LAWS OF DELAWARE
VOLUME 85
CHAPTER 348
153rd GENERAL ASSEMBLY
FORMERLY
SENATE SUBSTITUTE NO. 2
FOR
SENATE BILL NO. 1

AN ACT TO AMEND TITLE 16, TITLE 18, TITLE 29, AND TITLE 31 OF THE DELAWARE CODE, AND CHAPTER 237, VOLUME 83 OF THE LAWS OF DELAWARE, RELATING TO PRIMARY CARE SERVICES.

WHEREAS, from 2022 to today, efforts of the General Assembly and the Office of Value-Based Health Care Delivery within the Department of Insurance have more than doubled commercial insurer primary care investment in the state; and

WHEREAS, continued progress is being made with a projected $70 million invested in primary care for the Delaware commercial, fully insured market in 2025, up from $59 million spent in 2024, $44 million spent in 2023, and nearly $30 million in 2022; and

WHEREAS, more than 800 providers have engaged in care transformation since the outset of these efforts, receiving $13.6 million in prospective payments for 2024, and $18 million projected in 2025, but distribution of investment has remained inequitable; and

WHEREAS, efforts have increased prospective payments to physicians engaged in care transformation from $3 per member per month in 2022, to $19 per member per month in 2023, to $26 per member per month in 2024, and $39 per member per month projected in 2025; and

WHEREAS, prospective payments are a method of advanced payments that help physicians invest in value-based care resources that increase quality of care, improve efficiency and coordination, and overall increase access while creating a cost control; and

WHEREAS, commercial rates over this period have remained stable and the investment has proven not to carry a substantive premium impact for consumers including individuals and businesses purchasing group insurance; and

WHEREAS, Delaware’s efforts to increase primary care spending in the commercial insurance market only impact roughly 10% of residents, limiting progress on affordability and on provider support; and

WHEREAS, the percent of medical costs spent on primary care in the commercial, fully insured market in Delaware is similar to other states in the region, but the absolute dollars spent are nearly double due to higher health-care costs in Delaware overall; and

WHEREAS, Delaware ranks among the top 5 highest health-care cost states despite ranking low in primary care access; and

WHEREAS, the shift toward value-based care and quality improvement has been stymied by a lack of uniformity or commonality in offerings to encourage provider participation and accountability, resulting in only 41% of providers participating in care transformation; and

WHEREAS, sufficient standards have been developed and the effectiveness of the approach has been clearly demonstrated in order to scale the policies into Medicaid and the State Group Health Insurance Plan to offer Delawareans equitable access to the highest quality, most comprehensive primary care experience while reducing administrative burden for providers; and

WHEREAS, the legislation that has furthered this progress sunsets on January 1, 2027, but regulatory enforcement remains necessary, and components should be considered in insurer rate development and provider engagement prior to this date; and

WHEREAS, without the permanence of enforceable cost containment measures and primary care spending requirements much progress will be lost.

NOW, THEREFORE:

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

Section 1. Amend § 9903, Title 16 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 9903. Duties and authority of the Commission.

(a) The Commission may hire staff, contract for consulting services, conduct any technical or actuarial studies which it deems to be necessary to support its work, and publish reports as required in order to accomplish its purposes in accordance with the provisions of this chapter.

(1) The Commission shall, in coordination with the Primary Care Reform Collaborative established under § 9904A of this title, monitor the uptake and compliance of primary care providers with value-based care delivery models~~, including advising and approving a Delaware Primary Care Model designed to do both of the following:~~ established under § 334 of Title 18.

~~a. Achieve targets for value-based care through increased participation in alternative payment models that are not paid on a fee for service or per claim basis and include quality and performance improvement requirements.~~

~~b. Reward primary care services that are designed to reduce health disparities and address social determinants of health.~~

Section 2. Amend § 9904A, Title 16 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 9904A. Primary Care Reform Collaborative.

(c) The Commission may also require the submission of written reports by any health insurer, as defined in § 4004 of Title 18, to the extent permitted under federal law, and any hospital or acute health-care facility licensed under Chapter 10 of this title, regarding all of the following matters:

(1) The hospital's, acute health-care facility's, or health insurer's progress in adopting and implementing value-based payment models during the fiscal year immediately preceding the annual reporting deadline and the overall progress of the reporting ~~entity on having at least 60% of Delawareans attributed to meaningful valuebased payment models by 2025.~~ entity.

Section 3. Amend § 329, Title 18 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 329. Administrative penalty.

(a) Notwithstanding any other provisions of this title or any regulation implementing said title, the Commissioner, upon a finding after notice and hearing conducted in accordance with the provisions of this chapter, that any person, insurer or insurance holding company has violated any provision of this title or any regulation implementing said title, may impose or order an administrative penalty in an amount of money that is reasonable and appropriate in view of the facts and circumstances surrounding the violation. In determining what the amount of penalty shall be, the Commissioner may take into consideration such matters as the nature of the violation, the amount of loss resulting from the violator's conduct, the intent of the violator, the damages caused by the violation, any efforts made by the violator to correct the violation and prevent a reoccurrence, and the recommendations of any hearing officer. ~~In no event shall the administrative penalty per violation exceed $15,000 for those licensed under Chapter 17 of this title, and $50,000 per violation for insurance companies, insurance holding companies and all other persons licensed under this title.~~

(b) In no event shall the administrative penalty per violation exceed $15,000 for those licensed under Chapter 17 of this title.

(c) Except as identified in subsection (f) of this section, in no event shall the administrative penalty per violation exceed $50,000 for insurance companies, insurance holding companies, and all other persons licensed under this title.

~~(b)~~ (d) Any administrative penalty imposed pursuant to this section may be in addition to any penalty, fine or sentence ordered by a court in any civil or criminal proceeding.

~~(c)~~ (e) ~~Any~~ Except as identified in subsection (g) of this section, any penalty that may be imposed or ordered by the Commissioner after the hearing shall be paid to the State Treasurer for deposit in the General Fund.

(f) An administrative penalty imposed for a violation of § 2503(a)(12), § 2503(a)(15), § 3342B, and § 3556A of this title may not exceed the equivalent monetary value associated with the relevant violation.

(g) There shall be established a Primary Care Fund whereby penalties imposed under subsection (f) of this section are deposited. Funds in the Primary Care Fund shall be used by the Statewide Benefits Office and the Division of Medicaid and Medical Assistance in the performance of various functions and duties involved in implementation and support of § 5204(d) and § 5224 of Title 29, and § 539 of Title 31, subject to annual appropriations by the General Assembly. The maximum unencumbered

balance which shall remain in the Primary Care Fund after use at the end of any fiscal year is $5,000,000. At the end of each fiscal year, the unencumbered balance in the Primary Care Fund in excess of $5,000,000 shall be transferred to the OPEB Fund established under § 5281 of Title 29.

Section 4. Amend § 334, Title 18 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 334. Office of Value-Based Health Care Delivery.

(c) The Office of Value-Based Health Care Delivery shall do all of the following:

(2) Establish, through regulations adopted under this section, mandatory minimums for payment innovations, including alternative payment models, provider price increases, carrier investment in primary care, and other activities deemed necessary to achieve the purpose of this ~~section, to support a robust system of primary care by January 1, 2026.~~ section.

(3) Collect data from carriers and providers, including any organization contracting with commercial carriers or government payers on behalf of Delaware-licensed clinicians, including physician organizations, health systems, hospitals, and outpatient facilities, and develop reports regarding carrier investments in health care to monitor and evaluate all of the following:

e. Carrier compliance with value-based care program offerings required under §§ 3342B and 3556A of this title.

f. Outcomes of value-based care reported on an annual basis including metrics relating to quality of care, efficiency, and patient experience. The Office of Value-Based Health Care Delivery shall develop, through regulation, a standardized set of measures and a methodology for assessing primary care provider performance against these measures.

(7) Establish, through regulations adopted under this section, value-based care program designs to increase provider accountability and improve provider access to enhanced investment.

(8) By January 1, 2029, promulgate regulations establishing limitations on covered persons' financial responsibility for covered services that are subject to the filing requirements referenced in § 2503(a)(15) of this title.

(d) No waiver of any applicable privilege or claim of confidentiality in the documents, materials, or information shall occur as a result of disclosure to the Office of Value-Based Health Care Delivery under this section or as a result of reporting as authorized in paragraph (c)(3) of this section. However, the Commissioner is authorized to use the documents, materials, or other information in the furtherance of any regulatory or legal action brought as a part of the Commissioner's official duties.

Section 5. Amend § 2503, Title 18 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 2503. Making of rates.

(a) Rates must be made in accordance with the following provisions:

(12) a. Rate filings for health benefit plans may not include aggregate unit price growth for nonprofessional services that exceed the following:

3. ~~In~~ For rate filings filed in 2024, 2025, ~~and~~ 2026, and 2027, the greater of 2% or Core CPI plus 1%.

b. For purposes of this paragraph (a)(12) and ~~paragraphs (a)(13) and (a)(14)~~ paragraphs (a)(13) through (a)(15) of this section:

c. The Commissioner shall annually determine the Core CPI by March 31 of the applicable rate filing year using the bimonthly indices ending with the bimonthly index issued in January of the applicable rate filing year through 2027.

e. Paragraph (a)(12)a.3 of this section does not apply in any of the following circumstances:

1. When a hospital meets the definition of a Free-Standing Children's Hospital under this section.

2. When a hospital meets the definition of a Medicare-Dependent Rural Hospital pursuant to paragraph (a)(15)g.1. of this section.

3. When a hospital meets the definition of an Urban Medicaid DSH Hospital under this section.

(14) All rate filings by carriers who have issued health benefit plans in the Delaware commercial market for the last 2 years and whose plans ~~with health benefit plans that~~ cover more than ~~10,000~~ 5,000 members across all fully-insured products must have ~~reflect progress with achieving the targets described in § 9903(a)(1) of Title 16, at a minimum, must have~~ either 50% or the highest achievable percentage based on actuarial credibility requirements of total cost of care tied to an alternative payment model contract that meets the Health Care Payment Learning and Action Network (HCP-LAN) Category 3 or Category 4 ~~definition for shared savings or shared savings with downside risk by 2023,~~ with a minimum of ~~25%~~ 15% or the highest achievable percentage based on actuarial credibility requirements of total cost of care covered by an alternative payment model contract that meets the definition of HCP-LAN Category 3B~~,~~ ~~which includes only contracts with downside risk.~~ or Category 4.

(15) For rate filings filed in and after 2028, as set forth in paragraphs (a)(15)m. and (a)(15)n.of this section, costs per inpatient hospital service, outpatient service, and emergency department service for health benefit plans may not exceed the applicable Medicare Reference-Based Pricing Target set forth in paragraph (a)(15)m. of this section, as of the date of service, for comparable services for the applicable plan year, and Freestanding Children's Hospital Outpatient Medicare Rates may not exceed the applicable Medicare Reference-Based Pricing Target set forth in paragraph (a)(15)n. of this section, as of the date of service.

a. "Emergency department service" means services generally performed in an emergency department, including trauma services, triage, and observation.

b. "Free-Standing Children's Hospital" means a dedicated, independent pediatric facility, not integrated within a general adult hospital, identified by the Center for Medicaid and CHIP Services (CMCS) as a hospital that provides specialized care for infants, children, teens, and individuals predominately under 18 years of age.

c. "Free-Standing Children's Hospital Medicare Outpatient Payment Rate" means, for purposes of Free-Standing Children's Hospitals, payments for Free-Standing Children's Hospitals that include all payments made under the Medicare Outpatient Prospective Payment System (OPPS), as established August 1, 2000, and codified at 42 C.F.R. Part 419.

d. "Full Medicare rate" means the applicable wage-adjusted Medicare rate, inclusive of any applicable adjustments, as updated by the Centers for Medicare and Medicaid Services (CMS) on an annual basis.

e. "Inpatient hospital service" means services generally performed in an inpatient acute hospital care setting, including general inpatient hospital services covered under Medicare Part A, labor and delivery, and intensive care.

f. "Medicare" means the federal Medicare Program (U.S. Public Law 89-87, as amended) (42 U.S.C. § 1395 et seq.).

g. "Medicare-Dependent Rural Hospital" means a hospital that meets at least one of the following requirements for the applicable rate filing year:

1. The hospital meets the definition of a Medicare-dependent hospital as defined under 42 C.F.R. § 412.108 for at least 3 of the 5 years immediately preceding the applicable rate filing year.

2. The hospital operates solely within a county that is classified by the federal Health Resources and Services Administration (HRSA) as a Rural Health Area, a Medically Underserved Area, and a Health Professional Shortage Area for Primary Care, and the hospital's gross patient revenue attributed to Medicare patients accounts for more than 60% of its total gross patient revenue.

h. "Medicare Reference-Based Pricing (RBP) Target" means a percentage of the Full Medicare Rate as set forth in paragraph (a)(15)d. of this section. With respect to Free-Standing Children's Hospitals, "Medicare Reference-Based Pricing (RBP) Target" has the meaning as defined in paragraph (n) of this section.

i. "Outpatient service" means nonprofessional services not otherwise captured in the definition of Inpatient Hospital Service or emergency department service.

j. "TEFRA Rate" means the target amount under the federal Tax Equity and Fiscal Responsibility Act (TEFRA) Waiver Program applicable to Free-Standing Children's Hospitals set forth in 42 U.S.C. § 1395ww(b), including any updates and adjustments thereto.

k. “Urban Medicaid DSH Hospital” means a hospital that met the criteria described in § 1923(b) of the federal Social Security Act [42 U.S.C. § 1396r-4(b)] and received Medicaid Disproportionate Share Hospital Program (DSH) payments from the state between July 1, 2021, and July 1, 2026.

l. If a comparable Medicare reimbursement rate is not available to determine the full Medicare rate for inpatient hospital services, outpatient services, or emergency department services, a carrier’s rate filings shall propose reimbursement for services at the rates generally available under Medicare for similar services, which shall be further delineated by regulation, unless otherwise specified in this section.

m. Applicable Medicare Reference-Based Pricing Targets for inpatient hospital services, outpatient services, and emergency department services. Unless otherwise specified in this section, rate filings for services provided by non-Free-Standing Children’s Hospitals shall reflect Medicare Reference-Based Pricing Targets as follows:

1. For the 2028 and 2029 rate filings applying to plan years 2029 and 2030, all of the following apply:

A. 275% of the full Medicare rate for outpatient services.

B. 310% of the full Medicare rate for inpatient hospital services and emergency department services.

2. For the 2030 and 2031 rate filings applying to plan years 2031 and 2032, all of the following apply:

A. 250% of the full Medicare rate for outpatient services.

B. 275% of the full Medicare rate for inpatient hospital services and emergency department services.

3. For all rate filings occurring on and after 2032 for the following plan year, beginning with plan year 2033, 250% of the full Medicare rate for inpatient hospital services, outpatient services, and emergency department services.

n. Applicable Medicare Reference-Based Pricing Targets for Free-Standing Children’s Hospitals. Unless otherwise specified in this section, rate filings for services provided by Free-Standing Children’s Hospitals shall reflect Medicare Reference-Based Pricing Targets as follows:

1. For the 2028 and 2029 rate filings applying to plan years 2029 and 2030, all of the following apply:

A. 275% of the Free-Standing Children’s Hospital Medicare Outpatient Payment Rate for outpatient services.

B. 310% of the TEFRA Rate for inpatient hospital services.

C. 310% of the Free-Standing Children’s Hospital Medicare Outpatient Payment Rate for emergency department services.

2. For the 2030 and 2031 rate filings applying to plan years 2031 and 2032, all of the following apply:

A. 250% of the Free-Standing Children’s Hospital Medicare Outpatient Payment Rate for outpatient services.

B. 275% of the TEFRA Rate for inpatient hospital services.

C. 275% of the Free-Standing Children’s Hospital Medicare Outpatient Payment Rate for emergency department services.

3. For all rate filings occurring on and after 2032 for the following plan year, beginning with plan year 2033, all of the following apply:

A. 250% of the Free-Standing Children’s Hospital Medicare Outpatient Payment Rate for outpatient services.

B. 250% of the TEFRA Rate for inpatient hospital services.

C. 250% of the Free-Standing Children’s Hospital Medicare Outpatient Payment Rate for emergency department services.

o. Reference-Based Pricing Target Exemptions and Modifications. Paragraphs (a)(15)a. through (a)(15)n. of this section do not apply in any of the following circumstances:

1. When a hospital meets the definition of a Medicare-Dependent Rural Hospital pursuant to paragraph (a)(15)g.1. of this section.

2. When a hospital meets the definition of a Medicare-Dependent Rural Hospital pursuant to paragraph (a)(15)g.2. of this section and the Office of Value-Based Health Care Delivery has determined that the hospital has made demonstrative progress in adopting and implementing value-based payment models.

3. When a hospital meets the definition of an Urban Medicaid DSH Hospital under this section.

4. When the carrier and the hospital or applicable contracting provider entity are participants in a federal or state multi-payer global budget model approved by the Department. The Department shall provide notice annually of global budget models that are approved pursuant to this paragraph.

Section 6. Amend § 3342B, Title 18 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 3342B. Primary care coverage.

(b) (3) A carrier shall do the following:

e. By 2026 and each year thereafter, spend at least 11.5%, 5% of which must be via prospective primary care management payments, of its total cost of medical care on primary care.

(g)(1) A carrier shall offer value-based care programs that meet the program design element requirements issued by the Department by the first full plan year following the Department's promulgation of regulations pursuant to § 334 of this title.

(2) A carrier may not deny a contracted provider the opportunity to participate in an offered value-based care program if the provider is willing to accept the terms and conditions established for other providers as a condition of program participation.

(h) In calculating total cost of medical care for purposes of this section, the Commissioner shall, by regulation, authorize the exclusion of high-cost claims and may authorize the exclusion of other costs actually incurred by carriers.

Section 7. Amend § 3556A, Title 18 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 3556A. Primary care coverage.

(b) (3) A carrier shall do the following:

e. By 2026 and each year thereafter, spend at least 11.5%, 5% of which must be via prospective primary care management payments, of its total cost of medical care on primary care.

(g)(1) A carrier shall offer value-based care programs that meet the program design element requirements issued by the Department by the first full plan year following the Department's promulgation of regulations pursuant to § 334 of this title.

(2) A carrier may not deny a contracted provider the opportunity to participate in an offered value-based care program if the provider is willing to accept the terms and conditions established for other providers as a condition of program participation.

(h) In calculating total cost of medical care for purposes of this section, the Commissioner shall, by regulation, authorize the exclusion of high-cost claims and may authorize the exclusion of other costs actually incurred by carriers.

Section 8. Amend Section 14, Chapter 237, Volume 83 of the Laws of Delaware by making deletions as shown by strike through and insertions as shown by underline as follows:

Section 14. ~~Sections 5 and 6 of this Act and § 2503(a)(12)a. of Title 18 as contained in Section 4 of this Act expire on January 1, 2027.~~ [Repealed].

Section 9. Amend § 5204, Title 29 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 5204. Selection of the group insurance carrier.

(c)(1) For plan year 2030 and thereafter, as set forth in paragraphs (c)(16) and (c)(17) of this section, health-care insurance shall be provided by a carrier whose cost per inpatient hospital service, outpatient service, and emergency department service may not exceed the applicable Medicare Reference-Based Pricing Target set forth in paragraph (c)(16) of this section, as

of the date of service, for comparable services for the applicable plan year, and Free-Standing Children's Hospital Outpatient Medicare Rates may not exceed the applicable Medicare Reference-Based Pricing Target set forth in paragraph (c)(17) of this section, as of the date of service. For such services under the Group Health Insurance Plan, a covered individual is not liable for payment of any amount other than the copayments, coinsurance, and deductibles applicable under the terms of the covered individual's health benefit plan, as determined by the network status of the provider. Any such cost sharing shall be calculated based on the carrier's allowed payment amount. A covered individual shall not be billed or charged any amount in excess of the carrier's allowed payment for such services.

(2) "Emergency department service" means services generally performed in an emergency department, including trauma services, triage, and observation.

(3) "Free-Standing Children's Hospital" means a dedicated, independent pediatric facility, not integrated within a general adult hospital, identified by the Center for Medicaid and CHIP Services (CMCS) as a hospital that provides specialized care for infants, children, teens, and individuals predominately under 18 years of age.

(4) "Free-Standing Children's Hospital Medicare Outpatient Payment Rate" means, for purposes of Free-Standing Children's Hospitals, payments for Free-Standing Children's Hospitals that include all payments made under the Medicare Outpatient Prospective Payment System (OPPS), as established August 1, 2000, and codified at 42 C.F.R. Part 419.

(5) "Full Medicare rate" means the applicable wage-adjusted Medicare rate, inclusive of any applicable adjustments, as updated by the Centers for Medicare and Medicaid Services (CMS) on an annual basis.

(6) "Inpatient hospital service" means services generally performed in an inpatient acute hospital care setting, including general inpatient hospital services covered under Medicare Part A, labor and delivery, and intensive care.

(7) "Medicare" means the federal Medicare Program (U.S. Public Law 89-87, as amended) (42 U.S.C. § 1395 et seq.).

(8) "Medicare-Dependent Rural Hospital" means a hospital that meets at least one of the following requirements for the applicable plan year:

a. The hospital meets the definition of a Medicare-dependent hospital as defined under 42 C.F.R. § 412.108 for at least 3 of the 5 years immediately preceding the applicable plan year.

b. The hospital operates solely within a county that is classified by the federal Health Resources and Services Administration (HRSA) as a Rural Health Area, a Medically Underserved Area, and a Health Professional Shortage Area for Primary Care, and the hospital's gross patient revenue attributed to Medicare patients accounts for more than 60% of its total gross patient revenue.

(9) "Medicare Reference-Based Pricing (RBP) Target" means a percentage of the Full Medicare Rate as set forth in paragraph (c)(5) of this section. With respect to Free-Standing Children's Hospitals, "Medicare Reference-Based Pricing (RBP) Target" has the meaning as defined in paragraph (c)(17) of this section.

(10) "Nonprofessional services" means services categorized as inpatient hospital, outpatient hospital, and other medical services. "Nonprofessional services" does not include professional services.

(11) "Outpatient service" means nonprofessional services not otherwise captured in the definition of Inpatient Hospital Service or emergency department service.

(12) "Professional services" includes primary care, dental, specialist, therapy, the professional component of laboratory and radiology, and similar services, other than the facility fee component of hospital-based services.

(13) "TEFRA Rate" means the target amount under the federal Tax Equity and Fiscal Responsibility Act (TEFRA) Waiver Program applicable to Free-Standing Children's Hospitals set forth in 42 U.S.C. § 1395ww(b), including any updates and adjustments thereto.

(14) "Urban Medicaid DSH Hospital" means a hospital that met the criteria described in § 1923(b) of the federal Social Security Act [42 U.S.C. § 1396r-4(b)] and received Medicaid Disproportionate Share Hospital Program (DSH) payments from the state between July 1, 2021, and July 1, 2026.

(15) If a comparable Medicare reimbursement rate is not available, reimbursement for services under the State of Delaware Group Health Insurance Plan shall be determined using the Medicare rates generally applicable to similar services, as reasonably determined by the Statewide Benefits Office.

(16) Applicable Medicare Reference-Based Pricing Targets for inpatient hospital services, outpatient services, and emergency department services. Unless otherwise specified in this section, services provided by non-Free-Standing Children's Hospitals shall reflect Medicare Reference-Based Pricing Targets as follows:

a. For plan years 2030 and 2031, all of the following apply:

1. 275% of the full Medicare rate for outpatient services.

2. 310% of the full Medicare rate for inpatient hospital services and emergency department services.

b. For plan years 2032 and 2033, all of the following apply:

1. 250% of the full Medicare rate for outpatient services.

2. 275% of the full Medicare rate for inpatient hospital services and emergency department services.

c. Beginning with plan year 2034, 250% of the full Medicare rate for inpatient hospital services, outpatient services, and emergency department services.

(17) Applicable Medicare Reference-Based Pricing Targets for Free-Standing Children's Hospitals. Unless otherwise specified in this section, services provided by Free-Standing Children's Hospitals shall reflect Medicare Reference-Based Pricing Targets as follows:

a. For plan years 2030 and 2031, all of the following apply:

1. 275% of the Free-Standing Children's Hospital Medicare Outpatient Payment Rate for outpatient services.

2. 310% of the TEFRA Rate for inpatient hospital services.

3. 310% of the Free-Standing Children's Hospital Medicare Outpatient Payment Rate for emergency department services.

b. For plan years 2032 and 2033, all of the following apply:

1. 250% of the Free-Standing Children's Hospital Medicare Outpatient Payment Rate for outpatient services.

2. 275% of the TEFRA Rate for inpatient hospital services.

3. 275% of the Free-Standing Children's Hospital Medicare Outpatient Payment Rate for emergency department services.

b. Beginning with plan year 2034, all of the following apply:

1. 250% of the Free-Standing Children's Hospital Medicare Outpatient Payment Rate for outpatient services.

2. 250% of the TEFRA Rate for inpatient hospital services.

3. 250% of the Free-Standing Children's Hospital Medicare Outpatient Payment Rate for emergency department services.

(18) Reference-Based Pricing Target Exemptions and Modifications. Paragraphs (c)(1) through (c)(17). of this section do not apply in any of the following circumstances:

a. When a hospital meets the definition of a Medicare-Dependent Rural Hospital pursuant to paragraph (c)(8)a. of this section.

b. When a hospital meets the definition of a Medicare-Dependent Rural Hospital pursuant to paragraph (c)(8)b. of this section and the Office of Value-Based Health Care Delivery has determined that the hospital has made demonstrative progress in adopting and implementing value-based payment models.

c. When a hospital meets the definition of an Urban Medicaid DSH Hospital under this section.

d. When the carrier and the hospital or applicable contracting provider entity are participants in a federal or state multi-payer global budget model approved by the Department under § 2503(a)(15)o.3 and § 2503(a)(15)p. of Title 18. The Department shall provide notice annually of global budget models that are approved pursuant to this paragraph.

(d) The health-care insurance coverage shall be provided by a carrier offering value-based care programs equivalent to those required by §§ 3342B and 3556A of Title 18.

Section 10. Amend § 5224, Title 29 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 5224. Primary care coverage.

(a) The plan shall do all of the following:

(1) Provide coverage in compliance with § 5204(c) of this title.

(2) Exclude certain high-cost claims in calculating the total cost of medical care for purposes of this section, as authorized by the State Employee Benefits Committee.

(3) Report data to the Office of Value-Based Health Care Delivery on high-cost claims and on the percentage of primary care spending as a percentage of total medical costs for plan year 2027 by July 1, 2029, and for plan year 2028 by July 1, 2030.

(4) In plan year 2029, increase primary care spending by 1% from the higher of the 2 prior plan years.

(5) In plan years 2030, 2031, and additional plan years as necessary, increase primary care spending by 1% until primary care spending reaches 11.5% of total medical costs.

(6) Spend at least 11.5% of total cost of medical care on primary care each plan year thereafter.

Section 11. Amend Chapter 5, Title 31 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 539. Primary care coverage.

(a) To the extent consistent with federal law:

(1) The entities providing health insurance under §505(3) of this title shall report data for 2 plan years on the percentage of primary care spend as a percentage of total medical costs, each by July 1 of the following year.

(2) In the third year, the entities providing health insurance under § 505(3) of this title shall increase primary care spending by 1% from the higher of the 2 prior plan years.

(3) In fourth, fifth, and additional plan years as necessary, the entities providing health insurance under § 505(3) of this title shall increase primary care spending by 1% until primary care spending reaches 11.5% of total medical costs.

(4) The entities providing health insurance under § 505(3) of this title shall spend at least 11.5% of total cost of medical care on primary care thereafter.

(5) The methodology for compliance with this section shall be determined by the Division, to the extent feasible, consistent with regulations set forth by the Office of Value-Based Health Care Delivery under § 334 of Title 18.

(b) The Division of Medicaid and Medical Assistance may exclude certain high-cost claims in calculating total cost of medical care for purposes of this section.

(c) The entities providing health insurance under § 505(3) of this title shall offer value-based care programs as determined by contract with the Division.

Section 12. The Department of Insurance shall promulgate regulations pursuant to this Act within 18 months of enactment, except that the Department shall promulgate regulations on or before January 1, 2027, establishing a methodology to determine any appropriate annual inflationary or other applicable adjustments to a hospital's Full Medicare Rate, under Sections 2503(a)(15)d. and 5204(d)(5) of Title 18.

As part of the regulatory development process, the Department of Insurance and the State Employee Benefits Office shall lead a process, in consultation with Delaware hospitals subject to these provisions and other stakeholders, to recommend an appropriate methodology to determine and apply any inflationary or other applicable adjustments not otherwise captured in a hospital's annual Medicare rate update, by January 1, 2027.

Approved July 20, 2026