employer carrier shall keep on file for a period of at least six (6) years the calculations used to determine the change in base premium rates and new business premium rates for each health benefit plan for each rating period.

6.5

6.5.1 Except as provided in sections 6.4.2.1 through 6.4.2.4, a change in premium rate for a small employer shall produce a revised premium rate that is no more than the following:

6.5.1.1 the base premium rate for the small employer (as shown in the rate manual as revised for the rating period), multiplied by

6.5.1.2 one (1) plus the sum of:

6.5.1.2.1 the risk load applicable to the small employer during the previous rating period, and

6.5.1.2.2 fifteen (15%) percent (prorated for periods of less than one year).

6.5.2 In the case of a health benefit plan into which a small employer carrier is no longer enrolling new small employers, a change in premium rate for a small employer shall produce a revised premium rate that is no more than the following:

6.5.2.1 the base premium rate for the small employer (given its present composition and as shown in the rate manual in effect for the small employer at the beginning of the previous rating period), multiplied by

6.5.2.2 one (1) plus the lesser of:

6.5.2.2.1 the change in the base rate or (ii) the percentage change in the new business premium for the most similar health benefit plan into which the small employer carrier is enrolling new small employers, multiplied by (c) one (1) plus the sum of:

6.5.2.2.1.1 the risk load applicable to the small employer during the previous rating period and

6.5.2.2.1.2 fifteen (15%) percent (prorated for periods of less than one year).

6.5.3 In the case of a health benefit plan described in 18 Del.C. §7205(a)(6), if the current premium rate for the health benefit plan exceeds the ranges set forth in 18 Del.C. §7205 (a), the formulae set forth in sections 6.5.1 and 6.5.2 will be applied as if the fifteen (15%) percent adjustment provided in section 6.5.1.2.2 and Paragraph (2)(c)(ii) (?) were a zero (0) percent adjustment.

6.5.4 Notwithstanding the provisions of section 6.5.1 and 6.5.2, a change in premium rate for a small employer shall not produce a revised premium rate that would exceed the limitations on rates provided in 18 Del.C. §7205(a)(2).

6.6

6.6.1 A representative of a Taft Hartley trust (including a carrier upon the written request of such a trust) may file in writing with the Commissioner a request for the waiver of application of the provisions of 18 Del.C. §7205 (a) with respect to such trust.

6.6.2 A request made under section 6.5.1 shall identify the provisions for which the trust is seeking the waiver and shall describe, with respect to each such provision, the extent to which application of such provision would:

6.6.2.1 adversely affect the participants and beneficiaries of the trust; and

6.6.2.2 require modifications to one or more of the collective bargaining agreements under or pursuant to which the trust was or is established or maintained.

6.6.2.3 A waiver granted under 18 Del.C. Ch. 72 shall not apply to an individual who participates in the trust because such individual is an associate member of an employee organization or the beneficiary of such an individual.

7.0 Requirement to insure entire groups

7.1

7.1.1 A small employer carrier that offers coverage to a small employer shall offer to provide coverage to each eligible employee and to each dependent of an eligible employee. Except as provided in section 7.1.2 and 7.1.3, the small employer carrier shall provide the same health benefit plan to each such employee and dependent.

7.1.2 A small employer carrier may offer the employees of a small employer the option of choosing among one or more health benefit plans, provided that each employee may choose any of the offered plans. Except as provided in 18 Del.C. §7207 (c) (with respect to exclusions for preexisting conditions) the choice among benefit plans may not be limited, restricted or conditioned based upon the risk characteristics of the employees or their dependents.

7.2

7.2.1 A small employer carrier shall require each small employer that applies for coverage, as part of the application process, to provide a complete list of eligible employees as defined in 18 Del.C. §§7202 (m) and 7202 (n). The small employer carrier shall require the small employer to provide appropriate supporting documentation (such as the W-2 Summary Wage and Tax Form) to verify the information required under this paragraph.

7.2.2 A small employer carrier shall secure a waiver with respect to each eligible employee and each dependent of an eligible employee who declines an offer of coverage under a health benefit plan provided to a small employer. A small employer carrier may issue a health benefit plan to a small employer that excludes an eligible employee or the dependent of an eligible employee only if:

7.2.2.1 The excluded individual does not have a risk characteristic or other attribute that would cause the carrier to make a decision with respect to premiums or eligibility for a health benefit plan that is adverse to the small employer, or

7.2.2.2 The excluded individual can demonstrate that he or she has waived coverage for other legitimate reasons, such as that found in 18 Del.C. §7207 (c)(4)c.

If unwillingness to make a premium contribution is the reason stated for waiver of coverage under section 7.2.2.1, the small employer carrier shall take affirmative steps to verify the voluntary nature of the waiver. The waiver shall be signed by the eligible employee (on behalf of such employee or the dependent of such employee) and shall certify that the individual who declined coverage was informed of the availability of coverage under the health benefit plan. The waiver form shall require that the reason for declining coverage be stated on the form and shall include a written warning of the penalties imposed on late enrollees. Waivers shall be maintained by the small employer carrier for a period of six (6) years.

7.2.2.3

7.2.2.3.1 A small employer carrier shall not issue coverage to a small employer that refuses to provide the list required under section 7.2.1 or a waiver required under section 7.2.2.

7.2.2.3.2

7.2.2.3.2.1 A small employer carrier shall not issue coverage to a small employer if the carrier, or a producer for such carrier, has reason to believe that the small employer has induced or pressured an eligible employee (or dependent of an eligible employee) to decline coverage due to the individual's risk characteristics.

7.2.2.3.2.2 A producer shall notify a small employer carrier, prior to submitting an application for coverage with the carrier on behalf of a small employer, of any circumstances that would indicate that the small employer has induced or pressured an eligible employee (or the dependent of an eligible employee) to decline coverage due to the individual's risk characteristics.

7.2.2.4

7.2.2.4.1 New entrants to a small employer group shall be offered an opportunity to enroll in the health benefit plan currently held by such group. A new entrant that does not exercise the opportunity to enroll in the health benefit plan within the period provided by the small employer carrier may be treated as a late enrollee by such carrier, provided that the period provided to enroll in the health benefit plan extends at least thirty (30) days after the date the new entrant is notified of his or her opportunity to enroll. If a small employer carrier has offered more than one health benefit plan to a small employer group pursuant to section 7.1.2, the new entrant shall be offered the same choice of health benefit plans as the other members of the group.

7.2.2.4.2 A small employer carrier shall not apply a waiting period, elimination period or other similar limitation of coverage (other than an exclusion for preexisting medical conditions consistent with 18 Del.C. §7207 (c)(2)) with respect to a new entrant that is longer than sixty (60) days.

7.2.2.4.3 New entrants to a group shall be accepted for coverage by the small employer carrier without any restrictions or limitations on coverage related to the risk characteristics of the employees or their dependents, except that a carrier may exclude coverage for preexisting medical conditions, subject to the provisions provided in 18 Del.C. §7207 (c).

7.2.2.4.4 A small employer carrier may assess a risk load to the premium rate associated with a new entrant, consistent with the requirements of 18 Del.C. §7205. The risk load shall be at the same risk load charged to the small employer group immediately prior to acceptance of the new entrant into the group.

7.2.2.5

7.2.2.5.1

7.2.2.5.1.1 In the case of an eligible employee (or dependent of an eligible employee) who, prior to the effective date of 18 Del.C. §7207(a), was excluded from coverage or denied coverage by a small employer carrier in the process of providing a health benefit plan to an eligible small employer (as defined in 18 Del.C. §7207 (a)(3)), the small employer carrier shall provide an opportunity for the eligible employee (or dependent of such eligible employee) to enroll in the health benefit plan currently held by the small employer.

7.2.2.5.1.2 A small employer carrier may require an individual who requests enrollment under this subsection to sign a statement indicating that such individual sought coverage under the group contract (other than as a late enrollee) and that such coverage was not offered to the individual.

7.2.2.5.2 The opportunity to enroll shall meet the following requirements:

7.2.2.5.2.1 The opportunity to enroll shall begin March 31, 1992, and shall last for a period of at least three (3) months.

7.2.2.5.2.2 Eligible employees and dependents of eligible employees who are provided an opportunity to enroll pursuant to this subsection shall be treated as new entrants. Premium rates related to such individuals shall be set in accordance with section 7.2.2.4.1.

7.2.2.5.2.3 The terms of coverage offered to an individual described in section 7.2.2.5.1.1 may exclude coverage for preexisting medical conditions if the health benefit plan currently held by the small employer contains such an exclusion, provided that such exclusion period shall be reduced by the number of days between the date the individual was excluded or denied coverage and the date coverage is provided to such individual pursuant to this subsection.

7.2.2.5.2.4 A small employer carrier shall provide written notice at least forty-five (45) days prior to the opportunity to enroll provided in section 7.2.2.5.1.1 to each small employer insured under a health benefit plan offered by such carrier. The notice shall clearly describe the rights granted under this subsection to employees and dependents who were previously excluded from or denied coverage and the process for enrollment of such individuals in the employer's health benefit plan.

8.0 Consideration of industry

8.1 Except as provided in section 8.2 and 8.3, a small employer carrier may not consider the trade or occupation of the employees of a small employer or the industry or type of business in which the small employer is engaged in determining whether to issue or continue to provide coverage to the small employer.

8.2 A small employer carrier may use industry as a case characteristic in establishing premium rates, subject to 18 Del.C. §7205 (a)(6).

8.3 A small employer carrier may consider trade, occupation or industry as part of the eligibility criteria for a class of business, subject to 18 Del. C. §7207 (a)(2)b.

9.0 Application to reenter state

9.1 A carrier that has been prohibited from writing coverage for small employers in this state pursuant to 18 Del.C. §7206(b) may not resume offering health benefit plans to small employers in this state until the carrier has made a petition to the Commissioner to be reinstated as a small employer carrier and the petition has been approved by the Commissioner. In reviewing a petition, the Commissioner may ask for such information and assurances as the Commissioner finds reasonable and appropriate.

9.2 In the case of a small employer carrier doing business in only one established geographic service area of the state, if the small employer carrier elects to nonrenew a health benefit plan under 18 Del.C. §7206 (a)(6), the small employer carrier shall be prohibited from offering health benefit plans to small employers in any part of the service area for a period of five (5) years. In addition, the small employer carrier shall not offer health benefit plans to small employers carrier in any other geographic area of the state without the prior approval of the Commissioner. In considering whether to grant approval, the Commissioner may ask for such information and assurances as the Commissioner finds reasonable and appropriate.

10.0 Qualifying previous and qualifying existing coverages

10.1 In determining whether a health benefit plan or other health benefit arrangement (whether public or private) shall be considered qualifying previous coverage or qualifying existing coverage for the purposes of 18 Del.C. §§7202 (r), 7207 (c)(2) and 18 Del.C. §7207 (c)(5), a small employer carrier shall interpret the

Chapter no less favorably to an insured individual than the following:

10.1.1 A health insurance policy, certificate or other health benefit arrangement shall be considered employer-based if an employer sponsors the plan or arrangement or makes a contribution to the plan or arrangement.

10.1.2 A health insurance policy, certificate or other benefit arrangement shall be considered to provide benefits similar to or exceeding the benefits provided under the basic health benefit plan if the policy, certificate or other benefit arrangement provides benefits that:

10.1.2.1 Have an actuarial value (as considered for a normal distribution of groups) that is not substantially less than the actuarial value of the basic health benefit plan; or

10.1.2.2 Provides coverage for hospitalization and physician services that is substantially similar to or exceeds the coverage for such services in the basic health benefit plan.

10.1.3 In making a determination under this subsection, a small employer carrier shall evaluate the previous or existing policy, certificate or other benefit arrangement taken as a whole and shall not base its decision solely on the fact that one portion of the previous or existing policy, certificate or benefit arrangement provides less coverage than the comparable portion of the basic health benefit plan.

10.2 For the purposes of 18 Del.C. §7207 (c)(2), an individual will be considered to have qualifying previous coverage with respect to a particular service if the previous policy, certificate or other benefit arrangement covering such individual met the definition of qualifying previous coverage contained in 18 Del.C. §7202 (x) and provided any benefit with respect to the service.

10.3 A small employer carrier shall ascertain the source of previous or existing coverage of each eligible employee and each dependent of an eligible employee at the time such employee or dependent initially enrolls into the health benefit plan provided by the small employer carrier. The small employer carrier shall have the responsibility to contact the source of such previous or existing coverage to resolve any questions about the benefits or limitations related to such previous or existing coverage.

11.0 Restrictive riders

11.1 A restrictive rider, endorsement or other provision that would violate the provisions of 18 Del.C. §7207 (c)(5)(b) and that was in force on the effective date of this Regulation may not remain in force beyond the first anniversary date of the health benefit plan subject to the restrictive provision that follows the effective date of this Regulation. A small employer carrier shall provide written notice to those small employers whose coverage will be changed pursuant to this subsection at least thirty (30) days prior to the required change to the health benefit plan.

11.2 Except as permitted in 18 Del.C. §7207 (c)(2), a small employer carrier shall not modify or restrict a basic or standard health benefit plan in any manner for the purposes of restricting or excluding coverage or benefits for specific diseases, medical conditions or services otherwise covered by the plan.

11.3 Except as permitted in 18 Del.C. §7207 (c)(2), a small employer carrier shall not modify or restrict any health benefit plan with respect to any eligible employee or dependent, through riders, endorsements or otherwise, for the purpose of restricting or excluding coverage or benefits for specific diseases, medical conditions or services otherwise covered by the plan.

12.0 Rules related to fair marketing

12.1

12.1.1 A small employer carrier shall actively market each of its health benefit plans to small employers in this state. A small employer carrier may not suspend the marketing or issuance of the basic and standard health benefit plans unless the carrier has good cause and has received the prior approval of the Commissioner.

12.1.2 In marketing the basic and standard health benefit plans to small employers, a small employer carrier shall use at least the same sources and methods of distribution that it uses to market other health benefit plans to small employers. Any producer authorized by a small employer carrier to market health benefit plans to small employers in the state shall also be authorized to market the basic and standard health benefit plans.

12.2

12.2.1 A small employer carrier shall offer at least the basic and standard health benefit plans, as found in Appendix A and Appendix B of this Regulation, to any small employer that applies for or makes an inquiry regarding health insurance coverage from the small employer carrier. The offer shall be in writing and shall include at least the following information:

12.2.1.1 a general description of the benefits contained in the basic and standard health benefit plans and any other health benefit plan being offered to the small employer, and

12.2.1.2 information describing how the small employer may enroll in the plans. The offer may be provided directly to the small employer or delivered through a producer.

12.2.2

12.2.2.1 A small employer carrier shall provide a price quote to a small employer (directly or through an authorized producer) within ten (10) working days of receiving a request for a quote and such information as is necessary to provide the quote. A small employer carrier shall notify a small employer (directly or through an authorized producer) within five (5) working days of receiving a request for a price quote of any additional information needed by the small employer carrier to provide the quote.

12.2.2.2 A small employer carrier may not apply more stringent or detailed requirements related to application for enrollment for the basic and standard health benefit plans than are applied for other health benefit plans offered by the carrier.

12.2.3

12.2.3.1 If a small employer carrier denies coverage under a health benefit plan to a small employer on the basis of a risk characteristic, the denial shall be in writing and shall state with specificity the reasons for the denial (subject to any restrictions related to confidentiality of medical information). The written denial shall be accompanied by a written explanation of the availability of the basic and standard health benefit plans from the small employer carrier. The explanation shall include at least the following:

12.2.3.1.1 A general description of the benefits contained in each such plan;

12.2.3.1.2 A price quote for each such plan; and (iii) Information describing how the small employer may enroll in such plans.

The written information described in this subparagraph may be provided (within the time periods provided in section 12.2.2.1 directly to the small employer or delivered through an authorized producer.

12.2.3.2 The price quote required under section 12.2.3.1.2 shall be for the lowest-priced basic and standard health benefit plan for which the small employer is eligible.

12.3 A small employer carrier shall establish and maintain a toll-free telephone service to provide information to small employers regarding the availability of small employer health benefit plans in this state. Such service shall provide information to callers on how to apply for coverage from the carrier. Such information may include the names and phone numbers of producers located geographically proximate to the caller or such other information that is reasonably designed to assist the caller to locate an authorized producer or to otherwise apply for coverage.

12.4 The small employer carrier shall not require a small employer to join or contribute to any association or group as a condition of being accepted for coverage by the small employer carrier, except that, if membership in an association or other group is a requirement for accepting a small employer into a particular health benefit plan, a small employer carrier may require the small employer to be a member of the association or group as a condition of eligibility for the health benefit plan, subject to the requirements of 18 Del.C. §7207 (a)(2)(b).

12.5 A small employer carrier may not require, as a condition to the offer or sale of a health benefit plan to a small employer, that the small employer purchase or qualify for any other insurance product or service.

12.6

12.6.1 Carriers offering individual and group health benefit plans in this state shall be responsible for determining whether the plans are subject to the requirements of 18 Del.C. Ch. 72 and this Regulation. Carriers shall elicit the following information from applicants for such plans at the time of application:

12.6.1.1 Whether or not any portion of the premium will be paid by or on behalf of a small employer, either directly or through wage adjustments or other means of reimbursement; and

12.6.1.2 Whether or not the prospective policyholder, certificateholder or any prospective insured individual intends to treat the health benefit plan as part of plan or program under Section 162 (other than Section 162(1)), Section 125 or Section 106 of the United States Internal Revenue Code.

12.6.2 If a small employer carrier fails to comply with section 12.6.1 such small employer carrier shall be deemed to be on notice of any information that could reasonably have been gained if the small employer carrier had complied with section 12.6.1.

12.7

12.7.1 A small employer carrier shall file annually the following information with the Commissioner related to health benefit plans issued by the small employer carrier to small employers in this state:

12.7.1.1 The number of small employers that were issued health benefit plans in the previous calendar year (separated as to newly issued plans and renewals);

12.7.1.2 The number of small employers that were issued the basic health benefit plan and the standard health benefit plan in the previous calendar year (separated as to newly issued plans and renewals and as to class of business);

12.7.1.3 The number of small employer health benefit plans in force in each county (or by zip code) of the state as of December 31 of the previous calendar year;

12.7.1.4 The number of small employer health benefit plans that were voluntarily not renewed by small employers in the previous calendar year;

12.7.1.5 The number of small employer health benefit plans that were terminated or nonrenewed (for reasons other than nonpayment of premium) by the carrier in the previous calendar year; and

12.7.1.6 The number of small employer health benefit plans that were issued to small employers that were uninsured for at least the three months prior to issue.

12.7.2 The information described in section 12.7.1 shall be filed no later than March 15 of each year.

13.0 Status of carriers as small employer carriers

13.1 Within 30 days after the effective date of 18 Del.C. Ch. 72, each carrier providing health benefit plans in this state shall make a filing with the Commissioner indicating whether the carrier intends to operate as a small employer carrier in this state under the terms of this Regulation.

13.2 Subject to section 13.3, a carrier shall not offer health benefit plans to small employers, or continue to provide coverage under health benefit plans previously issued to small employers in this state, unless the filing provided pursuant to section 13.1 indicates that the carrier intends to operate as a small employer carrier in this state.

13.3

13.3.1 If the filing made pursuant to section 13.1 indicates that a carrier does not intend to operate as a small employer carrier in this state, the carrier may continue to provide coverage under health benefit plans previously issued to small employers in this state only if the carrier complies with the following provisions:

13.3.1.1 The carrier complies with the requirements of 18 Del.C. Ch. 72 (other than 18 Del.C. §§ 7208, 7209, and 7210) with respect to each of the health benefit plans previously issued to small employers by the carrier.

13.3.2 The carrier provides coverage to each new entrant to a health benefit plan previously issued to a small employer by such carrier. The provisions of 18 Del.C. Ch. 72 (other than 18 Del.C. §§7208, 7209, and 7210) and this Regulation shall apply to the coverage issued to such new entrants.

13.3.3 The carrier complies with the requirements of 18 Del. C. Ch. 72 §3 and section 11.0 of this Regulation as they apply to small employers whose coverage has been terminated by the carrier and to individuals and small employers whose coverage has been limited or restricted by the carrier.

13.4 A carrier that continues to provide coverage pursuant to this subsection shall not be eligible to participate in the reinsurance program established under 18 Del.C. §7210.

13.5 If the filing made pursuant to Subsection A (13.1) indicates that a carrier does not intend to operate as a small employer carrier in this state, the carrier shall be precluded from operating as a small employer carrier in this state (except as provided for in section 13.3) for a period of five (5) years from the date of such filing. Upon a written request from such a carrier, the Commissioner may reduce the period provided for in such sentence if the Commissioner finds that permitting the carrier to operate as a small employer carrier would be in the best interests of the small employers in the state.

14.0 Restoration of coverage

14.1

14.1.1 Except as provided in section 14.1.2, a small employer carrier shall, as a condition of continuing to transact business in this state with small employers, offer to provide a health benefit plan as described in section 14.3 to any small employer whose coverage was terminated or not renewed by such small employer carrier after January 9, 1992.

14.1.2 The offer required under section 14.1.1 shall not be required with respect to a health benefit plan that was not renewed if:

14.1.2.1 The health benefit plan was not renewed for reasons permitted in 18 Del.C. §7206 (a), or

14.1.2.2 The nonrenewal was a result of the small employer voluntarily electing coverage under a separate health benefit plan.

14.2 The offer made under section 14.1 shall occur not later than thirty (30) days after a carrier indicates its intention to operate as a small employer carrier in this state pursuant to section 13.3.1. A small employer shall be given at least sixty (60) days to accept an offer made pursuant to section 14.1.

14.3 A health benefit plan provided to a terminated small employer pursuant to Subsection A shall meet the following conditions:

14.3.1 The health benefit plan shall contain benefits that are identical to the benefits in the health benefit plan that was terminated or nonrenewed.

14.3.2 The health benefit plan shall not be subject to any waiting periods (including exclusion periods for preexisting conditions) or other limitations on coverage that exceed those contained in the health benefit plan that was terminated or nonrenewed. In applying such exclusions or limitations, the health benefit plan shall be treated as if it were continuously in force from the date it was originally issued to the date that it is restored pursuant to this 18 Del. C. Ch. 72, §3.

14.3.3 The health benefit plan shall not be subject to any provision that restricts or excludes coverage or benefits for specific diseases, medical conditions or services otherwise covered by the plan.

14.3.4 The health benefit plan shall provide coverage to all employees who are eligible employees as of the date the plan is restored. The carrier shall offer coverage to each dependent of such eligible employees.

14.3.5 The premium rate for the health benefit plan shall be no more than the premium rate charged to the small employer on the date the health benefit plan was terminated or nonrenewed; provided that, if the number or case characteristics of eligible employees (or their dependents) of the small employer has changed between the date the health benefit plan was terminated or nonrenewed and the date that it is restored, the carrier may adjust the premium rates to reflect any changes in case characteristics of the small employer. If the carrier has increased premium rates for other similar groups with similar coverage to reflect general increases in health care costs and utilization, the premium rate may further be adjusted to reflect the lowest such increase given to a similar group. The premium rate for the health benefit plan may not be increased to reflect any changes in risk characteristics of the small employer group until one year after the date the health benefit plan is restored. Any such increase shall be subject to the provisions of 18 Del.C. §7205.

14.3.6 The health benefit plan shall not be eligible to be reinsured under the provisions of 18 Del.C. §7209, except that the carrier may reinsure new entrants to the health benefit plan who enroll after the restoration of coverage.

15.0 Separability

15.1 If any provision of this regulation or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the regulation and the application of such provision to other persons or circumstances shall not be affected thereby.

16.0 Effective date

16.1 This regulation shall become effective on January 4, 1993, to correspond with the effective date of 18 Del.C. Ch. 72, under which authority Regulation 1308 (Formerly Regulation 72) is promulgated. The public welfare requires the promulgation of this regulation with less than 30 days' notice, and therefore, under the emergency provisions of 29 Del.C. §10123, this regulation may become effective less than 30 days from signature.

APPENDIX A -- PLAN ONE

BASIC INDEMNITY BENEFIT PLAN

BENEFIT BASIC INDEMNITY

Physician Services:

Prescribed

Periodic Screening Covered in full

The following primary care outpatient services are covered at the co-insurance amount after \$150 of services have been provided without co-insurance or deductible application:

Prenatal & postnatal office visits First \$150 paid, then 70%/30%

Primary care visits First \$150 paid, then 70%/30%

Surgery (outpatient) First \$150 paid, then 70%/30%

Diagnostic Lab (physician's office) First \$150 paid, then 70%/30%

Inpatient visits Covered in full after paying (Medical/surgical) deductible. Maximum 30 days per calendar year.

Outpatient surgery Covered after deductible

Ambulatory Surgicenters (facility charge)

Hospital Services (No deductible)

Inpatient 70%/30%. Maximum 30 day

(Semi-private rate) per calendar year

Emergency Room \$50 co-pay per visit

(waived if admitted)

Outpatient Services

Diagnostic X-ray, Diagnostic Lab, Covered after deductible

Chemotherapy, Radiation therapy

Physical therapy Covered after deductible; limit 20 visits per calendar year.
Condition must be subject to significant improvement.

Mental Health Inpatient: 70%/30%

Maximum \$500

Outpatient: \$50 max per visit; five visit maximum. Ambulance 70%/30%
(emergency only)

Home Health Care In place of hospitalization,

30 days, 70%/30%

Outpatient Prescription drugs, Not covered

Substance abuse, allergy tests,

allergy treatment

Other Conditions:

☐ \$250 deductible, two person maximum

☐ Coinsurance limit \$3000, two person maximum

☐ Out-of-pocket maximum \$3250, two person maximum

☐ Coinsurance: carrier pays 70%, patient pays 30%, up to out-of-pocket maximum, then carrier pays 100% per calendar year

☐ \$50,000 maximum benefit per member per calendar year. All limits are calendar year limits. All hospital inpatient benefits are paid at the prevailing semi-private rate. Physician benefits paid at the providers' usual and customary charge.

- ☐ Pre-admission testing required for non-emergency admissions.
- ☐ Pre-certification required for all non-emergency admissions.

APPENDIX A -- PLAN TWO

STANDARD INDEMNITY BENEFIT PLAN

BENEFITS STANDARD INDEMNITY

Physician Services

Prescribed periodic screening Covered in full

THE FOLLOWING PRIMARY CARE OUTPATIENT SERVICES ARE COVERED AT THE COINSURANCE AMOUNT AFTER \$150 OF SERVICES HAVE BEEN PROVIDED WITHOUT CO-INSURANCE OR DEDUCTIBLE APPLICATION:

Prenatal & postnatal office visits First \$150 paid, then 80%/20%

Primary care visits First \$150 paid, then 80%/20%

Office visit to referral provider First \$150 paid, then 80%/20%

Surgery (outpatient) First \$150 paid, then 80%/20%

Diagnostic Lab (Phys. office) First \$150 paid, then 80%/20%

Inpatient visits Covered in full after (Medical/surgical) deductible met. Maximum 30 days per calendar year.

Outpatient surgery Covered after deductible Ambulatory Surgicenters (facility charge)

Hospital Services (No deductible)

Inpatient (semi-private room) 80%/20%; maximum 30 days per calendar year.

Emergency Room \$50 co-pay/visit (waived if admitted)

Outpatient Services

THE FOLLOWING SERVICES ARE COVERED AT THE CO-INSURANCE AMOUNT AFTER THE DEDUCTIBLE:

Diagnostic X-ray, Diagnostic lab, Covered after deductible

chemotherapy, radiation therapy

Physical therapy Covered after deductible; limit 20 visits per calendar year. Condition must be subject to significant improvement.

Mental health Inpatient 80%/20%; max \$5000. Outpatient \$50 max per visit, 20 visit max per cal. year. Ambulance (emergency only) 80%/20%

Home health care In place of hospitalization: 30 days, 80%/20%

Outpatient Prescription drugs Co-pay the greater of \$5 or 25% of the drug cost, to a max of \$500 per calendar year.

Substance Abuse Covered as mental health benefit

Allergy tests Covered as phys. office visit

Allergy treatment Covered as phys. office visit

Other Conditions:

- ☐ \$150 deductible, two person maximum
- ☐ Coinsurance limit: \$2500, two person maximum
- ☐ Out-of-pocket maximum: \$2650, two person maximum
- ☐ Coinsurance: carrier pays 80%, patient pays 20%, up to out-of-pocket, then carrier pays 100% per calendar year
- ☐ All limits are calendar year limits; except mental health
- ☐ Lifetime maximum - \$20,000
- ☐ Mental health lifetime maximum - \$1,000,000
- ☐ All hospital inpatient benefits paid at the prevailing semi-private rate
- ☐ Physician benefits paid at the providers' usual and customary charge
- ☐ Pre-admission testing required for non-emergency admissions
- ☐ Pre-certification required for all non-emergency admissions

PLAN EXCLUSIONS

(Applicable to both Basic and Standard Indemnity Benefit Plans):

There are no benefits available for the following services, supplies or charges:

1. Which are not medically necessary.

2. Which are determined to be experimental or investigational in nature; including any service, supply, procedure or treatment directly related to an experimental or investigational treatment.

3. For any condition, disease, illness or bodily injury which occurs in the course of employment if benefits or compensation is available, in whole or in part, under the provisions of any legislation of any government unit. This exclusion applies whether or not the member claims the benefits or compensation.

4. To the extent benefits are provided by any governmental unit except as required by federal law for treatment of veterans in Veterans Administration or armed forces facilities for non-service-related medical conditions.

5. For any illness or injury suffered as a result of any act of war or while in the military service.

6. For which the member would have no legal obligation to pay in the absence of this or similar coverage.

7. Received from any dental or medial department maintained by or on behalf of an employer, labor union, trust or similar person or group

8. Surgery and any related services intended solely to improve appearance, but not to restore bodily function or to correct deformity resulting from disease, trauma, congenital or developmental anomalies.

9. Incurred prior to the member's effective date.

10. Incurred after the member's termination date.

11. For telephone consultations, charges for failing to keep an appointment, charges for completion of forms or charges for medical information.

12. For inpatient visits primarily for diagnostic studies.

13. For whole blood, blood components and blood derivatives which are not classified as drugs.

14. For custodial, domiciliary care or rest cures.

15. For reverse sterilization.

16. For dental work or treatment which includes hospital or professional care when performed in conjunction with: - an operation or treatment for the fitting or wearing of dentures - orthodontic care of treatment for malocclusion - operations on or treatment of or to the teeth or supporting tissues of the teeth except for removal of malignant tumors and cysts.

17. For treatment of weak, strained or flat feet, including orthopedic shoes or other supportive devices, or for the cutting, removal or treatment of corns, calluses or nails, other than with corrective surgery, or for the metabolic or peripheral vascular disease.

18. For eye glasses or contact lenses and the vision examination for prescribing or fitting of eye glasses or contact lenses, except for aphakic patients; and soft lenses or scleral shells intended for use and when used for the treatment of disease or injury.

19. For hearing aids and supplies, tinnitus maskers, or examinations for the prescription or fitting of hearing aids.

20. For radial keratotomy, myopic keratomileusis and any surgery which involves corneal tissue for the purpose of altering, modifying or correcting myopia, hyperopia or stigmatic error.

21. For inpatient admissions which are primarily for physical therapy.

22. For any treatment leading to or in conjunction with transsexualism, sex changes or modification, including but not limited to surgery.

23. For treatment of sexual dysfunction not related to organic disease.

24. For conditions related to autistic disease of childhood, hyperkinetic syndromes, learning disabilities, behavioral problems, mental retardation, or for inpatient confinement for environmental change.

25. For services or supplies for or related to fertility testing, treatment of infertility and conception by artificial means, including but not limited to: artificial insemination, in vitro fertilization, ovum or embryo placement or transfer, gamete intra-fallopian tube transfer, or cryogenic or other preservation techniques in such or similar procedures.

26. For travel whether or not recommended by a physician.

27. For complications or side effects arising from services, procedures or treatments excluded by this policy.

28. For private duty nursing.

29. For skilled nursing facility, unless specifically provided for in this contract.

30. For home health care, unless specifically provided for in this contract.

31. For durable medical equipment, unless specifically provided for in this contract.

32. For prescription drugs, unless specifically provided for in this contract.

33. For the care and treatment of an injury due to the commission of, or an intent to commit, an assault or a felony or an injury or illness incurred while engaging in an illegal act or occupation.

34. For wigs.

35. For weekend admission charges, except for emergencies or maternity.

36. For speech therapy except to restore speech abilities which were lost due to an injury or illness.

37. For treatment of Temporomandibular Joint Dysfunction (TMJ) and Craniomandibular Pain Syndrome (CPS).

APPENDIX B -- PLAN ONE

Basic HMO Benefit Plan

BENEFITS BASIC HMO BENEFITS

All care must be provided by or authorized by the primary care physician

Physician services

Prescribed Periodic Screening Covered in full

Prenatal & postnatal office visits \$10 copay per visit

Primary care visits \$10 copay per visit

Office visit to referral provider \$20 copay per visit

Surgical care in physicians office \$50 copay per procedure

Inpatient visits Medical/surgical) Same as referral office visits

Outpatient surgery \$100 copay per procedure

Hospital Services

Inpatient (Semi private rate) \$250 per day days 1-5

balance paid at 100%

Emergency Room \$100 copay/visit

(waived if admitted)

Outpatient services

Outpatient non-surgical care Covered in full

(including lab and xray)

Mental Health \$250 per day

- Inpatient 3 days per calendar year

- Outpatient \$20 copay per visit

5 visit per calendar year

Ambulance \$25 copay (emergency only)

Home Health Care, Outpatient Not covered

prescription drugs, Substance Abuse

Maternity Care Same as all other illness

Other conditions;

☐ No deductible

☐ Maximum out of pocket limit 200% of annual premium

☐ all limits are calendar year limits

☐ All hospital inpatient benefits paid at the prevailing semi-private rate

☐ Physician benefits paid at the providers usual and customary charge

☐ Pre-admission testing required for non-emergency admissions

☐ Pre-certification required for all non-emergency admissions

☐ All Managed care utilization controls apply

APPENDIX B -- PLAN TWO

Standard HMO Benefit Plan

BENEFITS STANDARD HMO BENEFITS

All care must be provided by or authorized by the primary care physician

Physician services

Prescribed Periodic Screening Covered in full

Prenatal & postnatal office visits \$10 copay per visit

Primary care visits \$10 copay per visit

Office visit to referral provider \$10 copay per visit

Surgical care in physicians office \$25 copay per procedure

Inpatient visits Medical/surgical) Same as referral office visits

Outpatient surgery \$50 copay per procedure

Hospital Services

Inpatient (Semi private rate) \$100 per day days 1-5

balance paid at 100%

Emergency Room \$50 copay/visit

(waived if admitted)

Outpatient services

Outpatient non-surgical care Covered in full

(including lab and xray)

Mental Health 100 per day

-Inpatient 10 days per calendar year

-Outpatient \$10 copay per visit

20 visit per calendar year

Ambulance \$25 copay (emergency only)

Home Health Care \$10 copay per visit

Outpatient prescription The greater of \$5 copay or 25%

drugs of the cost of the drug

Substance Abuse Not covered

Maternity Care Same as all other illness

Other conditions;

☐ No deductible

☐ Maximum out of pocket limit 200% of annual premium

☐ all limits are calendar year limits

☐ All hospital inpatient benefits paid at the prevailing semi-private rate

- ☐ Physician benefits paid at the providers usual and customary charge
- ☐ Pre-admission testing required for non-emergency admissions
- ☐ Pre-certification required for all non-emergency admissions
- ☐ All Managed care utilization controls apply

PLAN EXCLUSIONS

(Applicable to both Basic and Standard HMO Benefit Plans):

There are no benefits available for the following services, supplies or charges;

****All services must be provided by or authorized by the patients primary care physician.**

1. Which are not medically necessary
2. Which are determined to be experimental or investigational in nature; including any service, supply, procedure or treatment directly related to an experimental or investigational treatment
3. For any condition, disease, illness or bodily injury which occurs in the course of employment if benefits or compensation is available, in whole or in part, under the provisions of any legislation or any governmental unit. This exclusion applies whether or not the member claims the benefits or compensation
4. To the extent benefits are provided by any governmental unit except as required by federal law for treatment of veterans in Veterans Administration or armed forces facilities for non- service related medical conditions.
5. For any illness or injury suffered as a result of any act of war or while in military service
6. For which the member would have no legal obligation to pay in the absence of this or similar coverage.
7. Received from any dental or medical department maintained by or on behalf of an employer, labor union, trust or similar person or group.
8. Surgery and any related services intended solely to improve appearance, but not to restore bodily function or to correct deformity resulting from disease, trauma, congenital or developmental anomalies
9. Incurred prior to the members effective date
10. Incurred after the members termination date
11. For telephone consultations, charges for failing to keep an appointment, charges for completion of forms or charges for medical information

12. For inpatient visits primarily for diagnostic studies
13. For whole blood, blood components and blood derivatives which are not classified as drugs
14. For custodial, domiciliary care or rest cures
15. For reverse sterilization
16. For dental work or treatment which includes hospital or professional care when performed in conjunction with; - an operation or treatment for the fitting or wearing of dentures - Orthodontic care of treatment for malocclusion - operations on or treatment of or to the teeth or supporting tissues of the teeth except for; . removal of malignant tumors and cysts
17. For treatment of weak, strained or flat feet, including orthopedic shoes or other supportive devices, or for the cutting, removal or treatment of corns, calluses or nails, other than with corrective surgery, or for metabolic or peripheral vascular disease
18. For eye glasses or contact lenses and the vision examination for prescribing or fitting of eye glasses or contact lenses; except for aphakic patients and soft lenses or scleral shells intended for use and when used for the treatment of disease or injury
19. For hearing aids and supplies, tinnitus maskers, or examinations for the prescription or fitting of hearing aids
20. For radial keratotomy, myopic keratomileusis and any surgery which involves corneal tissue for the purpose of altering, modifying or correcting myopia, hyperopia or stigmatic error
21. For inpatient admissions which are primarily for physical therapy
22. For any treatment leading to or in conjunction with transsexualism, sex changes or modification, including but not limited to surgery
23. For treatment of sexual dysfunction not related to organic disease
24. For conditions related to autistic disease of childhood, hyperkinetic syndromes, learning disabilities, behavioral problems, mental retardation, or for inpatient confinement for environmental change
25. For services or supplies for or related to fertility testing, treatment of infertility and conception by artificial means, including but not limited to; artificial insemination, in vitro fertilization, ovum or embryo placement or transfer, gamete intra-fallopian tube transfer, or cryogenic or other preservation techniques in such or similar procedures
26. For travel whether or not recommended by a physician
27. For complications or side effects arising from services, procedures or treatments excluded by this policy

- 28. For private duty nursing
- 29. For skilled nursing facility, unless specifically provided for in this contract
- 30. For home health care, unless specifically provided for in this contract
- 31. For Durable Medical equipment, unless specifically provided for in this contract
- 32. For Prescription drugs, unless specifically provided for in this contract
- 33. For the care or treatment of an injury due to the commission of, or an intent to commit, an assault or a felony or an injury or illness incurred while engaging in an illegal act or occupation
- 34. For wigs
- 35. For weekend admission charges, except for emergencies or maternity
- 36. For speech therapy except to restore speech abilities which were lost due to injury or illness
- 37. For the treatment of Temporomandibular Joint Dysfunction (TMJ) and Craniomandibular Pain Syndrome (CPS).

State of Delaware
Small Employer Health Plan
March 24, 2003

Presented by:



State of Delaware Small Employer Health Plan

Summary of Palmer & Cay Recommendations

Palmer & Cay Consulting Group (PCCG) was retained to review the considerations and programs developed by the Small Business Task Force to address methods to improve the access and affordability of health insurance for small employers in Delaware. The Task Force asked PCCG to provide expected rates for a proposed indemnity program and address a number of considerations. PCCG has prepared this summary of recommendations for amending the current Small Group Reform legislation in Delaware to promote competition, pricing uniformity, reasonable underwriting and eligibility and offer choice of health care options for small employers.

The various discussion points to be considered, the expected rates and rating methodology follow this summary.

- Title 18, Chapter 72 of the Delaware Insurance Code provides the means for small employers (1-49 employees) to obtain health insurance regardless of individual health status. The interpretation of the Chapter by the insurance market, however, has led to significant price deviation based on health risk, resulting in unaffordable costs for many employers. We believe that the Chapter should be revised to provide more uniform product and prices for the 1-9 employee market. Once successful, it could be extended to the 10 – 49 employee groups. For this discussion, we refer to the 1-9 market as the small employer market.
- PCCG recommends that Delaware promote managed competition between insurers and health maintenance organizations (HMO) for the small employer market, but establish rules of participation that spread risk fairly and consistently among all vendors. To that end, the following actions should be considered:
 - Develop bid specifications and/or regulations for filing with requirements surrounding rating methodology, cost indexing, eligibility, administrative fees, commissions, etc.
 - Require bidders follow the prescribed specifications/regulations in order to offer coverage to the small employer market
 - Require that any insurance company and HMO wishing to offer insurance coverage to larger employers in Delaware offer coverage to the small employer market.
 - Provide that the standard and basic products be offered to the small employer market with no risk adjusted pricing. Provide for additional programs to be offered with no or limited ability to adjust the rates by risk.

State of Delaware Small Employer Health Plan

Summary of Palmer & Cay Recommendations (Continued)

- Currently, there are a number of alternative plans available to small employers, with significant price variation depending upon the risk factors associated with the covered members. To ensure the appropriate spread of risk, Delaware based small employers desiring group health insurance would be required to purchase the small group reform products.
 - *Note: Based upon our meeting with the Task Force on March 11, 2003, there is concern that this would be difficult to administer, particularly for the sole proprietors. The one-person employers would still be able to access the individual market, be medically underwritten and potentially obtain better rates based upon their health status. This issue needs further discussion and consideration. Many States do not include sole proprietors within the context of small group reform. Removing these individuals from the current Delaware reform, however, could be disruptive and problematic.*
- While mandating employers to offer health coverage is not practical or advisable; the ability for employers to join or drop coverage creates underwriting instability and results in higher prices for all participating employers. To provide the insurer with as much predictability of the risk they are undertaking, we feel that two important features must be considered.

1. Age-based Rates

By basing the rates on the actual age of the insured, the vendor can more accurately reflect the risk of the individual participant, particularly when risk adjusted rating is eliminated from the programs. While this could result in higher prices for older employees, it also serves to attract and retain younger employees in the mix, thus spreading the risk associated with the older workers across a broader base of participants. Individual employers would have the ability to calculate average rates internally and charge each employee the same contribution. Note: The current practice of including industry and geographic loads should be eliminated from the rating process.

2. Eligibility & Participation Requirements

In order to avoid adverse selection by individual employees within each employer group, rules related to eligibility and participation should be examined and maintained. These would include minimum premium funding levels by employers and minimum % participation of all eligible employees, depending upon the size of the group.

State of Delaware Small Employer Health Plan

Summary of Palmer & Cay Recommendations (Continued)

In addition, employees would not be able to change their elections unless they have a corresponding life event change, such as marriage, birth, etc.

- The Task Force is considering an indemnity plan based upon Medicare RBRVS reimbursement. PCCG believes that the reimbursement may not be readily accepted by the provider community and if, mandated, would create cost shifting to the remaining commercial market. Currently, insurers and HMOs have negotiated some level of provider discounts within their preferred provider, point of service and HMO options. PCCG recommends that the small employer market take advantage of the existing delivery systems and discounts.
- PCCG recognizes that the brokerage community, Chambers of Commerce and other business organizations play an important and critical role in helping small employers obtain and design the best benefit programs for their employees. Their role should be continued within the small employer market. We also recommend that each insurer be required to file rates which include 5% commission. To the extent a Chamber of Commerce or other business alliance provides additional administrative services on behalf of an insurer, the insurer could pay for these services out of their filed administrative fees, in addition to commissions.
- With healthcare costs rising by double-digit inflation over the past several years and with no expectation that these trends will subside in the short-term, employers throughout the county are struggling to maintain affordable protection for their employees. During the 1980's, with the introduction of managed care programs, deductibles and coinsurance responsibility was replaced by 100% reimbursement after small co-payments. Employees have little perception of the true cost of medical expenses and perceive that their co-payments represent the cost of care. As the effectiveness of managed care has run its course, it is necessary to reintroduce deductibles and coinsurance responsibility to reduce premium expense and engage the consumer in healthcare spending decisions. Many employers are considering high deductible plans, with some also reviewing the health reimbursement accounts.

To offer employers and employees affordable options, PCCG recommends the committee consider changing the standard plan offering to a more catastrophic health plan with a front-end deductible of \$1,000 and coinsurance responsibility, thereafter. Employers would have the flexibility to purchase this plan and self-insure a portion of employees' out of pocket expenses, if desired. In addition, the

State of Delaware
Small Employer Health Plan

Summary of Palmer & Cay Recommendations (Continued)

carriers would offer additional programs, without underwriting that would allow employers to “buy-up” to lower deductible plans for an additional premium.

Prescription drug coverage could either be incorporated into the standard plan or offered as a rider.

On-going evaluation of the small group market is essential and therefore, an Oversight Commission is recommended. The insurers and HMOs would be required to file rates with the Insurance Commissioner’s Office and the Oversight Commission could evaluate the filings and provide recommendations to the commissioner.

State of Delaware Small Employer Health Plan

Discussion Points

Size of Group – 1-9 Employees, including self-employed individuals – Size of group will not permit exceptions.

Palmer & Cay Consulting Group (PCCG) recommends that the initial offering should be developed to provide coverage to the 1-9 market only. The 10-50 market would remain under the current State reform plans. Depending upon the success of the 1-9 program, future consideration should be made toward expansion. The majority of small employers in Delaware fall into the 1-9 size category, so the new program will meet the needs of a significant number of employers

To obtain the best spread of risk for the awarded carrier(s), coverage for the 1-9 market should only be available under the new Small Employer Health plan. Small employers with headquarters in Delaware, providing healthcare to themselves and their employees will have to procure it through the filed plans and will not be permitted to join other programs, including associations, Chamber of Commerce or multiple employer health plans. There may be exceptions for “grandfathering” existing employers and bargaining units, which fall under Taft-Hartley plans. This limitation may create concern, particularly with Chambers of Commerce, as the health care programs provide an attractive retention tool for these organizations. It may be worthwhile to obtain the Chamber’s support in developing the Small Employer Health Plan and perhaps provide some level of compensation for this support.

The current practice of allowing groups to move at will to different risk pools, creates adverse selection, “cherry picking” of preferred risks and will ultimately lead to higher prices for all employers.

Medicare Fee Schedule at 100% (Out of State issues). Suggest a possible regional approach.

This approach, while somewhat effective in reducing claim costs and therefore, premiums, is problematic. Without acceptance by the provider community of the Medicare allowance, patients can be balance billed above the allowance up to charges. The awarded carrier(s) may not be able to negotiate participating agreements with providers to accept this reimbursement. To assure provider acceptance, the State of Delaware would have to enact legislation that would require provider acceptance of the allowance within the small employer programs.

State of Delaware Small Employer Health Plan

Discussion Points

Medicare Fee Schedule at 100% (Out of State issues). Suggest a possible regional approach. (continued)

If such legislation could be enacted, providers would be unable to shift costs to Medicare and Medicaid (since these contracts are fixed). The only place to shift costs would be to the large group commercial population. This cost shift would result in higher prices for major employers in Delaware, as well as the State of Delaware Employee Benefit Plan. The out of state issue could be addressed by having vendors pay a typical usual & customary allowance to out of state providers who would not have to accept Medicare RBRVS. This would reduce potential out-of-pocket balances to members seeking care outside of Delaware and would encourage as much care as possible delivered within the State.

Within the marketplace in Delaware today, many professional providers are accepting reduced fee for service reimbursement under their Preferred Provider Organization (PPO), Point of Service (POS) and Health Maintenance Organization (HMO) contracts with vendors. In many circumstances the professional reimbursement levels are close to Medicare RBRVS and therefore, are already delivering the type of discounts to the members the committee desires. In addition, providers accepting the discounted reimbursements agree to file claims directly to the vendors and accept the vendors discounted allowance as payment in full. This is a significant benefit to patients, as they are protected from balance billing. We feel, therefore, that rather than set forth an indemnity plan as the standard, the committee may wish to consider using existing PPO, POS and HMO networks as the delivery systems for the small employers.

We have set forth pricing on a usual and customary basis (indemnity), the proposed Medicare Allowance basis, as well as PPO, POS and HMO reimbursements for comparative purposes. This comparison will help the committee examine the impact of the different reimbursement and delivery models.

Bid Process

While developing a bid and selecting only one carrier may result in the most favored rates for the 1-9 market, this approach could create adverse market conditions in Delaware for 10+ employer-sized groups. As the majority of businesses in Delaware fall within the 1-9 size, carriers unable to compete for this business may decide to leave the

State of Delaware Small Employer Health Plan

Discussion Points

Bid Process (continued)

State as an insurer for larger employers. With the number of qualified insurers and HMOs diminishing, the lack of competition within the State could create higher cost and less choice for all.

Alternatively, we feel a better approach would be for the State to develop bid specifications and/or regulations for filing, with requirements for rating methodology, cost indexing, eligibility, administrative fees, commissions, etc. Each bidder able to offer programs meeting the desired specifications or regulations would be able to compete within the small employer market. This would create a competitive market-based arrangement, allowing each vendor to compete on an equitable and comparable basis for customers. The managed competition environment will be advantageous to participating vendors and offer greater choice and flexibility to small employers.

Carriers selected to be offered to the small employers would be able to offer additional buy-up plans, however, we recommend that the current ability to adjust the rates for risk should be modified. Currently, vendors are allowed to significantly increase the costs for adverse health conditions within a small employer. At the very least, the degree to which risk adjustments can be made should be modified as part of the managed competition environment. This will result initially in the better risk populations getting a large cost increase, while the adverse risk populations obtaining more competitive rate structures, but in the end will be more equitable to all small employers.

Two of three year retention for carrier awarded bid

We agree that providing stability to the carriers over a 2 - 3 year period will assure the most competitive price structure. The bid specifications or regulations would provide for clear articulation by the vendors of their rate renewal process over the fixed period, with the goal of guaranteed not to exceed rate increases, to the extent possible.

Small business regulation enforced when not in conflict with HIPAA Regulations

It appears that HIPAA portability should be followed for the Small Employer Group plans. The main issue is whether the portability should apply to sole proprietors, as this is not required by Federal Law. The specifications/regulations prepared by the State should expand HIPAA portability to the sole proprietors.

State of Delaware Small Employer Health Plan

Discussion Points

HIPAA regulations must be followed

Please review comments above. HIPAA rules define a small employer as having between 2 and 50 employees. This includes part-time employees, but not sole proprietors. If possible, HIPAA should be extended to the sole proprietors.

63 days = twelve months back, eighteen months forward

Under HIPAA, allowable application of preexisting condition exclusions is limited. Employers may impose a pre-existing condition exclusion only for conditions for which the individual actually received or was recommended medical advice, diagnosis, care or treatment within the six month period prior to the enrollment date in the plan. This is referred to as the *six month look-back rule*. Under HIPAA, a plan is prohibited from imposing a preexisting condition exclusion for more than 12 months from the enrollment date, except in the case of late enrollees where the limit on imposing a preexisting condition exclusion is 18 months. HIPAA also reduces the maximum length of a pre-existing condition exclusion by any periods of credible coverage. Ideally, credible coverage can completely offset the 12 or 18 month period of exclusion. This 12 to 18 month period of exclusion from coverage is called the *look forward period*. There are two different ways to calculate credible coverage - the standard method or the alternative method. Under the standard method, a period of health coverage preceding a break in coverage of 63 days or more does not count as credible coverage. The break essentially "wipes out" what would have been considered credible coverage.

It may be worthwhile to follow HIPAA provisions with respect to pre-existing condition limitations, although this could be an administrative challenge to the vendors (having to obtain proof of creditable coverage). These provisions could be applied to sole proprietors as well. Late enrollees would be subject to both medical underwriting and pre-existing condition limitations to attempt to encourage them to join when first eligible, rather than waive coverage until they need it.

Drug formulary and/or percentage

We recommend that each vendor provide coverage for prescription drug coverage. To obtain the most competitive cost structure, it is recommended that a formulary approach be implemented. The proposed benefits provide for a lower copay (\$20) for formulary brands and a higher copay (\$35) for non-formulary brands. The committee may want to consider even higher copays to lower the premium cost for prescription drug, and include indexing of the copays into the benefit formula in future years to keep up with inflation.

State of Delaware Small Employer Health Plan

Discussion Points

Drug formulary and/or percentage (continued)

A coinsurance percentage may also be considered. Patients cost sharing would increase naturally with prescription drug inflation. The downside of a coinsurance model is the lack of financial protection for members utilizing very expensive drugs. To combat this issue, a coinsurance structure with a maximum out of pocket expense per prescription may be considered. (i.e. member pays 25% of cost not to exceed \$50 per prescription).

A mandatory generic program should be considered as part of the plan structure. Basically this means that patients who select a brand name medication when a generic is available will only obtain reimbursement up to the generic price and will have to pay the difference in price between the generic and brand medication.

In addition, vendors should disclose all fees, rebates and costs within their programs for comparison purposes. Other utilization management tools such as prior-authorization and step therapy may be employed to keep the cost of the prescription drug benefit affordable. Also, the \$5,000 maximum benefit per year should be maintained to keep premium rates as low as possible. “Buy-up” options could be available at an additional cost, but underwriting conditions should be modified to even the playing field.

Mandatory enrollment. All new hires 18 and above are required to enroll.

It may be extremely difficult to require enrollment of all full-time employees. A more practical approach may include the following conditions:

- All employees working a base number of hours would be eligible for coverage (30 – 40 hours)
- The employer would be required to pay at least 50% of the cost for single coverage for full-time employees and a pro-rata share for part-time employees
- Each group must enroll 75% - 100% of eligible employees based on size, unless the employee can demonstrate group coverage through another source
- Employees would only be able to change their election for coverage throughout the year based upon life events (marriage, birth, spouse losing or gaining coverage, etc.)
- New hires must enroll when initially eligible. If they waive coverage when initially eligible, (and cannot demonstrate other group benefits), they will only be allowed to join the plan with acceptable medical underwriting.
- All eligible employees would be able to access coverage without individual medical underwriting or group based health appraisals when first eligible.
- Employers would be able to move their existing insured's to a new vendor without underwriting, so long as the participation requirements are met.
- Rates will not vary by health risk.

State of Delaware Small Employer Health Plan

Discussion Points

Banded rates – 18 to 29 and 30 – 64?

We feel that age-banded rates are appropriate, however the above bands appear too broad. In order for the vendors to appropriately set their rates for the risk, with the lack of medical underwriting, they will need to be able to rate based on age.

Our rating displays typical age bands based on actuarial risk. Following these types of bands would provide the most reliable method of rating for the vendors to assess risk.

The committee may want to require that the spread between the lowest and highest rate bands are limited to no more than 200%. This would essentially assist the older aged employers by having the younger employees subsidize their costs. It could have a detrimental impact, however, in attracting and retaining younger participants in the healthcare plan.

We also feel that the current industry and geographic loads are arbitrary, and should be eliminated. There is no longer a discernable difference in cost between lower and upper Delaware.

Extra premium for smokers?

We do not recommend this requirement, as it would increase the complexity of the rating process and is based upon honesty on the part of the participants. Conversely, we encourage the vendors to offer within their programs discounts and other rewards for smoking cessation and other wellness programs.

Pre-tax deduction

Employer costs for healthcare premiums are a tax-deductible expense. Employees could take advantage of pre-tax deductions for health contributions, as well as out of pocket healthcare expenditures through the use of Section 125 – Cafeteria Benefits..

In and out procedure for seasonal employees

Reasonable guidelines can be developed for these unique situations, whereby, the employees can exit the plan when they are no longer employed and re-enter when they are hired back. As the program would not be “underwritten”, some of the concerns regarding exit and re-entry may be mitigated.

State of Delaware Small Employer Health Plan

Discussion Points

Agents – all health agents in good standing in the State

We see no need to limit the number of agents offering the small employer plans in the State. They offer a valuable service to the employer community

Commission – minimum 5%

We feel that a 5% commission is appropriate for this size market and would suggest that that be the standard and only commission basis set. In the event, the programs are endorsed and applied for through a Chamber of Commerce, it may be appropriate to provide 1% of the 5% commission to the Chamber for their support.

Would establish a small group oversight commission under the supervision of the Insurance commission.

We feel that ongoing evaluation of the small group market should be maintained and an oversight commission makes sense. The commission would ensure that the goal of providing accessible, affordable healthcare is being accomplished, while maintaining a competitive market environment for the insurance carriers and HMOs.

Any rate increase would have to be submitted to the small group oversight commission for approval.

Once the Small Employer Plan was created, each interested vendor would be required to submit rate filings on an on-going basis, subject to Insurance commission approval. The oversight commission could evaluate the filings and provide recommendations to the Insurance Commissioner.

Catastrophic Pool

We recommend that the initial approach assumes full risk assumption on the part of the officering insurers and HMOs. In the event, this approach fails to achieve the desired outcome of a competitive marketplace for small employers, then the State may need to look for ways in which to create their own risk pool and underwrite some portion of the risk.

State of Delaware Small Employer Health Plan

Discussion Points

Additional comments of the proposed plan design

While the proposed indemnity plan includes deductibles and coinsurance responsibility, the overall benefits may produce rating levels that are still considered unaffordable by the small employer market. Many small employers may be interested in a catastrophic program to reduce premium rates. As noted above, the indemnity approach to the standard plan may also be problematic. The Medicare RBRVS allowance would result in a cost-shift to larger employers and a usual and customary basis does not take advantage of existing provider discounts and balance billing protection.

We suggest the committee consider a standard plan with a high front-end deductible (at least \$1,000), with potentially some “first dollar” preventive coverage (after copays). We would also suggest maintaining a prescription drug card, but increasing the proposed copayments or changing to a coinsurance model to reduce premiums. The catastrophic based plan would serve as the base plan, offering the lowest premiums available. Employers could select this plan or purchase riders to reduce the deductibles and copayments for additional premium, but with limited risk rating. Some employers may choose to “self-fund” a portion of the deductible if employees submit an EOB for reimbursement.

Should the carriers providing State Employee Benefits be required to insure the small employers?

In a broader context, we would recommend that the regulations require any insurer or HMO who offers coverage to employers of 10 or more, insure the 1-9 market based upon the final plan structure, underwriting rules and rating methodologies set forth in the final regulations. This will allow an equitable playing field for all insurers.

Requiring vendors that administer the State of Delaware Employee Benefits plan to offer an insured solution for the 1-9 market, could result in less competition for both the State employees and the Delaware market in general.

Another potential solution would be to include the small employers within the current self-funded State employee benefit plans. There are a number of considerations to be examined under this approach, including:

- Would the plans be duplicative of the State offerings?
- How would the rates be established?
- Who would take the risk in the event claims exceeded premium charges?
- Would a reinsurance market be available?

State of Delaware Small Employer Health Plan

Discussion Points

Should the carriers providing State Employee Benefits be required to insure the small employers? (continued)

- How would the plans be marketed and communicated?
- Could web based tools be employed to offer more efficient administration?
- Who would provide the enrollment and premium billing services?
- Would brokerage services still be necessary and if so, what would be the fair level of compensation for service?

Similar to our discussion related to the catastrophic pool, Palmer & Cay Consulting Group recommends that through regulation, we encourage insurers and HMOs to compete for the small employer market, on an equitable basis, eliminating adverse selection, “cherry picking” and risk rating. In addition, we recommend the committee consider a catastrophic health plan as the “standard” plan with full utilization of current managed care delivery systems.

State of Delaware Small Employer Health Plan

Pricing Assumptions

- Baseline expected claims costs of the Small Group Reform Task Force plan design were developed based on State of Delaware Employee Benefits Plan claims cost history and projected FY04 claims cost
- The State of Delaware Employee Benefits Plan cost was utilized as the baseline due to the following:
 - Large, credible Delaware-based employee population
 - No underwriting/guaranteed issue population, similar to that proposed in our reform package
- State of Delaware FY 2004 claims cost was adjusted for the following:
 - Value of benefits program to be offered
 - Impact of provider discounts on claims cost
 - Demographic mix of the population in Small Group Market versus those in State Employee Benefits Plan
 - January 1, 2004 effective date (adjusted at 15% per annum)
- Small Group Task Force “New Standard Plan” used for benefit pricing
- Demographic Data based on ***Current Population Survey, March 2000-2002***, provided by the Center for Applied Demography and Survey Research, University of Delaware

Note: PCCG did not receive demographic data on the sole proprietor population, estimated at roughly 50,000. The inclusion of this population in our analysis may impact the overall “community role” developed for each plan, assuming the age of this population is older than the small group population at large. However, it should not have an impact on the age-banded rates developed.

- Based on the limited data provided on the demographics of the small group market population, assumptions were made on coverage level (single, family, etc.) and average contract size (members per contract) based on normative demographic data
- Retention (Expense) level of 24% of premium was added to expected claims costs, which includes an assumed 5% for agent/broker commissions
- Age-based rates were developed from the developed “community rate” based on actuarial expected claim levels by age and assumed contract mix.

STATE OF DELAWARE SMALL GROUP REFORM

PER MEMBER PER MONTH CLAIMS COST DEVELOPMENT - NEW STANDARD PLAN WITH U&C REIMBURSEMENT

PMPM Premium Development

	<u>Medical</u>	<u>Drug</u>	Total
SOD Employee Benefits Plan Expected Claim Cost - FY04	\$202.78	\$55.94	\$258.71
Adjustment for Plan Design	0.872	0.956	
Adjustment for Provider Reimbursement to Indemnity U&C level	1.100	1.000	
Adjustment for Demographic Mix	0.998	0.998	
Adjustment for January 1, 2004 Effective Date (6 months trend)	1.072	1.100	
Projected Claims "New Standard Plan" effective January 1, 2004	<u>\$208.13</u>	<u>\$58.70</u>	<u>\$266.83</u>
Administration/Retention	\$65.73	\$18.54	\$84.26
Required Premium - Standard Plan - Indemnity with U&C	<u>\$273.86</u>	<u>\$77.23</u>	<u>\$351.09</u>
Projected Members			144,390
Projected Annual Premium			\$608,325,344

Premium Rate Development

	<u>Est. Lives</u>	<u>Rate Ratio</u>	<u>Base/Community Rate</u>
Single	27,804	1.00	\$390.24
Parent/Child(ren)	6,729	1.80	\$702.43
H/W	10,349	2.20	\$858.52
Family	22,407	3.00	\$1,170.71
Total	67,289		\$608,325,344

**STATE OF DELAWARE SMALL GROUP REFORM
ILLUSTRATIVE JANUARY 1, 2004 AGE-BANDED RATES**

COMMITTEE "NEW" STANDARD PLAN

INDEMNITY - USUAL & CUSTOMARY COST REIMBURSEMENT LIMITS

Age Group	Single	Parent/Child(ren)	H/W	Family
<25	\$230.72	\$415.29	\$507.57	\$692.15
25-29	\$268.36	\$483.05	\$590.40	\$805.09
30-34	\$256.85	\$462.34	\$565.08	\$770.56
35-39	\$263.65	\$474.58	\$580.04	\$790.96
40-44	\$284.61	\$512.29	\$626.13	\$853.82
45-49	\$332.08	\$597.75	\$730.58	\$996.25
50-54	\$434.40	\$781.91	\$955.67	\$1,303.19
55-59	\$610.94	\$1,099.68	\$1,344.06	\$1,832.81
60-64	\$840.31	\$1,512.56	\$1,848.68	\$2,520.93
65+	\$964.90	\$1,736.83	\$2,122.79	\$2,894.71
Community Rate	\$390.24	\$702.43	\$858.52	\$1,170.71

INDEMNITY -MEDICARE RBRVS REIMBURSEMENT

Age Group	Single	Parent/Child(ren)	H/W	Family
<25	\$176.18	\$317.13	\$387.60	\$528.55
25-29	\$204.93	\$368.88	\$450.85	\$614.80
30-34	\$196.14	\$353.06	\$431.51	\$588.43
35-39	\$201.34	\$362.40	\$442.94	\$604.01
40-44	\$217.33	\$391.20	\$478.14	\$652.00
45-49	\$253.59	\$456.46	\$557.90	\$760.77
50-54	\$331.72	\$597.10	\$729.79	\$995.16
55-59	\$466.53	\$839.76	\$1,026.37	\$1,399.60
60-64	\$641.69	\$1,155.04	\$1,411.72	\$1,925.07
65+	\$736.84	\$1,326.31	\$1,621.04	\$2,210.51
Community Rate	\$298.00	\$536.40	\$655.60	\$894.00

PPO

Age Group	Single	Parent/Child(ren)	H/W	Family
<25	\$199.25	\$358.66	\$438.36	\$597.76
25-29	\$231.77	\$417.18	\$509.89	\$695.30
30-34	\$221.83	\$399.29	\$488.02	\$665.48
35-39	\$227.70	\$409.86	\$500.94	\$683.10
40-44	\$245.80	\$442.43	\$540.75	\$737.39
45-49	\$286.80	\$516.24	\$630.96	\$860.39
50-54	\$375.16	\$675.29	\$825.35	\$1,125.48
55-59	\$527.63	\$949.73	\$1,160.78	\$1,582.88
60-64	\$725.72	\$1,306.30	\$1,596.59	\$2,177.17
65+	\$833.33	\$1,499.99	\$1,833.32	\$2,499.98
Community Rate	\$337.02	\$606.64	\$741.45	\$1,011.07

HMO/POS

Age Group	Single	Parent/Child(ren)	H/W	Family
<25	\$186.67	\$336.01	\$410.67	\$560.01
25-29	\$217.13	\$390.83	\$477.69	\$651.39
30-34	\$207.82	\$374.07	\$457.20	\$623.45
35-39	\$213.32	\$383.98	\$469.30	\$639.96
40-44	\$230.27	\$414.49	\$506.60	\$690.81
45-49	\$268.68	\$483.63	\$591.11	\$806.05
50-54	\$351.47	\$632.64	\$773.23	\$1,054.40
55-59	\$494.30	\$889.74	\$1,087.47	\$1,482.91
60-64	\$679.89	\$1,223.80	\$1,495.75	\$2,039.66
65+	\$780.70	\$1,405.25	\$1,717.53	\$2,342.09
Community Rate	\$315.74	\$568.33	\$694.62	\$947.21

Out-of the-Box Subcommittee Report

PROPOSALS

Option	Overview
Play or pay	Under this proposal, employers would be required to either provide a health care plan meeting specified standards or pay a payroll tax to cover workers under a public-sponsored plan, which would also be extended to non-workers. Subsidies proposed for low-income participants.
Low limit policies	In an effort to increase availability and affordability, plan reduces the annual (or lifetime) benefit payout.
Bare-bones policies	In an effort to increase availability and affordability, plan increases cost sharing by increasing deductibles, co-pays, benefit exclusions, etc.
Employer mandate	Requires all employers to offer at least a core health insurance program to all eligible employees. Costs shared between employee (subject to a cap) and employer. Subsidies proposed for low-income participants.
Individual mandate	A program that requires each individual to obtain his or her own health insurance, much the way they purchase car insurance. In addition to a government-approved basic plan, insurance companies could offer various levels of enhanced coverage. Subsidies proposed for low-income participants.
All-payer	Under an all-payer rate-setting mechanism, a public body determines the prices to be paid for medical services by public and private payers alike. Offers potential to help control prices. Currently used in Maryland hospitals.
Tax credits	Current proposal calls for a non-means tested premium support tax credit of \$1,000 per person (\$2,000-\$3,000 per family) to help individuals buy coverage through employers, associations or on the open market.
DelaCare	A non-employer based universal plan that would create large risk pools to encourage competitive bidding. Benefit options similar to those available under the state employee program. Individuals would be responsible for paying for their own coverage, but the plan recognizes that the most efficient funding mechanism would be through the tax system.
Medicare expansion	An effort to expand the current Medicare system to include middle age populations most in need of – but most at risk of losing -- their insurance.
Single-payer	A tax-financed, non-employer based plan offering a comprehensive, standard set of benefits to everyone.

Consumer-directed	Employers would deposit a set amount in an employee spending account (e.g., \$1,500 annually). When exhausted, the employee would be personally responsible for a portion of any remaining charges (e.g., next \$3,000), after which a major medical plan would kick in.
Alliance plans	Attempts to leverage the buying power of large groups by permitting affinity organizations to band together to purchase coverage for their membership. Supposed to offer small businesses more plan choices at a lower price.
MSA's	Plan that permits self-employed people and small businesses to set up tax-free medical spending accounts to pay for routine medical expenses. Plan contains a major medical feature to cover catastrophic care costs.
State plan buy-in	Allows a small employer to take advantage of the state's buying power by participating in the state employee health care program.
FEHBP expansion	Expand the largely tax-funded federal program to all citizens. Program offers a wide range of insurance options all built on a mandatory core of benefits.

OUT-OF THE-BOX PROPOSALS
SMALL BUSINESS HEALTH INSURANCE TASK FORCE

Option	Benefit	Participation	Cost Sharing	Public Cost
Play or pay	½Y	Y	½Y	↑
Low limit policies	N	N	N	↔
Bare-bones policies	N	N	N	↔
Employer mandate	½Y	N	N	↔
Individual mandate	½Y	Y	½Y	↓
All-payer	N	N	½Y	↓
Tax credits	N	N	N	↑
DelaCare	Y	Y	Y	↓
Medicare expansion ¹	N	N	Y	↓
Single-payer	Y	Y	Y	↓
Consumer-directed	N	N	N	↔
Alliance plans	N	N	N	↔
MSA's	N	N	N	↑
State plan buy-in	N	N	N	↔
FEHBP expansion	½Y	Y	½Y	↓

Definitions:

Benefit – does the option treat participants equally regardless of employment status, age, health history, employer size, income or net worth?

Participation – does the option provide coverage for everybody?

Cost Sharing– does the option spread the costs fairly throughout the population?

Notes:

¹ Assumes gradual expansion of Medicare only through age groups most at risk (i.e., age 65 down to 50).

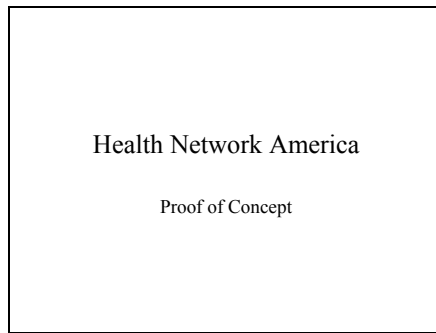
OUT-OF THE-BOX PROPOSALS
 SMALL BUSINESS HEALTH INSURANCE TASK FORCE
 COMPOSITE SCORING OF SELECTED OPTIONS

	DelaCare	Individual Mandate	Single-Payer	FEHBP Expansion
Maximize broad political support	4	7	4	6
Maximize existing admin. structures	3	5	5	6
Maximize global resource planning	7	2	9	5
Maximize equitable financing	8	4	9	6
Maximize simplicity & transparency	7	4	9	4
Minimize disincentives to work	4	3	5	4
Minimize stigma & maximize dignity	8	6	8	7
Minimize public coverage subsidies	6	6	8	6
Minimize changes required in federal laws	5	5	5	7
Minimize use of costly medical resources	4	5	8	3
Total	56	47	70	54

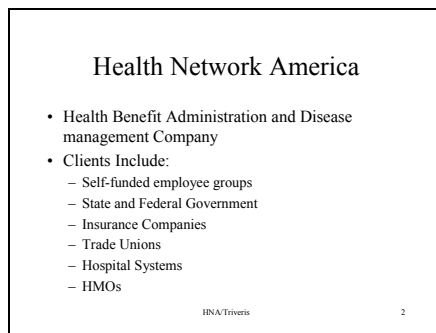
Each option is scored on a scale of one to ten with ten offering the most benefit.
 Maximum desirability score is 100. Scores rounded to nearest integer.

HNA Proof of Concept Presentation

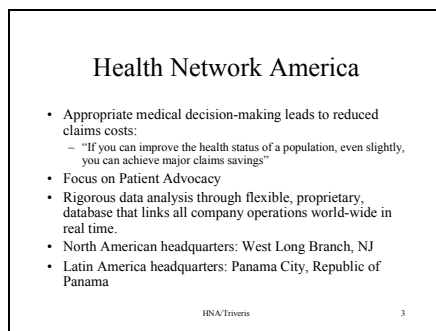
Slide 1



Slide 2



Slide 3



Slide 4

Panama Canal Area Benefit Plan
What is the PCABP?

- A Federal Employee Health Benefit Plan
- Created in 1960 for the US employees of the Panama Canal and their families
- A closed plan with an aging population (No new enrollees permitted)
- Experienced uncontrolled medical expense increases during the 1990s

HNA/Trivaris 4

Slide 5

What did HNA do for this plan?

- Introduced HNA paradigms
 - patient advocacy
 - Dedicated nursing, member service, and claims administration
 - elimination of financial conflicts of interest
 - medical education for physicians and patients
 - network management including
 - physician and hospital performance analysis
 - medical outcomes reporting
 - network (POS) plan design
- Once introduced, the benefit plan and design remained essentially the same since HNA has managed the plan.

HNA/Trivaris 5

Slide 6

**Demographics of the PCABP Plan
(1998-2002)**

	Median Age	Female	Male	Total
1998	55 yr	51.3%	48.7%	27,989
1999	57 yr	51.5%	48.5%	26,344
2000	59 yr	52.1%	47.9%	24,298
2001	60 yr	52.1%	47.9%	22,396
2002	62 yr	52.3%	47.7%	20,523

HNA/Trivaris 6

Slide 7

Demographics of the PCABP Plan (1998-2002)		
	Member >80 yr	% of member over 80 yrs. old
1998	1,884	6.7%
1999	2,516	9.6%
2000	2,749	11.3%
2001	2,918	13.0%
2002	3,046	14.8%

HNA/Trivaris 7

Slide 8

PCABP Hospitalization (01/98-10/02)		
	Hospital admissions Per 1,000 member yr	Bed Days Per 1,000 member yr
1998	269	1,993
1999*	291	1,975
2000	277	1,697
2001	253	1,479
2002* (10 months)	299	1,854

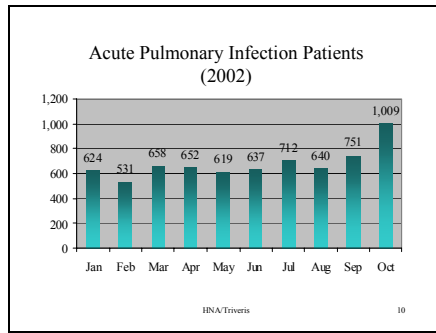
*Influenza epidemics; statistical reporting highlights importance of epidemiological surveillance for accurate explanation of variance. HNA/Trivaris 8

Slide 9

Acute Pulmonary Infection (Influenza) (ICD-9: 460-466, 480-487) (1998-2002)				
	patients	Hospital admissions Per 1,000 member yr	Bed Days Per 1,000 member yr	LOS
1998	5,846	22.6	188.2	8.3
1999	7,158	36.2*	256.2	7.1
2000	6,039	29.0	196.4	6.8
2001	4,563	24.7	195.1	7.9
2002 (10 months of data)	3,732	21.9**	182.2	8.3

*Introduced flu vaccine after epidemic as a covered benefit with good success in following years
**Increased median age; older more frail when infected with different flu strain
HNA/Trivaris 9

Slide 10



Slide 11

**PCABP Claim Expense
(01/01/98-10/31/02)**

	Eligible Expense PMPM	Paid Amount PMPM
1998	\$162.21	\$162.21
1999	\$175.70	\$175.70
2000	\$183.13	\$183.13
2001	\$151.00	\$145.15
2002 (10 Months)	\$182.24	\$174.46

HNA/Trivaris 11

Slide 12

How HNA controls costs

- Aggressive utilization and disease management
- Real-time medical data audit and analysis
- Innovative provider contracting based on performance

HNA/Trivaris 12

Slide 13

PCABP <u>Diabetic</u> Patients (01/98-10/2002)					
	1998	1999	2000	2001	2002
Patients	2,947	3,090	3,155	2,869	2,832
Claim PMPM	2.9	3.3	3.6	3.5	3.7
Median Age	68.6	68.8	69.4	70.3	71.1
HgbA1c	30.4%	47.8%	48.2%	51.2%	59.9%
Hospital admissions per 1000 member yr	816.1	759.0	706.0	597.0	737.0
Bed days per 1000 member yr	5,594	5,135	4,571	3,932	5,052

HNA/Trivaris 13

Slide 14

PCABP <u>Chronic Renal Failure</u> Patients (01/98-10/2002)					
	1998	1999	2000	2001	2002
Patients	288	331	370	419	435
Claim PMPM	6.8	8.6	8.2	9.0	9.4
Median Age	74.4	75.5	75.6	76.4	77.6
Hospital admissions per 1000 member yr	2,063	2,058	1,732	1,626	2,072
Bed days per 1000 member yr	22,559	19,329	14,004	13,797	17,031

HNA/Trivaris 14

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PCABP <u>Hypertension</u> Patients (01/98-10/2002)					
	1998	1999	2000	2001	2002
Patients	8,024	8,099	8,214	7,290	6,996
Median Age	68.1	68.8	69.6	70.6	71.3
Office Visits PMPM	0.54	0.59	0.64	0.56	0.59
ER visits per 1000 member yr	37	35	40	35	32
Hospital admissions per 1000 member yr	41	17	39	23	26
Bed days per 1000 member yr	220	238	167	119	144

HNA/Trivaris 15

Slide 16

How we continue to obtain positive results

- Focus on what makes medical sense
- On site, concurrent utilization review by care management nurses
- On-site discharge planning by care management nurses
- Home follow-up calls by care management nurses
- Member education
- Provider education
- Home care services
- Social services
- Benefit coverage for prescription drugs
- Eliminate financial conflicts of interest
- Quality controlled data driven decisions

HNA/Trivaris 16

Slide 17

Primary Care Physician Evaluation Risk Adjusted For Illness and Age

- Cost PMPM
- LOS
- Frequency of visits PMPM
- Frequency of admissions PMPM
- Compliance with preventive care

HNA/Trivaris 17

Slide 18

Benefit Improvement Based on Data

Fact: 25% of Plan members earn <\$600/Mo
50% of Plan members earn <\$900/Mo

- Benefit Improvement to include formulary prescription drug coverage for diabetes and its complications
 - 13% of Plan members are diabetic
 - 28% of total plan expense is dedicated to treating diabetes and its complications

HNA/Trivaris 18

Slide 19

Conclusions

Our experience has demonstrated:

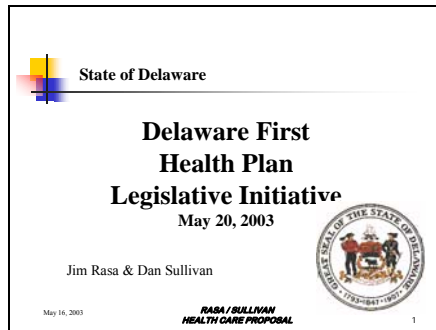
- Correctly applied, quality patient care and preventive health measures control costs and improve health status.
- Reasonable provider contracting and patient advocacy are essential components of good health plan management.
- Strategic use of data permits effective risk management.
- Patient advocacy decreases plan costs.

HNA/Trivaris

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Conventional Subcommittee Proposal for Medical Management Plan


Slide 1



Slide 2



Slide 3




Health Plan Principles

- ▣ Affordable, Predictable, Self Sustaining Rates
- ▣ Comprehensive benefits
- ▣ Promotion of prevention/medical disease management
- ▣ Promotion of Quality and Better Outcomes
- ▣ Comprehensive Network
- ▣ Operational Excellence
- ▣ Obligation for all stakeholders to contribute
- ▣ Demonstration of Independence of plan administration from plan financial risk taker

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HEALTH CARE PROPOSAL**

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Slide 4




Affordable, Predictable, Self Sustaining Rates

- For all Small Businesses (1-50)
 - a. Group 1-50 Including Sole Proprietors
 - i. Protection for sole proprietor - See Colorado Law
 - ii. Proof of Work
 - a. Rates
 - i. Modified community rating (age banding)
 - ii. Rate increases > 10% requires approval by appointed committee established by law

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Slide 5



Comprehensive Benefits

“With an emphasis on wellness and disease management”


Plan Design > 18 years

- i. Physician Co-pay - \$20
- ii. Inpatient Hospital co-pay - \$500/stay (establish maximum out-of-pocket)
- iii. Inpatient hospital surgery co-pay - \$150 (establish maximum out-of-pocket)
- iv. Outpatient surgery facility co-pay - \$100 (establish maximum out-of-pocket)
- v. Outpatient surgery physician co-pay - \$100 (establish maximum out-of-pocket)
- vi. ER Co-pay - \$100 (waived if admitted)
- vii. Pharmacy – unlimited generic only (brand when no generic equivalent and medically necessary). Formularies with pre-cert requirements for non-preferred drugs. \$10 co-pay
- viii. Out-of-network - \$2000 deductible, 80% coinsurance

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Slide 6



Comprehensive Benefits (continued)

“A sincere effort to take care of children”


Plan Design < 18 years

- i. Physician Co-pay - \$2
- ii. Inpatient Hospital co-pay - \$100/stay (Establish maximum out-of-pocket)
- iii. Inpatient hospital surgery co-pay - \$75 (Establish maximum out-of-pocket)
- iv. Outpatient surgery facility co-pay - \$50 (Establish maximum out-of-pocket)
- v. Outpatient surgery physician co-pay - \$25 (Establish maximum out-of-pocket)
- vi. ER co-pay - \$75 (waived if admitted)
- vii. Pharmacy – unlimited generic only (brand when no generic equivalent and medically necessary). Formularies with pre-cert requirements for non-preferred drugs. \$10 co-pay.
- viii. Out-of-network - \$2000 deductible, 80% coinsurance

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Slide 7



Comprehensive Benefits (continued)


Wellness

- i. **Women > 21 years:** Pap smear: \$25 success certificate one per 12 month rolling time period from last test
- ii. **Black men > 40 years:** PSA \$25 success certificate one per 12 month rolling time period from last test
- iii. **White men > 50 years:** PSA \$25 success certificate one per 12 month rolling time period from last test
- iv. **Women > 40 years:** Mammography: \$25 success certificate one per 12 month rolling time period from last test

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Slide 8




Promotion of Prevention/ Medical Disease Management (continued)

- v. **Diabetic Patients:** HgbA1-C \$15 success certificate one per three month rolling period
- vi. **Colorectal screening** > 50 when indicated
 1. **stool for occult blood:** rolling limit one per 12 month rolling time period from last test \$25 success certificate
 2. **sigmoidoscopy:** rolling limit one per 12 month rolling time period from last test \$25 success certificate
 3. **colonoscopy:** rolling limit one per 12 month rolling time period from last test \$25 success certificate

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Slide 9




Promotion of Quality and Better Outcomes

Medical report card:
A once-a-year summary of enrolled member's health care including diagnosis, cost, provider and dates of service for any plan member that requests information.

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Slide 10



Promotion of Quality and Better Outcomes (continued)


Application for plan should include the following elements:
(Not for underwriting purposes)

- Weight
- Height
- Race
- Smoking history
 - packs per day
 - how long have they smoked
- Treatment and/or medication for certain identified conditions

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Slide 11



Promotion of Quality and Better Outcomes (continued)

Required Pre treatment education program for maximum benefits under the plan:


Pre cert treatment for all Hospitalizations, Outpatient, and Ambulatory surgery

- focused second opinions when required by plan medical managers
- reduced benefit if opinion not obtained
- final decision for treatment plans always remains with patient and their physician**
- no denial** of covered benefits under the plan if pre treatment education is obtained regardless of patient's choice of treatment plan

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Slide 12



Promotion of Quality and Better Outcomes
(continued)


All eligible members are enrolled in the plan's medical management registries for:

- Diabetes
- Acute low back pain
- Obesity
- Smoking
- Pregnancy

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Slide 13



Promotion of Quality and Better Outcomes
(continued)


Physician Standardized Metrics

- Satisfaction survey
- Cancer prevention effectiveness
- Efficiency of care
- Overall outcome of care

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Slide 14



Promotion of Quality and Better Outcomes
(continued)


Member Support Programs

- Medical report card
- Satisfaction survey
- Quarterly health fairs
- Best-of-the-Net medical info
- Patient advocacy nurse:
Availability during working hours for discussion with plan members all aspects of elective medical care

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Slide 15




Comprehensive Network

All state qualified and credentialed providers must participate.

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Slide 16



Operational Excellence


Timely payment to providers

- Web-based ACH payments to physicians
- Excellent customer service
- Web-based provider enrollment maintenance

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Slide 17



Obligation for all stakeholders to contribute


Provider contributions

- Reduced Physician Rates – 100% of current Medicare FFS
- Reduced Hospital Rates:
 - “Most favored nation” pricing for all facilities. Obligation of hospitals to disclose most favored rate through audit process.
 - Predictability – establish per diem rates (with payments no greater than an established multiple of Medicare), eliminate stop loss provisions, and no-charge master provisions.

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Obligation for all stakeholders to contribute
(continued)

Insurer Contributions


High Risk Pool Subsidy Established

- Small businesses that meet certain criteria (i.e. can provide health insurance but are currently not doing so) pay an assessment (pay or play)
- Carriers – current carriers in the marketplace may be assessed based upon current market share assessment

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Obligation for all stakeholders to contribute
(continued)

Plan Member Contributions

- Must conform to preventive care and medical care guidelines or pay more for health care


State of Delaware Contributions

- Acting partner through marketing, education and promotion ...

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Slide 20



**Demonstration of Independence
of Plan Administration from Financial Risk
and Better Outcomes**


Purpose:

- Avoids conflicts of interest when providing medical information to plan members.
- Increases confidence of plan members in plan administration
- Eliminates conflict of interest with providers

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Summary and Conclusions

As Albert Einstein said:
"Insanity is doing the same
thing
every day and expecting a
different result."

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Slide 22



Summary & Conclusions

Adopt the Eight Principles of Successful Change:

- ▣ Affordable, Predictable, Self Sustaining Rates
- ▣ Comprehensive benefits
- ▣ Promotion of prevention/medical disease management
- ▣ Promotion of Quality and Better Outcomes
- ▣ Comprehensive Network
- ▣ Operational Excellence
- ▣ Obligation for all stakeholders to contribute
- ▣ Demonstration of Independence of plan administration from plan financial risk

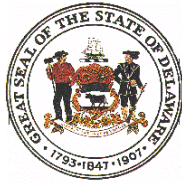
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Conventional Subcommittee Pilot Proposal

Medicaid and Small Group Reform

A First Private Public Partnership for Health
In Delaware



Rasmussen 6/6/03

Delaware Demonstration Model Medicaid and Small Group Reform

Sussex and Kent Counties

- HNA/Triveris Demonstration for Medicaid alternative administration
 - Participants (plan members)
 - All Medicaid eligible members in two counties
 - Or all fee for service Medicaid eligible members in State of Delaware
 - Providers
 - Hospital rates are already established by Medicaid DRG rates
 - Doctors: Pay them more than Medicaid Rates so they will participate (120% RBRVS)
 - Plan design
 - Medicaid fee for service coverage

Rasmussen 6/6/03

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Delaware Demonstration Model

Medicaid and Small Group Reform

Sussex and Kent Counties

- Small Group Insured Product
 - Participants (plan members)
 - New small group pool established for non insured and underinsured
 - Bring into coverage those who have no coverage
 - Providers
 - Hospitals and doctors will get reimbursed at Medicaid rates for care of patients that previously they had no opportunity to get reimbursed from
 - Incentive for physicians: higher than Medicare reimbursement
 - Hospitals: Decrease uninsured creating paying patient population that uses the hospital's facilities
 - Plan design
 - Benefit Model as previously outlined by Rasa/Sullivan

Rasa/Sullivan 6/6/03

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Delaware Demonstration Model

Medicaid and Small Group Reform

Sussex and Kent Counties

- Premium subsidy for Small Group
 - Hospital rates: are Medicaid DRG rates
 - Direct negotiation with hospitals with Governor's office support
 - Physician rates are 110-120% RBRVS
 - Some sort of Delaware support for catastrophic loss-needs to be defined
 - e.g. pay or play law for small employers

Rasa/Sullivan 6/6/03

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