

## The Delaware Public Policy Institute (DPPI)

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This report was prepared for DPPI by Jack Meyer and Sharon Silow-Carroll of Health Management Associates ([www.healthmanagement.com](http://www.healthmanagement.com)). Health Management Associates is a national research and consulting firm specializing in complex health care program and policy issues. Founded in 1985, in Lansing, Michigan, Health Management Associates provides leadership, experience, and technical expertise to local, state, and federal governmental agencies, regional and national foundations, investors, multi-state health system organizations and single site health care providers, as well as employers and other purchasers in the public and private sectors.

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## Introduction

The following implementation plan builds upon the two policy recommendations outlined in the Delaware Public Policy Institute's (DPPI) February 2008 consensus report: *Small State, Big Opportunity: Taking Action for the Uninsured in Delaware*, aimed at reducing the number of uninsured in Delaware. After a series of meetings and consultations with a range of policy analysts, a group of Delaware leaders from both the government and the private sector recommended prompt action in two areas:

- Outreach strategies targeting Delawareans who are eligible for existing public coverage programs, but are not enrolled, with a particular focus on children; this entails both linking and sharing information across various programs, and working with other groups to launch a major education and media campaign to enhance enrollment; and
- Dual and complementary coverage combining access to a "medical home" emphasizing primary care and preventive health services, along with insurance protection against very high, or "catastrophic," health expenses.

The recent DPPI consensus report, *Small State, Big Opportunity: Taking Action for the Uninsured in Delaware*, notes the composition of the working group and the process it followed to achieve consensus on the twin recommendations. The consensus report also provides background information on the nature and magnitude of the problem, and provides a rationale for the policy reforms selected by the group. This supplement report takes the recommendations a step further, providing more detail on the two policy reforms, clarifying how they could work in practice, and delineating practical action steps to move Delaware forward toward implementation.

It is beyond the scope of this report to conduct formal modeling (e.g., microsimulation) or provide detailed cost estimates of the recommended actions. Such work requires additional research, many design decisions (which are delineated in this report), and numerous assumptions. There are, however, very rough "order of magnitude" figures for some components of the recommended reforms, which indicate that the costs are likely to be relatively modest and affordable. Moving forward it will be appropriate for a group of stakeholders such as the Delaware Health Care Commission to refine the model further and commission a more detailed cost analysis.

This report begins with implementation strategies for enhancing outreach and enrollment of eligible people into existing public and private coverage, and then turns to design and implementation of the combination medical home/catastrophic coverage plan.

### I. Outreach & Enrollment: Identifying Those Eligible for Coverage

The outreach focus has two main components: 1) linking non-health related programs in order to share information to identify and enroll large numbers of people, particularly children, who are already eligible for Medicaid or Delaware Healthy Children (the state's SCHIP program); and 2) enhancing education and outreach to connect consumers, employers, healthcare providers, health centers, and patient groups in the community to various sources of affordable health coverage; this could involve

collaborating with Delaware Covering Kids and Families, the Healthcare Leadership Council (HLC), Community Healthcare Access Program (CHAP), and other organizations.

### *A. Linking Programs for Targeted Outreach*

An estimated 67 percent of the nation's 9 million uninsured children, or about 6 million kids, are eligible for Medicaid or SCHIP but not participating, and children comprise 20 percent of the uninsured nationally.<sup>1</sup> Roughly another 4.5 million adults are Medicaid-eligible, but not enrolled. Thus, close to one in four of the uninsured could be in a government insurance program, but remain uninsured. In Delaware, a little more than one in four of the uninsured—or over 27,000 state residents—were uninsured but eligible for either Medicaid or Delaware Healthy Children in 2007.<sup>2</sup>

Such high rates of eligible, but unenrolled, people are attributed to obstacles to participating in publicly-sponsored healthcare programs. First, many people are unaware of these programs or do not realize they may be eligible. Second, despite some valiant efforts to simplify the application process on the part of many states, applying for Medicaid or SCHIP can still be a formidable process with numerous barriers. Assembling the documentation to establish eligibility may require considerable work, or documents may not be accessible. Going to a welfare office and waiting in line to see a clerk may require taking half a day off work, with serious consequences for a lower-income working person. Language and transportation barriers often exacerbate these problems.

One way to reduce these barriers is to shift from the current system that places the burden of verification on the individual, toward a system of “auto-enrollment” and “presumptive eligibility,” whereby potential beneficiaries are automatically enrolled based on reliable information indicating they are likely to be eligible, unless they actively opt out. Subsequent verification would affirm eligibility.

There is ample evidence that these types of policy shifts can make a substantial difference in the participation of eligible populations. For example, when the Medicare Part D prescription drug program was launched at the beginning of 2006, 74 percent of the people eligible for low-income subsidies under the program were enrolled in less than six months. This represented the highest take-up rate in any federal means-tested program during its first year. It was achieved through data matches with state Medicaid agencies and the Social Security Administration; individuals who received Medicaid or Supplemental Security Income (SSI) during the previous year were automatically enrolled for Medicare Part D subsidies. Only 14 percent of those eligible for these subsidies actually filled out an application form, as 60 percent were automatically enrolled.<sup>3</sup>

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<sup>1</sup> Genevieve Kenney. “The Role of Public Programs in Addressing the Uninsured Problem in the U.S.” Health Plan Foundation Leadership Roundtable: Priorities in Children’s Health: Access to Health Insurance and Services.” March 25, 2008.

<sup>2</sup> Delaware Health Care Commission. 2007.

<sup>3</sup> Stan Dorn. “Automatic Enrollment Strategies: Helping State Coverage Expansions Achieve Their Goals.” Academy Health. August 2007. pp. 6-7.

A subsidized health plan in Massachusetts, CommCare, has realized similar success in automatically enrolling people previously covered by the state's Uncompensated Care Pool who had incomes below the federal poverty line. Another example involves "default" enrollment in 401k pension plans. When people are asked to enroll in IRA plans on their own, only one in ten typically completes the process. When workers starting new jobs are handed a form to get an IRA, this raises the proportion enrolled to about three of ten workers. However, when new hires are placed in a company-sponsored 401k plan unless they specifically opt out, nine of ten enroll. Setting the default as enrollment rather than non-enrollment makes a significant difference.<sup>4</sup>

### Linking to Federal Nutrition Programs

Delaware could build on its recent progress in integrating means-tested programs to move further toward a system of auto-enrollment of children into Medicaid and SCHIP. Delaware now offers a common application for five different programs: Medicaid/SCHIP, food stamp benefits, Child Care Services, Cash Assistance (TANF), and Long Term Care. It also offers a web-based Application for Social Services and Internet Screening (ASSIST), which serves as a screening tool and single access point for the five medical and social service programs.<sup>5</sup>

The Delaware Department of Health and Social Services (DHSS) is already receiving information from Food Stamps, which uses a federally determined eligibility threshold requiring household income to be under 130 percent of the federal poverty line. If children are receiving Food Stamps, their family income almost certainly will qualify them for SCHIP. The only reason we cannot assert with certainty that all of these children participating in Food Stamps are eligible for SCHIP is that various means-tested programs use different methods of counting and "disregarding" income. "Countable income" may vary from one program to another.

The next step would be to build a linkage with the National School Lunch Program (NSLP) whereby children's participation in the program would trigger an eligibility review for Medicaid and SCHIP. Because children are eligible for the Delaware Healthy Children Program (SCHIP) if their family income is under 200 percent of the poverty line, many of the children participating in NSLP will be eligible for one of the health programs.

Delaware Insurance Commissioner Matt Denn proposed using schools' information about participation in NSLP to bolster enrollment in health insurance programs. As a result several members of the Delaware legislature introduced a bipartisan bill in January 2008 that would use information from schools to identify children who are eligible for SCHIP (House Bill 286, see Appendix). This bill was signed into law by Governor Minner on June 18, 2008 and will begin collecting information in November 2008. Under this new law, school districts will provide DHSS with the child's eligibility information for the free or

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<sup>4</sup> Etheredge, L. *Health Insurance Coverage At Transitions: What Works, What Doesn't Work?* Maryland Department of Health and Mental Hygiene, State Planning Grant. April 11, 2003.

<sup>5</sup> For more information on ASSIST, see:

[https://assist.dhss.delaware.gov/PGM/ASP/SC031.asp?hdn\\_SessionId=8962793737534012408170002&hdn\\_ApplicationNum=](https://assist.dhss.delaware.gov/PGM/ASP/SC031.asp?hdn_SessionId=8962793737534012408170002&hdn_ApplicationNum=)

reduced price meal or free milk program, and DHSS will then send information about SCHIP and Medicaid to the children's parents. Further, the Department of Insurance is looking into how to "reward" school nurses and schools help DHSS receive this important information.

Information sharing between school systems and DHSS is essential, but there are some important hurdles that must be overcome. The most significant is that the public school system is very decentralized. There are nineteen school districts in the state, and according to a DHSS official, data on NSLP participation is not currently reported to a statewide central repository from which it could be transmitted readily and in a consistent format to DHSS.

It is also important to build bridges between DHSS and private and charter schools since 20% of students in Delaware attend these schools. Private and charter schools also participate in NSLP and should gather data in a consistent fashion to report to the state.

This process is not simple. DHSS, which administers both Medicaid and SCHIP, will need to cross-check the monthly lists with their own beneficiaries, contact the un-enrolled families to ascertain whether the child(ren) are uninsured and indeed meet all of the eligibility criteria, and then enroll the eligible members. If experience indicates that the great majority of the children from NSLP are in fact eligible for Medicaid or SCHIP but unenrolled, Delaware could move further toward auto-enrollment.

A very preliminary assessment of what is needed to implement this type of linkage between NSLP and Medicaid/SCHIP indicates that the costs to the state are quite modest. Recent data show that 85,672 children in Delaware participated in NSLP in Fiscal Year 2007. A list of these children would first need to be crosschecked with Medicaid and SCHIP to "eliminate" those who are already insured in the health programs.<sup>6</sup> Additional staff would be required for outreach and screening to determine whether children are eligible for Medicaid and SCHIP, and to facilitate their enrollment if they are eligible. Full screenings could occur every two years (or some other designated period), with only screening of new NSLP participants between full screenings. If, for example, about 25 new staff persons were needed for these tasks, the cost would be approximately \$1 million per year.<sup>7</sup> Even if twice the number of staff were needed, the cost would still be a modest \$2 million per year. In addition, a state official estimated that it might cost DHSS approximately \$100,000 per year for information technology (IT) improvements related to this initiative. There would also be some additional costs to the school districts for automating their systems and developing/implementing common reporting.

It should be stressed that these figures are simply illustrative of the magnitude of the budget required to implement this program. We would suggest that the Delaware Health Care Commission explore this in more depth and work with DHSS to refine the estimates. Further, a full cost/benefit analysis would identify and estimate certain savings likely to emerge over time as additional children move from

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<sup>6</sup> This effort could be combined with the current efforts to screen Food Stamp and TANF recipients for Medicaid/SCHIP eligibility.

<sup>7</sup> According to a DHSS official, the approximate cost of each outreach staff person (salary plus benefits) is about \$40,000 on an annual basis.

uninsured to insured status. Such benefits would be derived, for example, from improved health, a rise in school attendance, a reduction in safety net outlays, and other positive outcomes.

### Other Potential Program Linkages

While federal nutrition programs present one way to identify and conduct targeted outreach to eligible but unenrolled children, other approaches can also be considered that would identify uninsured people or those at-risk for becoming uninsured. These approaches also involve sharing information across programs or agencies. Potential strategies include the following:<sup>8</sup>

- **Modification of the W-4 form** that employers use in payroll withholding to allow new hires (as well as existing workers if W-4s are collected every year) to check a box indicating which members of their family, if any, are uninsured and giving permission to the Delaware Division of Revenue to share this information with DHSS. DHSS could send information and applications to the families with uninsured members indicating that if their family income is less than a certain amount, they may be eligible for government-supported health coverage or CHAP.
- **Modification of state income tax forms** to give filers a chance to seek assistance in obtaining affordable health coverage. This is particularly useful in Delaware, where filers eligible for the state's Earned Income Tax Credit (EITC), which supplements the federal EITC, are low income and the children are more likely to be eligible for Medicaid or SCHIP. Again, the Division of Revenue would forward information (with the individual's permission) to DHSS for follow up.
- **Devotion of resources** necessary to follow up on school health form inquiries about public programs. At the start of every school year, parents fill out health forms for their children. Delaware has already started the process of giving parents who fill out these forms the option of inquiring about the children's eligibility for other government programs, including health programs. But Delaware has not yet devoted the resources to follow up on such inquiries and provide real linkages between schools and health programs.
- **Modification of applications for unemployment compensation benefits.** Workers could check a box if they (and family members) will be without coverage now that they are unemployed. For example, they may have worked for a small company that is not COBRA eligible (fewer than 20 employees), or the worker may be unable to afford COBRA premiums (the worker pays 102 percent of the premium).<sup>9</sup> Another option beyond the unemployment insurance application is to have health plan administrators add a box to check on forms they are required to give to laid-off workers under COBRA.

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<sup>8</sup> Dorn, 2007.

<sup>9</sup> The Consolidated Omnibus Budget Reconciliation Act (COBRA) gives workers and their families who lose their health benefits the right to choose to continue group health benefits provided by their group health plan for limited periods of time under certain circumstances such as voluntary or involuntary job loss, reduction in the hours worked, transition between jobs, death, divorce, and other life events. Qualified individuals may be required to pay the entire premium for coverage up to 102 percent of the cost to the plan. (<http://www.dol.gov/dol/topic/health-plans/cobra.htm>)

- Requirements that public and private insurers provide young adults with information and application assistance pertaining to affordable coverage options. A “transition period” in which people frequently lose health coverage involves either young adults aging off their parents’ health coverage or the completion of college education. Further, teens become ineligible for SCHIP when they turn 19. Current Population Survey (CPS) data show that well over 8 million people 18-24 years old are uninsured. Delaware has taken a step in the right direction by defining dependents in both the individual and group insurance markets as persons up to age 24 provided they are a state resident, unmarried, full-time student and have no dependents and no other insurance coverage.<sup>10</sup>

### Data Security, Privacy & Federal Support for IT

Two important challenges to sharing information across programs involve data security/privacy issues and the need to upgrade information technology; these impediments can be addressed. The Government Accountability Agency (GAO) has identified several risks, and stipulated several procedures to protect against a breach of data security and privacy within government agencies. These are particularly relevant when different programs or agencies exchange information.<sup>11</sup> Delaware can comply with the GAO recommendations by developing a series of protocols within the state agencies that share information under one of the auto-enrollment or program linkage strategies described above. These data security protections (listed further below in Action Steps) are necessary to protect residents.

Another significant challenge involves developing the information technology infrastructure to support inter-agency electronic exchanges of data on people enrolled in several different government programs, some federal and some joint federal and state.

Enhanced federal matching funds are available to support Medicaid Management Information Systems (MMIS). States may actually receive 90 percent reimbursement from the federal government for MMIS development, but long-standing federal regulations deny this enhanced federal match for *eligibility determination systems*. Pending federal legislation, however, would provide enhanced federal matching funds for IT improvements related to automatic enrollment.<sup>12</sup>

Even under current law, enhanced federal matching money may be available under the Medicaid Information Technology Architecture (MITA) program. MITA was established to provide federal assistance to states to reengineer their data systems to improve efficiency across all aspects of Medicaid. MITA provides an enhanced match for the development of electronic medical records (EMRs). Eligibility information, including participation in other means-tested programs, can be incorporated into each beneficiary’s EMR. Since this information could have clinical significance and improve

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<sup>10</sup> Kaiser State Health Facts <http://www.statehealthfacts.org/index.jsp>

<sup>11</sup> Gregory C Wilshusen and David A. Powner. “Testimony before the Subcommittee on Emerging Threats, Cybersecurity, and Science and Technology; Committee on Homeland Security, House of Representatives,” *Information Security: Persistent Weaknesses Highlight Need for Further Improvement*. April 19, 2007. GAO-07-751T

<sup>12</sup> This type of provision is included in S. 1364, S. 1224, S. 1213, S. 895, H.R. 2147, H.R. 2055, and H.R. 1535 from the 110<sup>th</sup> Congress.

healthcare quality, the IT development needed to efficiently import data on eligibility for various means-tested programs might qualify for an enhanced (90 percent) federal match through MITA.<sup>13</sup>

### Action Steps

The Delaware Health Care Commission, composed of a diverse group of stakeholders and chaired by Lieutenant Governor John Carney, Jr., should continue to explore additional opportunities for sharing information to boost Medicaid and SCHIP enrollment. Activities should include the following:

- Creation of an inventory of the various data systems within both DHSS and the Delaware Department of Education;
- Assessment of the technical and administrative changes necessary for NSLP to provide DHSS on a monthly basis with the names, contact information, and reported family income (if available) of children enrolled in these programs;
- Pressure by state leaders and the Department of Education for the Delaware Public School System to develop a centralized, standardized reporting system on NSLP participation, and transmit this information electronically to DHSS on a monthly basis. This requires enhancing automation of records and developing a common transmission mechanism. Data would be reported from districts to the Delaware Department of Education, which would combine and transmit it to DHSS;
- Development of protocols by DHSS for cross-checking lists with current Medicaid/SCHIP rolls, notifying parents of children who are not currently enrolled, informing families of possible eligibility, and supplying information about eligibility criteria for Medicaid and SCHIP and application instructions; and
- Development of cost estimates and a timeline for implementation of data sharing and reassessment on a pilot basis, with an evaluation of progress at six-month intervals. Depending upon progress, this can be scaled up and assessment may commence on the feasibility of moving to actual auto-enrollment. The following components should be considered with the development of cost estimates and an implementation plan:
  - Examination of potential links to other agencies including the state tax system and Unemployment Compensation, and presentation of recommendations to the legislature;
  - Work on the data security and privacy issues noted above, to make information sharing across agencies possible without jeopardizing the privacy of families in the state. Specifically, this involves the following actions:<sup>14</sup> Develop access controls to assure that only authorized individuals can read, alter, or delete data;
  - Establish configuration management controls to provide assurance that only authorized software programs are implemented;

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<sup>13</sup> Stan Dorn. *Supra*. Page 10.

<sup>14</sup> GAO, 2007.

- Segregate duties to reduce the risk that one individual can perform inappropriate actions without detection;
- Maintain continuity of operations planning to prevent significant disruptions of computer-dependent operations;
- Establish an agency-wide information security program to provide the framework for ensuring that risks are understood and effective controls selected and properly implemented;
- Develop a system for reporting security breaches and other adverse incidents to external authorities;
- DHSS should begin (as soon as possible) to have conversations with those individuals in the Department who are responsible for DHSS' technology capabilities and explore the possibility of using Medicaid Information Technology Architecture (MITA) grants from the federal government providing a generous federal match for IT development, to support the capacity to cross-walk between data systems electronically; and
- Greater connections with the Delaware Health Information Network (DHIN) can also be made with any technology-based efforts.

### ***B. Enhancing Community Education and Outreach***

Another component of the outreach plan is to enhance current efforts to educate consumers and the business community about the importance of having health coverage, the availability of both public and private coverage options, and how to overcome barriers and apply for coverage for which one is eligible. As noted above, the majority of Delaware's uninsured children are eligible for, but not enrolled in, a public coverage program. Further, in some cases there are affordable private insurance products in the market, but individuals and employers are unaware of these options and need understandable information.

Delaware recently forged a partnership with the Healthcare Leadership Council (HLC) to launch HLC's Health Access America Campaign in the state. The campaign, which HLC is implementing in multiple sites across the country, focuses on expanding health coverage by building broad-based outreach coalitions, conducting information and enrollment activities, and using local events to advocate policy action to expand coverage accessibility. HLC campaign activities include grassroots education and enrollment, advocacy, media coverage, and research and polling.

HLC's efforts in Delaware build on other outreach activities already underway in the state, while also increasing the efforts aimed at the employers and the private sector. The Medical Society of Delaware, for example, is helping to extend the Delaware Covering Kids & Families (CKF) program, which provides information and application assistance to uninsured families who might be interested in and eligible for enrolling in Medicaid or SCHIP. The Community Healthcare Access Program (CHAP) has also played an important role in Delaware's outreach activities, helping to increase Medicaid and SCHIP enrollment by 10% from 2003 to 2007 through numerous CHAP and CKF activities. Specifically, the CHAP Program's

outreach activities have resulted in linking over 3,000 people to Medicaid and 100 people to primary care services at the Veteran's Association.<sup>15</sup>

Additionally, a coalition of public-private leaders throughout the community, *Healthy Delawareans Today & Tomorrow*, has worked over the past year to educate Delawareans about the availability of coverage and services. Since April 2007, they have been successful in linking over 4,000 Delawareans with existing services. Recently, the group launched Delaware's inaugural Cover the Uninsured Month that was supported by Governor Minner through a Proclamation.

Effective outreach to individuals has taken place at community centers, schools, churches, day-care centers, as well as clinics and hospital emergency departments, and this should continue. However, this should also be supplemented with outreach to employers. Delaware companies of all sizes offering health coverage could be encouraged to reduce the waiting period for covering new hires. Businesses could be encouraged to contribute to the health coverage of part-time workers. Companies that cannot take this step could be guided to arrangements set up by HR Policy Associates, a group representing employers that negotiates affordable health coverage options for part-time, temporary, seasonal, and contract workers who do not qualify for their employer's health plan.

Similarly, small firms must be educated about affordable health coverage options. According to HLC, many small firms not offering health insurance have some misperceptions about the cost. These firms may not realize, for example, that employer healthcare contributions are fully tax-deductible.

### **Action Steps**

The Delaware Health Care Commission should continue its efforts to further develop and implement a community education and outreach plan in addition to the following actions:

- Compile a list of existing efforts to educate consumers and employers about public and private coverage options;
- Invite an HLC leader to meet with them to discuss and plan their coordinated effort in Delaware, and to develop strategies for reaching out to and educating families and small firms;
- Develop a specific action plan and timetable for additional or complementary outreach/education activities; these may include health fairs, mailings and informational seminars to employers, media coverage, etc.;
- Assess costs and potential funding sources -- including resources for existing outreach initiatives through the Department of Health and Social Services, federal funding sources, the Covering Kids and Families initiative, corporate sponsorship, foundation support, and others; request, if necessary, modest additional funding from the legislature; and

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<sup>15</sup> Email communication from Paula Roy, Executive Director DE HCC. May 20, 2008.

- Implement the outreach plan.

## II. Developing a Combination Plan

This section outlines an implementation strategy for the second set of recommendations from the Summit participants related to ensuring uninsured Delawareans have access to a medical home that provides timely and appropriate primary and preventive care, and protection against catastrophic medical expenses. This section will try to fuse these two elements together, beginning with the medical home portion of this hybrid policy and then turning to the catastrophic protection component.

### *A. Access to a Medical Home and Primary/Preventive Care*

Summit participants recommended the development of a program that provides access to affordable primary and preventive care through a medical home, building on and extending Delaware's Community Healthcare Access Program (CHAP).

#### Community Healthcare Access Program (CHAP)

CHAP is a program, which provides free or reduced-cost care for primary and some follow-up specialty physician care, as well as lab work and imaging studies. CHAP targets adults who are not eligible for Medicaid with incomes between 100 and 200 percent of the federal poverty line (FPL), and currently has approximately 5,300 members (as of April 2008). The program does not cover inpatient hospitalization, emergency room care, and prescription drugs, although physicians may try to assist patients by providing medication samples or enrolling them in pharmaceutical manufacturers patient assistance programs. The CHAP network includes Federally Qualified Health Centers (FQHCs), several other community health centers, physicians who participate in the Medical Society's Volunteer Initiative Program (VIP), and hospitals that provide lab work, imaging, and diagnostic services. About 500 primary care and subspecialty physicians provide CHAP services through the VIP program. CHAP is administered by the Delaware Health Care Commission, which contracts with facilitators in FQHCs and hospitals to enroll people, and with the state Medical Society to administer assignment of enrollees to a medical home where they would seek primary and preventive care. Medical homes are about evenly split between FQHC and physician practices. The providers offer discounted fees, or in many cases free care, to enrollees. Electronic Data Systems (EDS) serves as an enrollment broker and can use data from other state programs where it plays the same function to check participants' self-reported income and eligibility for Medicaid or Delaware Healthy Children.

An important advantage to building on CHAP is that it already has a provider network and enrollment and income verification systems in place. However, extending or building on this program to provide the “front-end” services to more uninsured Delawareans as part of combination primary care/catastrophic care plan assumes that the CHAP network – comprised in large part by physicians participating in the Medical Society’s Volunteer Initiative Program (VIP) – has the capacity to expand to serve an influx of new, uninsured patients. We assume that additional financial support would be needed to extend this capacity (discussed further below), and that this issue must be thoroughly assessed. Further, the model supported by the Summit participants requires making a number of basic design choices:

### **Insurance or Direct Service Outreach?**

The first choice is whether to provide healthcare services through a new insurance program with premium payments, or through direct payments to physicians and other healthcare providers, with varying degrees of discounts or free care for those who cannot afford to pay providers’ regular fees. The Summit participants favored a direct payment approach, similar to the current CHAP initiative. Thus, this direct payment approach is expanded upon here. However, disadvantages of this approach include sicker people incurring greater costs, and such costs cannot be anticipated or budgeted in advance. The alternative insurance model involves a regular premium payment and could be more easily combined with the catastrophic, high-deductible insurance plan described further in the report. Further examination of this issue should take place.

### **Who Would be Covered by a CHAP expansion?**

CHAP is currently available to individuals with income up to 200 percent of FPL. It is recommended that this be extended to 300 percent of FPL. There would be two categories of enrollees—those currently eligible and those with incomes between 200 percent and 300 percent of FPL. Expansions beyond 300 percent of FPL could be considered if funding and enrollment success allows in the future.<sup>16</sup> Fees would be tied to these categories, with lower fees associated with lower income categories. To avoid people dropping their current insurance, there should be a stipulation that this program is available to people who have been uninsured for a minimum amount of time (e.g., six months, twelve months). After the program operates successfully for two or three years, eligibility could be extended to uninsured people at higher income levels, with fees rising to full provider costs.

### **What Would be Covered?**

Participants would be assigned to a medical home, which would offer preventive care such as screenings (PAP smears, cholesterol assessments), physical examinations, immunizations, and well-child

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<sup>16</sup> Some have proposed going as high as 500 percent of the FPL. While the problem of “crowd-out” should not be too serious because few people with reasonably comprehensive health coverage would want to give it up in exchange for the very limited benefits covered under CHAP, there may be some pushback regarding subsidizing people with incomes extending up to or above \$100,000 a year for a family of four. We recommend starting at a lower level that is more in line with some states’ SCHIP expansions.

visits, and some wellness programs such as smoking cessation assistance, as well as routine primary care and diagnostics. To make the program attractive and encourage preventive care, preventive services could be free to members. To the extent that specialists can be recruited to the program, some specialty care would be provided as well. This is important to assure that when primary care physicians discover a medical problem as they examine patients, such patients have access to affordable follow-up visits, tests, and treatment provided by specialist physicians. As with the current CHAP, inpatient care and emergency room visits would not be covered. Unlike current CHAP services, it is recommended that at least a limited number of pharmaceuticals be included, which can be critical for early intervention and/or the proper management of chronic conditions.<sup>17</sup>

### **Funding Options Vary - Provider Discounts and/or State Subsidies?**

The next choice is whether to rely solely on provider discounts to help make the services affordable, or to also use state subsidies, employer contributions or non-profit funding to fill the gap between provider fees and patients' ability to pay. The CHAP program currently relies solely on provider discounts, and in many instances, providers waive the fee entirely rather than do the necessary paperwork to determine the sliding scale fee or work out a payment plan with the low-income patients.<sup>18</sup>

The challenge is that moving toward universal access to affordable primary and preventive care, a goal that was widely shared among the Summit participants, will likely require the recruitment of many more physicians, both primary care doctors and, hopefully, specialists and sub-specialists. Hospitals, which provide lab work and imaging studies under CHAP, would also need to participate to a greater degree under an expanded program. But it is unrealistic to expect large numbers of physicians, and particularly specialists, to discount fees or provide what amounts to charity care for a substantial number of uninsured people, particularly as their income rises above 200 percent of FPL. Nor is it realistic or fair to urge physicians already participating in CHAP to take on more patients at heavily discounted rates. Therefore, state subsidies are recommended to supplement patient payments (described further below), in order to encourage enough providers to participate in the program.

There is a tradeoff, however - government subsidies will require the clinics, practices, and hospitals to collect some of the money from the patient and some from the state, which can be an administrative burden (and some may simply choose to not bill the state). This is a necessary element to ensure an adequate supply of providers.

Employer contributions should also be considered, but new processes or protocols would likely need to be put in place. Unlike premiums, where employers can make an easy monthly contribution, CHAP does not have premiums, and payments to providers are made at the time of the visit. Employers could

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<sup>17</sup> Currently, the Medical Society's VIP has on staff a full-time pharmacy assistance coordinator, who assists eligible CHAP members in enrolling in pharmaceutical manufacturer patient assistance programs that provide many pharmaceuticals at no cost.

<sup>18</sup> Analysis of CHAP prepared for the Delaware Health Care Commission by Elliot Wicks, Economic and Social Research Institute, 2006.

consider making contributions to the CHAP program to help offset the providers' fees, establish funds through CHAP for their employees specifically, or look to make contributions directly to providers. Further discussions with employers and CHAP administrators would be needed in order to determine what option makes the most sense.

### What Payment Mechanisms and Schedules are Appropriate?

People eligible for the new medical home (expanded CHAP) program would have a membership card designating a category based on their family income: (1) less than 200 percent of FPL, or (2) 200-300 percent of FPL.<sup>19</sup> Using some standard fee structure such as the BlueCross BlueShield fee schedule payments could involve a combination of provider discounts, patient contribution, and state subsidy. (An exception would be for preventive services, for which the state subsidy covers the patient's share.)<sup>20</sup>

Depending upon a patient's income category, the providers would discount the standard fees up to a certain percentage. The patient and state would each then contribute a share of the discounted fee. Because cash flow is a serious constraint for lower and even moderate-income patients, providers would collect the patient's share at the time of the visit, and bill the state health agency for the government's share of the discounted fee. This is one possible approach to sharing responsibility for cost. Clearly, other approaches and subsidy levels are possible and the final structure should be based on input from the provider community as well as affordability and cost factors. The following examples illustrate a 3-share approach between the provider, patient, and state:

- For those with incomes less than 200 percent of FPL, providers would be asked to discount their fees from a standard schedule by 20 percent, and the state would pay three-fourths of the remaining amount, with the patient paying the difference. Thus, if the fee schedule called for a payment to the provider of \$100, that provider would reduce the fee to \$80, with the state paying \$60 and the patient paying \$20.
- For members with incomes in the range of 200-300 percent of FPL, the provider would discount the fee by 10 percent. The patient and state subsidy would each contribute half of the discounted fee. Thus, if the fee schedule called for reimbursing the provider \$100, that provider would reduce the fee to \$90 and collect \$45 from the patient and \$45 from the state.
- If future discussions about expansions beyond 300 percent of FPL take place, the provider would not discount the requested reimbursement but rather ask for the amount called for by the fee schedule. The patient and possibly the state could then divide the bill.
- A possible future, optional feature of the new program would allow people with higher incomes to effectively "buy into" the expanded CHAP system by paying unsubsidized fees (including for preventive services). This could be done if the program is intended to eventually provide universal

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<sup>19</sup> Current CHAP enrollees carry a membership card with income information.

<sup>20</sup> BCBS does not make a fee schedule publicly available although providers are generally aware of BCBSD "allowables" for the CPT codes in their specialties.

access to primary and preventive care to all state residents. The relatively small number of uninsured people with incomes above the 300 percent threshold would benefit from a fee schedule. It is worth noting that uninsured individuals are frequently the only ones paying actual provider charges in our healthcare system. Thus, higher-income uninsured individuals may realize some savings even though they are neither subsidized nor given “charity care.”

#### **Cost of a CHAP Expansion: Rough Order of Magnitude**

The current per member cost for CHAP members is approximately \$236 per year,<sup>21</sup> including: administration, customer service, eligibility and enrollment, and basic care management. Importantly, this figure does not include payments to providers for most healthcare services, which are largely donated. A 2006 analysis conducted for the Delaware Health Care Commission estimated the enrollment and cost for an expanded, subsidized CHAP program somewhat similar to the CHAP expansion we describe in this report in which provider services are not donated. Using various assumptions and scenarios (re: eligibility, subsidy levels, covered services, utilization, provider costs, and provider discounts), the analysts estimated that from 2,500 to 4,000 individuals would initially enroll if eligibility is extended to uninsured people with income up to 500 percent of poverty, total healthcare service costs would range from about \$335,000 to \$853,000 per year, and costs to the state for subsidies would range from about \$118,000 to \$401,000 per year.<sup>22</sup> That is, the order of magnitude of costs to the state for subsidies is relatively modest. Of course, the number of uninsured people and health costs have increased since the Commission’s 2006 analysis, and the model described in this report suggests additional covered services (e.g., some specialist, diagnostic, and allied healthcare services and limited pharmaceuticals); however, the current model has a lower income threshold. A new, thorough cost analysis is warranted.

#### **How can Program Linkages, the Outreach Campaign, and Employers Play a Role?**

Using the various sources of information noted earlier (e.g. nutrition programs, schools, unemployment insurance, etc.), the state healthcare agencies would identify people who are uninsured and eligible for Medicaid, SCHIP, or the expanded CHAP program. The latter would target uninsured children with incomes in the range of 200-300 percent of FPL and uninsured adults in the range of 100-300 percent of FPL. Adults with incomes in the range of 100-200 percent of FPL are already eligible for CHAP and more of these adults could be encouraged to participate in CHAP along with those newly eligible.

Consideration should be given to whether or not additional outreach workers are needed to provide information to and/or contact those people who may be eligible for the new “CHAP-Plus” medical home program. The enhanced outreach campaign described above would include the new program in its

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<sup>21</sup> Delaware Health Care Commission, 2008.

<sup>22</sup> The analysts modeled a program in which uninsured Delawareans with income between 200 percent and 499 of the FPL are eligible, with state subsidies from 15 to 45 percent of service costs (tied to member income), and physician discounts are from 5 to 15 percent (tied to member income); it assumes take-up rates from 6.2 to 10 percent of eligible persons, and uses Blue Cross Blue Shield of Delaware 2005 data on utilization and provider costs for primary care visits.

education, media messages, and other activities. Employers should be both a target of the outreach/education campaign, and also participants. Outreach is needed to ensure employers understand the program, and encourage their eligible employees to enroll. For example, employers should be supplied with reader-friendly materials about coverage options to distribute to their uninsured workers.

Finally, primary care and other medical societies should be involved in designing the program, and informing and recruiting their members.

### How is The Medical Home Component Tied to Catastrophic Coverage?

For those with incomes above 200 percent of FPL, the expanded CHAP medical home/primary care program would be available *only if they purchase a catastrophic, or high-deductible plan, described below.*

#### ***B. Catastrophic Coverage***

The second part of the combination plan calls for protection against “catastrophic medical expenses.” This section lays out how this might be accomplished and how this protection would be financed. The design of this part of the proposal draws upon experience and lessons learned in Delaware by BlueCross BlueShield of Delaware.

#### **BlueCross BlueShield of Delaware Experience with High Deductible Plans**

BlueCross BlueShield (BCBS) has been offering high-deductible health plans for several years in both the individual market where people buy health coverage on their own, and in the small-group market (firms with up to 50 employees, including sole proprietors). Other health plans also offer such arrangements. They include plans with deductibles that range from \$1,000 per year to one plan with a deductible of \$5,000 for care received from in-network providers and \$10,000 for care received out-of-network.<sup>23</sup> They also cover some primary and preventive care services before the deductible is applied.

BCBS has learned that consumer interest in high deductible plans diminishes as the deductible rises, and tends to drop off above the level of \$2,500 per year. This is attributed to the fact that the premium reductions associated with higher deductibles are not very large. For example, in the BCBS PPO offerings in the individual market, for young adults 20-24, the premium is only \$123 per month for a plan with a deductible as low as \$250 for in-network use and \$500 out of network use. This premium drops by only \$5 per month to \$118 when the deductible is doubled to \$500/\$1,000 and by only another \$8 per month to \$110 when the deductible is doubled again (to \$1,000/\$2,000). Raising the deductible by another two and half times to \$2,500/\$5,000 only lowers the premium to \$95. And the highest-deductible option (\$5,000/\$10,000) carries a premium for those 20-24 years old of \$82 a month. Of course, these plans are medically underwritten and so the premiums would increase dramatically (e.g. over 600% higher) for those young adults with serious medical conditions. Others could be turned down

<sup>23</sup>BluePPO, Option 6 in the individual market  
<http://www.bcbsde.com/promotions/blueindividual/blueindividual.html>.

completely for coverage in this individual market. For individuals 45-49 years old, the premium range for this BCBS PPO is as high as \$247 per month for the lowest deductible (\$250/\$500) and as low as \$165 for the \$5,000/\$10,000).<sup>24</sup> Again, these premium rates could be several times higher for people with serious medical conditions.

Further, BCBS officials have indicated that there is very little consumer interest in Delaware in plans that would combine high deductibles with substantial patient cost sharing for hospital care (e.g. patient paying 20 percent of hospital costs). Consumers seeking a high deductible plan want to have a “full stop loss” above the deductible and do not want to be at further risk of high healthcare outlays. And since there is very little out-of-network use of services in these plans in Delaware (e.g. 2-5 percent depending on the market), stiff penalties on out-of-network use will not produce much savings nor will they be attractive to consumers.<sup>25</sup>

It is premature to lay the exact specifications of a catastrophic protection insurance package as part of the proposed combination primary/catastrophic program, but some guidelines could be established. The catastrophic component could be similar to existing high deductible plans on the market, but with some modifications.<sup>26</sup> Learning from the current market experience described in the text box above, the deductible could be limited to \$2,500/\$5,000, and hospital costs could be completely covered once the deductible is met.

The objective of the catastrophic coverage component is to protect low and moderate-income families against very high medical expenses and to also reduce the uncompensated care burden on hospitals. Therefore, as noted above, the combination plan we design here includes a requirement that for those in the 200-300% FPL range, the expanded CHAP component would be available only with the purchase of a high-deductible plan. (It would be optional for those under 200 percent of FPL, who are currently eligible for CHAP.) Given that even lower-cost, high-deductible plans can be unaffordable to low and moderate-income families, premium subsidies will likely be necessary to encourage people to obtain the coverage.

The state of Delaware should therefore develop a sliding scale subsidy to help lower-income working people afford this catastrophic coverage benefit. This subsidy would only be available to people without access to employer-sponsored health insurance. The following are recommendations for structuring this subsidy:

- To limit the “crowding out” of private insurance, there should be a waiting period of six to twelve months if a person drops such coverage;

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<sup>24</sup> Ibid.

<sup>25</sup> Interview with Blue Cross Blue Shield of Delaware, January 2, 2008.

<sup>26</sup> For example, the coverage for preventive and primary care services would not be necessary in the catastrophic plan since the CHAP component would cover these services. It must be noted, however, that removing the primary/preventive coverage will not likely reduce the cost of the typical high-deductible plans significantly, since these elements typically represent well under 10% of total premium.

- The subsidy would only apply to qualified high-deductible health plans;
- Receiving the subsidy is contingent on the person also participating in the medical home (expanded CHAP) plan. Along with the similar requirement for medical home subsidies, Summit participants strongly encourage the full combination primary care/catastrophic protection;
- The subsidy would cover 65 percent of the premium of catastrophic coverage plans for Delaware residents with incomes less than 200 percent of FPL. This is the same percentage as is used under the Trade Adjustment Assistance Act's Health Care Tax Credits (HCTC), a national program subsidizing health insurance premiums for workers who have lost a job due to international trade and older workers who have lost a job;
  - The state would collect the 35 percent share from the lower-income person and send this payment, plus its 65 percent share, to the health plan offering the qualified coverage; and
  - For workers with incomes in the range of 200-300 percent of FPL, the subsidy would drop to 50 percent of the premium. Employees with higher incomes would not be eligible for a premium subsidy.

Other parameters could be substituted for the ones presented here, depending upon the cost of the program and available state resources. But these features could present a starting point for deliberation in a legislative process.

A very important issue that needs to be considered is whether the new plan would be 'guaranteed issue' to all income-eligible applicants, or whether insurers could use medical underwriting to reject (or charge much higher premiums to) higher-risk individuals, as they currently do in Delaware's non-group market. The ability to reject higher-risk individuals would help keep the premiums affordable; however, it would exclude from coverage the people who need it most. Yet requiring guaranteed issue and limiting premium variation runs the risk of adverse selection - that is, higher risk people would enroll, and many lower risk people would wait until they needed to use services, resulting in higher premiums. This could lead to essentially a 'high risk pool' with premiums that would likely be unaffordable without heavy subsidies from the public or other entities. Some safeguards could help mitigate this risk, such as the six to twelve month "look back" periods mentioned above, waiting periods before coverage takes effect for pre-existing conditions, and allowing some rate variation based on age and other factors.

In addition to offering the CHAP-catastrophic combination to individuals, consideration can be given to adapting it to a small-group market product, similar to the high-deductible plans offered through HRAs and HSAs. That is, the combination model may be a product that employers could purchase and offer to their workers, contributing a certain portion of the premium for the catastrophic portion. This product may be available to firms that have not offered coverage in the past six or twelve months, to avoid "crowd out" of private coverage. Further, it might be available to small firms that have a designated portion of workers below a certain income. Because past experience with other "low cost" health plans underscored the difficulty selling to employers who have not offered coverage in the past, subsidies or

some other type of financial incentives may be necessary to reduce the cost of these new group plans. A major marketing campaign by the health plans offering the small group products, as well as education through the HLC and other outreach efforts, would be needed to inform employers about the products and encourage buy-in.

Through the outreach activities described earlier, both consumers and employers with uninsured, low-moderate income workers would be informed of the combination model. Employers would be strongly encouraged to provide that information to their workers; the participating insurers should supplement these efforts through marketing efforts and health plans.

To the extent allowed, strong consideration should be given to piloting the combination model with private funding (e.g., non-profit and/or corporate sponsors, with employer contributions encouraged) and an evaluation, with the option to expand and seek state funding after a two-year period.

### **Action Steps**

To further design and implement the combination medical home (enhanced CHAP)/catastrophic coverage program, the Delaware Health Care Commission could oversee the product development, education, and outreach effort in addition to the following steps:

- Refine the model described above, with input from hospital and physician groups, the insurance industry, community health centers, consumer advocates, and state officials. The design decisions (which will affect the cost of and participation in the program) include but are not limited to the following (note this report has offered recommendations on many of these items):
  - Direct payment approach or insurance mechanism for primary care component (discussed above);
  - Covered services, cost-sharing requirements, other elements of both the primary care and catastrophic components;
  - Eligibility for the program (family income, workers and/or non-workers, individuals and/or small employer groups, previously uninsured versus all within income categories, etc.);
  - Medical underwriting and rating rules for the catastrophic coverage (discussed above); i.e., whether all eligible applicants are accepted regardless of health risk, whether certain limitations are needed to guard against adverse selection (such as pre-existing condition waiting periods, etc.), whether and to what degree the insurance premiums could vary by age, health status, other factors;
  - Provider reimbursement rates for CHAP services, provider discounts to members, and subsidies for CHAP primary care services;
  - Requirements tying the primary care CHAP component to the catastrophic plans, and premium subsidies for the latter; and

- Incentives for employers to participate and contribute, and mechanisms for doing so.
- Commission quantitative modeling of the plan, with alternative scenarios, to assess the cost and likely impact of both the medical home and the catastrophic coverage components on the target population, the state, insurers, and providers; the modeling should also estimate the likely participation in the plan, using evidence on price elasticity for health insurance among low to moderate-income uninsured individuals;
- Urge the state of Delaware to establish an acceptable cost range and some basic parameters for the catastrophic insurance plan, and then request that private insurers and health plans develop their own plans (covered services, deductible, copayments, etc.) and submit 'bids' to the state. The state might select a few of the proposed models, offering into the market a choice of new approaches that differ somewhat from the products currently available and that could be coupled with the CHAP expansion or that could include primary and preventive care as part of the insurance plan;
- Explore how this combination model could be adapted to a small-group market product—similar to the high-deductible plans offered through HRAs and HSAs, as discussed above;
- Assess the capacity of the CHAP and VIP program for expansion, determine if a phased in approach is practical;
- Establish an implementation plan with timetables;
- Draft any necessary model legislation and identify sponsors in the state legislature; and
- Identify appropriate funding sources to cover the state's new costs related to subsidies for both the expanded CHAP program and the catastrophic insurance plans. Consider reaching out to non-profit organizations dedicated to bettering the health of Delawareans.

## Conclusion

Delaware can begin to take specific action steps this year to develop the foundation to launch two important measures to begin reducing the number of uninsured. Given the current state budget challenges, the DHCC should put together a strategy for execution in 2009.

The state government has already taken positive steps toward beginning the implementation of a greater outreach and enrollment plan through the passage of House Bill 286. Through the Delaware Health Care Commission, the state can explore linkages with additional sources of information, including state work force agencies operating Unemployment Compensation, and the Division of Revenue, to identify people who are uninsured and likely to be eligible for Medicaid or Delaware Healthy Children. This initiative can be effectively complemented by an outreach campaign directed at state residents and employers, educating them about affordable insurance coverage options.

Delaware should continue to build upon its success with the CHAP program to make primary and preventive healthcare accessible and affordable for more of its residents. This would be a good

investment in the health of the state's population and will yield savings in hospital and other costs that are in many cases avoidable. To complement direct access to "front-end" health services, the state could also design, cost out, and potentially implement a catastrophic protection plan providing insurance against major medical expenses.

This combination of prevention and protection will likely require a strong effort to recruit large numbers of physicians and other healthcare providers to participate in the initiative. It will also require some measure of state subsidies or other sources of funding for those who cannot contribute much to physician fees for primary care or insurance premiums for catastrophic coverage. This report has suggested design features, options, and action steps to move toward implementation of each of these health reform components.

This report is another call to action, for the state and its leaders, to continue working toward developing and legislating solutions aimed at getting more Delawareans the healthcare coverage and services they need. Delaware is poised for great change and should begin building the foundation now for 2009.

**Appendix: House Bill No. 286**

SPONSOR: Rep. Maier & Rep. Schooley & Rep. Hall-Long  
& Rep. M Marshall & Sen. Blevins & Sen.  
Sorenson  
Reps. Brady, Carey, Carson, Ewing, Johnson,  
Keeley, Kowalko, Longhurst, McWilliams,  
Miro, Mitchell, Schwartzkopf, Stone, Viola,  
Wagner, Walls

HOUSE OF REPRESENTATIVES  
144th GENERAL ASSEMBLY

HOUSE BILL NO. 286

AN ACT TO AMEND TITLE 14 AND TITLE 16 OF THE DELAWARE CODE TO ASSIST ENROLLMENT IN THE DELAWARE HEALTHY CHILDREN PROGRAM.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF DELAWARE:

1 WHEREAS, a substantial number of children eligible for the Delaware Healthy Children Program (CHIP)  
2 in Delaware are not enrolled in that program; and

3 WHEREAS, the result of this under-enrollment is that many Delaware children are needlessly  
4 uninsured, and are not receiving important preventative health care and check-ups; and

5 WHEREAS, the school districts' federally-funded free and reduced price lunch programs could provide  
6 the State with a ready source of information regarding families whose children are potentially eligible for the  
7 CHIP program;

8 NOW, THEREFORE:

9

10 BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF DELAWARE:

11

12 Section 1. Amend Title 14 of the Delaware Code by adding a new section 4134, which shall read as  
13 follows:

14 "§ 4134 Mandatory Reporting of Delaware Healthy Children Program and Medicaid Information.

15 (a) Each school district shall be required to report to the Department of Health and Social Services on  
16 or before November 1 of each calendar year beginning in 2008 the name, eligibility status, family income  
17 level, address, and telephone number of each child eligible for free and reduced price meals through  
18 programs subsidized by the National School Lunch Program, the School Breakfast Program, or the Special Milk  
19 Program for Children.

20 (b) The information required by subsection (a) shall be provided to the Department on a form and in  
21 a manner prescribed by the Department of Health and Social Services.

22 (c) On or before August 1, 2008, and during each subsequent application or renewal period for free  
23 or reduced price meals, each school district shall notify in writing each parent/guardian whose child receives  
24 or seeks to receive free or reduced price meals that:

25 (i) The child's free or reduced price meal or free milk eligibility information will be  
26 disclosed to DHSS unless the parent or guardian elects not to have the information  
27 disclosed;

28 (ii) The parent/guardian is not required to consent to the disclosure, and the information, if  
29 disclosed, will be used solely to identify children eligible for and seek to enroll children in  
30 a free or reduced price health insurance program; and

31 (iii) The parent/guardian's decision regarding disclosure will not affect the child's eligibility  
32 for free or reduced price meals or free milk.

33 (d) In connection with the disclosures required by subsection (c), the school district shall give the  
34 parent/guardian an opportunity to elect not to have information disclosed to DHSS.

35 (e) Prior to August 1, 2008, each school district shall enter into a written, signed agreement with  
36 DHSS stating that:

37 (i) DHSS will be receiving from the school district the names, eligibility status, family income  
38 level, address, and telephone number of each child eligible for free and reduced price  
39 meals through programs subsidized by the National School Lunch Program, the School  
40 Breakfast Program, or the Special Milk Program for Children;

41 (ii) DHSS will use the information received only to seek to enroll children in the state's CHIP  
42 and Medicaid programs;

43 (iii) The information disclosed by the school district will be protected from unauthorized uses  
44 and disclosures (with specific steps to protect the information described); and

45 (iv) There are federal criminal penalties associated with unauthorized use or disclosure of the  
46 information disclosed by the school district (along with a description of the specific  
47 criminal sanctions).

48 (f) The school districts shall cooperate with DHSS and the Office of the Insurance Commissioner in  
49 negotiating the agreements required by subsection (e) of this section, and may seek the assistance of the  
50 Insurance Commissioner in developing the form required by subsection (c) of this section.

51 (g) "School district" as used in this section shall mean school district as defined at section 1002(5) of  
52 this Title, along with vocational and technical school districts.

53 Section 2. Amend Title 16 of the Delaware Code by adding new subsections (k) through (p) to Title  
54 16, section 9909, which shall read as follows:

55 "(k) By September 1 of each calendar year beginning in 2008, DHSS shall develop a form and  
56 instructions for school districts to use in communicating to DHSS the information regarding free and reduced  
57 price meal eligibility whose submission is required by Title 14, section 4134 of the Delaware Code. Said form  
58 and instructions shall be communicated by October 1 of each calendar year to each school district.

59 (l) By January 1 of each calendar year beginning in 2009, DHSS shall communicate in writing with  
60 the family of each child who may be eligible for the CHIP or Medicaid programs based upon information  
61 submitted by the school districts pursuant to Title 14, section 4134 of the Delaware Code. Said  
62 communication shall inform the family that its children may be eligible for free or reduced price health  
63 insurance based upon income information received from the school district, and provide information to the  
64 family for applying for the CHIP and Medicaid programs.

65 (m) Only persons authorized to carry out initial processing of Medicaid or CHIP applications or  
66 make eligibility determinations with respect to Medicaid or CHIP applicants may review information received  
67 from the school districts pursuant to Title 14, section 4134 of the Delaware Code.

68 (n) Prior to August 1, 2008, DHSS shall enter into written agreements with each of the school  
69 districts meeting the requirements of Title 14, section 4134(e) of the Delaware Code.

70 (o) "School district" as used in this section shall have the meaning assigned to it at Title 14,  
71 section 4134(g) of the Delaware Code.

72 (p) DHSS shall cooperate with the school districts and the Insurance Commissioner in developing  
73 the written materials required by subsections (k) and (n) of this section. DHSS shall cooperate with the  
74 Insurance Commissioner in developing the written materials required by subsection (l) of this section."

75 Section 3. Amend Title 16, section 9909(a) of the Delaware Code by adding the words "or 'CHIP'"  
76 immediately after the word "Program" as it appears in parentheses therein.

### SYNOPSIS

This bill would require local school districts, vo-tech school districts, and the Department of Health and Social Services to take advantage of the right afforded by Title 7, Part 245 of the Code of Federal Regulations for school districts and state agencies to share data for the purpose of enrolling children in free or reduced price health insurance program