SPONSOR: Sen. Townsend & Rep. Bentz
Sens. Ennis, Gay, Lockman, S. McBride, Sokola, Sturgeon; Reps. Baumbach, Brady, Chukwuocha, Griffith, Heffernan, K. Johnson, Kowalko, Lynn, Osienski, K. Williams, Wilson-Anton

DELAWARE STATE SENATE
151st GENERAL ASSEMBLY

SENATE SUBSTITUTE NO. 1
FOR
SENATE BILL NO. 120

AN ACT TO AMEND TITLE 16 AND TITLE 18 OF THE DELAWARE CODE, CHAPTER 189, VOLUME 82 OF THE LAWS OF DELAWARE, AND CHAPTER 392, VOLUME 81 OF THE LAWS OF DELAWARE, AS AMENDED BY CHAPTER 141, VOLUME 82 OF THE LAWS OF DELAWARE, RELATING TO PRIMARY CARE SERVICES.

WHEREAS, south to north, rural to suburban to urban, no corner of Delaware is immune from the current and troubling shortfalls in primary health care resources; and

WHEREAS, shortfalls in primary health care resources can worsen existing inequities in health care and across many other facets of life for Delawareans; and

WHEREAS, Delaware's primary care crisis and shortfalls in primary care resources are exacerbated by the way in which Delaware's current health care laws, framework, and funding do not ensure adequate investment in primary health care structures and services; and

WHEREAS, other states have developed models that demonstrate how purposeful, guaranteed investment in primary health care can help remedy primary health care crises or shortfalls and have decreased overall health care spending with such purposeful investment; and

WHEREAS, studies have shown that investment in new primary care delivery models has resulted in better health outcomes and promises to be the backbone of an effective healthcare system that promotes value for all Delawareans; and

WHEREAS, Delaware also needs to shift from the status quo, which is unsustainable for the Delaware state budget, Delaware businesses, including Delaware primary care providers, and the pocketbooks of everyday Delawareans; and

WHEREAS, the medical and fiscal health of Delawareans cannot afford a delay in adopting solutions and lessons learned from other jurisdictions; and

WHEREAS, the Department of Insurance does not regulate Medicaid or employer-based plans provided under the Employee Retirement Income Security Act, or their rates.

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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 ~~shall have the authority to~~ may hire staff, contract for consulting services, conduct any technical ~~and/or~~ or actuarial studies which it deems to be necessary to support its work, and ~~to~~ 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:

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.

(2) The Commission shall develop, and monitor compliance with, alternative payment models that promote value-based care. The Commission may do all of the following:

a. Review and incorporate the Office of Value-Based Health Care Delivery's, established under § 334 of Title 18, analyses of primary care spending and affordability standards to achieve primary care targets without increasing costs to consumers or the total cost of care.

b. Solicit the following from a health insurer, as defined in § 4004 of Title 18, to the extent permitted under federal law, and from a hospital or acute health-care facility licensed under Chapter 10 of this title:

1. Quality and utilization reporting for providers participating in alternative payment arrangements with performance towards goals, targets, or benchmarks.

2. Demonstration of the practice transformation support for providers and evaluation of progress towards transformative milestones.

c. Adopt regulations to implement this paragraph (a)(2).

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.

(a) The Commission shall convene a Primary Care Reform Collaborative ("Collaborative") to assist with the development of recommendations to strengthen the primary care system in this State. The Collaborative may collect and accept advice and input from stakeholders, including the Delaware health-care and patient community.

(b) The Collaborative is comprised of the following members, or a designee appointed by the member serving by virtue of position:

(1) The Commission Chairperson. The Commission Chairperson is chair of the Collaborative.

(2) The Chair of the Senate ~~Health, Children~~ Health & Social Services Committee.

(3) The Chair of the House Health & Human Development Committee.

(4) ~~Two members,~~ One member, appointed by the Governor from a list of names provided by the Medical Society of Delaware.

(5) ~~Two members,~~ One member, appointed by the Governor from a list of names provided by the Delaware Nurses Association.

(6) ~~Two members,~~ One member, appointed by the Governor from a list of names provided by the Delaware Healthcare Association.

(7) Two members representing insurance carriers, appointed by the Governor.

(8) The Secretary, Department of Health and Social Services.

(9) The Director, Division of Medicaid and Medical Assistance.

(10) The Insurance Commissioner, Insurance Department.

(11) The Chair, State Employee Benefits Committee.

~~(12) One member representing large self-insured employers, appointed by the Delaware State Chamber of Commerce.~~

~~(13)~~(12) One member representing a Federally Qualified Health Center, appointed by the Governor.

(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 ~~§ 1001~~ 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 value-based payment models by ~~2021.~~ 2025.

(2) The hospital's, acute health-care facility's, or health insurer's efforts to support primary care access and primary care practitioners in the State, including financial, operational, and other support, in conjunction with the adoption of meaningful value-based payment models.

(d) (1) A quorum of the Collaborative is a majority of its members.

(2) Official action by the Collaborative requires the approval of a quorum of the Collaborative.

(3) The Collaborative may adopt rules necessary for its operation.

Section 3. 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.

(a) The Commission shall convene a Primary Care Reform Collaborative ("Collaborative") to assist with the development of recommendations to strengthen the primary care system in this State. The Collaborative may collect and accept advice and input from stakeholders, including the Delaware health-care and patient community.

(b) The Collaborative is comprised of the following members, or a designee appointed by the member serving by virtue of position:

(1) The Commission Chairperson. The Commission Chairperson is the Chair of the Collaborative.

(2) The Chair of the Senate ~~Health, Children~~ Health & Social Services Committee.

(3) The Chair of the House Health & Human Development Committee.

(4) ~~Two members,~~ One member, appointed by the Governor from a list of names provided by the Medical Society of Delaware.

(5) ~~Two members,~~ One member, appointed by the Governor from a list of names provided by the Delaware Nurses Association.

(6) ~~Two members,~~ One member, appointed by the Governor from a list of names provided by the Delaware Healthcare Association.

(7) Two members representing insurance carriers, appointed by the Governor.

(8) The Secretary, Department of Health and Social Services.

(9) The Director, Division of Medicaid and Medical Assistance.

(10) The Insurance Commissioner, Insurance Department.

(11) The Chair, State Employee Benefits Committee.

~~(12) One member representing large self-insured employers, appointed by the President Pro Tempore of the Senate from a list of names provided by the Delaware State Chamber of Commerce.~~

~~(13)~~(12) One member representing a Federally Qualified Health Center, appointed by the Governor.

(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 ~~§ 1001~~ 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 value-based payment models by ~~2021.~~ 2025.

(2) The hospital's, acute health-care facility's, or health insurer's efforts to support primary care access and primary care practitioners in the State, including financial, operational, and other support, in conjunction with the adoption of meaningful value-based payment models.

(d)(1) A quorum of the Collaborative is a majority of its members.

(2) Official action by the Collaborative requires the approval of a quorum of the Collaborative.

(3) The Collaborative may adopt rules necessary for its operation.

Section 4. 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:

1. In 2022, the greater of 3 percent or Core CPI plus 1 percent.

2. In 2023, the greater of 2.5 percent or Core CPI plus 1 percent.

3. In 2024, 2025, and 2026, the greater of 2 percent or Core CPI plus 1 percent.

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

1. "Core CPI" means the Consumer Price Index for All Urban Consumers, All Items Less Food & Energy, developed by the United States Bureau of Labor Statistics.

2. "Health benefit plan" means as defined under § 3342A(a)(3)a. and § 3559(a)(3)a. of this title.

3. "Inpatient hospital" means non-capitated facility services for medical, surgical, maternity, skilled nursing, and other services provided in an inpatient facility setting and billed by the facility.

4. “Nonprofessional services” means services categorized as inpatient hospital, outpatient hospital, and other medical services. “Nonprofessional services” does not include professional services.

5. “Other medical services” means non-capitated ambulance, home health care, durable medical equipment, prosthetics, supplies, and the facility component of vision exams, dental services, and other services when billed separately from the professional component.

6. “Outpatient hospital” means non-capitated facility services for surgery, emergency services, lab, radiology, therapy, observation, and other services provided in an outpatient facility setting and billed by the facility.

7. “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) All rate filings for health benefit plans subject to § 3342B and § 3556A of this title must reflect the spending requirements under § 3342B(b)(3) and § 3556A(b)(3) of this title.

(14) All rate filings by carriers with health benefit plans that cover more than 10,000 members across all fully-insured products must reflect progress with achieving the targets described in § 9903(a)(1) of Title 16, and, at a minimum, must have 50% 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 definition for shared savings or shared savings with downside risk by 2023, with a minimum of 25% 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.

Section 5. 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)(1) A carrier shall provide coverage for chronic care management and primary care at a reimbursement rate that is not less than the Medicare reimbursement for comparable services.

(2) This subsection applies to an individual health insurance policy, plan, or contract that is delivered, issued for delivery, or renewed by a carrier on or after January 1, 2019.

(3) A carrier shall do the following:

a. By 2022, spend at least 7 percent of its total cost of medical care on primary care.

b. By 2023, spend at least 8.5 percent of its total cost of medical care on primary care.

c. By 2024, spend at least 10 percent of its total cost of medical care on primary care.

d. By 2025, spend at least 11.5 percent of its total cost of medical care on primary care.

Section 6. 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)(1) A carrier shall provide coverage for chronic care management and primary care at a reimbursement rate that is not less than the Medicare reimbursement for comparable services.

(2) This subsection applies to a group health insurance policy, plan, or contract that is delivered, issued for delivery, or renewed by a carrier on or after January 1, 2019.

(3) A carrier shall do the following:

a. By 2022, spend at least 7 percent of its total cost of medical care on primary care.

b. By 2023, spend at least 8.5 percent of its total cost of medical care on primary care.

c. By 2024, spend at least 10 percent of its total cost of medical care on primary care.

d. By 2025, spend at least 11.5 percent of its total cost of medical care on primary care.

Section 7. 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.

(a) The Office of Value-Based Health Care Delivery is established within the Department to reduce health-care costs by increasing the availability of high quality, cost-efficient health insurance products that have stable, predictable, and affordable rates.

(b) For purposes of this section:

(1) "Affordability standard" means as defined by the Department in regulations promulgated under this section using information collected under paragraphs (c)(2) and (c)(3) of this section and may include any of the following:

a. Trends, including any of the following:

1. Historical rates of trend for existing products.

2. National medical and health insurance trends.

3. Regional medical and health insurance trends.

4. Inflation indices.

b. Price comparison to other market rates for similar ~~products.~~insurance products and medical services.

c. The ability of lower-income individuals to pay for health insurance.

d. Effective strategies carriers can use to maintain close control over administrative costs and enhance the affordability of ~~products.~~products and encourage delivery of high quality, efficient healthcare services.

(2) a. "Carrier" means any of the following:

1. "Health insurer" as defined in § 4004 of this title and licensed under this title.

2. A health insurer or other entity that is certified as a qualified health plan on the Delaware Health Insurance Marketplace for plan year 2019 or a subsequent plan year.

b. Notwithstanding paragraph (b)(2)a. of this section, "carrier" does not mean any of the following:

1. A plan of health insurance or health benefits designed for issuance to persons eligible for coverage under Titles XVIII, XIX, and XXI of the Social Security Act, 42 U.S.C. §§ 1395 et seq., 1396 et seq., and 1397aa et seq., known as Medicare, Medicaid, or any other similar coverage under a state or federal government plan.

2. An entity selected by the State Group Health Insurance Plan to offer supplemental insurance program coverage under Chapter 52C of Title 29.

(3) "Primary care" means as defined by the Department in regulations promulgated under this section.

(4) "Primary Care Reform Collaborative" means as defined in § 9904A of Title 16.

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

(1) Establish affordability standards for health insurance premiums based on recommendations from the Primary Care Reform Collaborative.

(2) ~~Establish targets for carrier investment in primary care~~ 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, ~~2025.~~ 2026.

(3) Collect data and develop reports regarding carrier investments in health care to monitor and evaluate all of the following:

a. The calculation of the amount of claims based and non-claims based primary care spending in this State, including data from the Delaware Health Care Claims Database, under subchapter II of Chapter 103 of Title 16.

b. Carrier compliance with reimbursement rates for primary care required under §§ 3342B and 3556A of this title.

c. Health-care spending data collected and reported through the state benchmarking process.

d. The percentage of spending in primary care that is delegated to hospitals and related networks for care coordination through alternative payment models.

(4) Annually evaluate whether primary care ~~spending, spending~~ is increasing in compliance with the requirements of, and regulations adopted under, this title, with consideration of overall total health-care spending.

(5) Make recommendations to the Insurance Commissioner and the Primary Care Reform Collaborative about appropriate reimbursement rates for primary care.

(6) Develop and annually evaluate affordability standards, through an open and transparent process, in collaboration with the Primary Care Reform Collaborative.

Section 8. Amend Section 10, Chapter 392, Volume 81 of the Laws of Delaware, as amended by Section 24, Chapter 141, Volume 82 of the Laws of Delaware, by making deletions as shown by strike through and insertions as shown by underline as follows:

Section 10. ~~Sections 5 through 8 of this Act expire 3 years after having become effective unless otherwise provided by a subsequent Act of the General Assembly.~~ [Repealed.]

Section 9. Amend Section 3, Chapter 189, Volume 82 of the Laws of Delaware by making deletions as shown by strike through and insertions as shown by underline as follows:

Section 3. The Insurance Commissioner shall promulgate regulations to implement Section 2 of this Act, § 334 of Title 18. ~~Regulations promulgated under this section may not establish mandatory or enforceable requirements regarding health insurance rates, health-care spending, or primary care spending and must not be deemed to or interpreted as establishing mandatory or enforceable requirements.~~

Section 10. If the same version of Senate Substitute No. 1 for Senate Bill No. 59 has not passed both chambers by July 1, 2021, Section 2 of this Act takes effect immediately and Section 3 of this Act does not take effect.

Section 11. If the same version of Senate Substitute No. 1 for Senate Bill No. 59 has passed both chambers by July 1, 2021, but is not enacted into law, Section 2 of this Act takes effect immediately and Section 3 of this Act does not take effect.

Section 12. If the same version of Senate Substitute No. 1 for Senate Bill No. 59 has passed both chambers by July 1, 2021, and is enacted into law, Section 3 of this Act takes effect 1 day after Senate Substitute No. 1 for Senate Bill No. 59 takes effect and Section 2 of this Act does not take effect.

Section 13. Section 1 and Sections 4 through 13 of this Act take effect immediately.

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.

SYNOPSIS

This Act is a substitute for Senate Bill No. 120. Like Senate Bill No. 120, this Substitute continues recent efforts to strengthen the primary care system in this State by doing the following:

(1) Directing the Health Care Commission to monitor compliance with value-based care delivery models and develop, and monitor compliance with, alternative payment methods that promote value-based care.

(2) Requiring rate filings limit aggregate unit price growth for inpatient, outpatient, and other medical services, to certain percentage increases.

(3) Requiring an insurance carrier to spend a certain percentage of its total cost on primary care.

(4) Requiring the Office of Value-Based Health Care Delivery to establish mandatory minimums for payment innovations, including alternative payment models, and evaluate annually whether primary care spending is increasing in compliance with the established mandatory minimums for payment innovations.

(5) In Sections 2 and 3 of this Act, revising the appointment process for members of the Primary Care Reform Collaborative who are not members by virtue of position to comply with the requirements of the Delaware Constitution. These revisions are largely similar to those proposed in Senate Substitute No. 1 to Senate Bill No. 59 (151st General Assembly) ("the Substitute"). As such, Section 2 is designed to take effect if the Substitute does not pass both chambers or passes but is not enacted; Section 3 is designed to take effect if the Substitute passes both chambers and is enacted.

(6) Making technical corrections to conform existing law to the standards of the Delaware Legislative Drafting Manual

This Substitute differs from Senate Bill No. 120 as it does all of the following:

(1) Adds a "whereas clause" stating that the Department of Insurance does not regulate Medicaid or employer-based plans provided under the Employee Retirement Income Security Act, or their rates.

(2) Provides that rate filings for health benefit plans may not include aggregate unit price growth for nonprofessional services that exceed the greater of 2% or Core CPI plus 1% in 2024, 2025, and 2026.

(3) Makes a technical correction to properly alphabetize definitions in Section 4 of the Act (relating to § 2503 of Title 18).

(4) Removes "mental health and substance abuse disorder" from the definition of an "inpatient hospital".

(5) Adds a definition of "professional services" and makes clear that "nonprofessional services", which are subject to the aggregate unit price growth limits of § 2503(a)(12)a. of Title 18, do not include professional services.

(6) Amends the definition of "other medical services" to make clear the term includes the facility component of vision exams, dental services, and other services when those services are billed separately from the professional component.

(7) Changes the date for mandatory minimums for payment innovations to support a robust system of primary care to January 1, 2026.

(8) Make clear that the Office of Value-Based Health Care Delivery is to annually evaluate whether primary care spending is increasing in compliance with the requirements of, and regulations adopted under, all of Title 18.

(9) Requires the Office of Value-Based Health Care Delivery to collect data and develop reports to monitor and evaluate the percentage of spending in primary care that is delegated to hospitals and related networks for care coordination through alternative payment models.

(10) Removes the sunset date on provisions requiring individual, group, and State employee insurance plans to reimburse primary care physicians, certified nurse practitioners, physician assistants, and other front-line practitioners for chronic care management and primary care at no less than the physician Medicare rate.

(11) Sunsets Sections 5 and 6 of this Act and § 2503(a)(12)a. of Title 18 as contained in Section 4 of this Act on January 1, 2027.

Author: Senator Townsend