SPONSOR: Sen. Townsend & Rep. Bentz
Sens. Hansen, Henry, McDowell; Reps. Baumbach, Brady

DELAWARE STATE SENATE
149th GENERAL ASSEMBLY

SENATE BILL NO. 199

AN ACT TO AMEND TITLES 18, 29 AND 31 OF THE DELAWARE CODE RELATING TO PRIMARY CARE SERVICES.

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

Section 1. Amend Chapter 33, Title 18 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 3342A. Primary Care Coverage.

(a) As used in this section:

(1) “Fixed Budget” means a budget that is neither increased nor decreased by the requirements of the section, but rather effects its changes within the Total Cost of Care which may expand or contract only with other outside market forces and regulatory requirements.

(2) “Insurer” means a health insurer, health service corporation, or health maintenance organization.

(3) "Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965 [42 U.S.C. § 1395 et seq.], as then constituted or later amended.

(4) “Primary Care” means services delivered by a person licensed under Title 24 and providing services in (1) family medicine, primary care pediatrics, primary care internal medicine, and (2) primary, preventive, or screening services provided in obstetrics and gynecology and psychiatry,

(5) “Total Cost of Care” means the total expenditures for physical and mental health care an insurer reimbursed on behalf of its members, except for expenditures on prescription drugs, vision, and dental care, whether paid on a fee-for-service basis or other payment mechanism or model.

(b) No individual policy or contract of health insurance, or certificate issued thereunder, which is delivered, issued for delivery or renewed in this State by any Insurer may reimburse for Primary Care at a rate less than Medicare reimbursement for comparable services.

(i) This shall include payment for care coordination services such as “chronic care management”, which also should not be subject to patient deductibles and copayments.

(ii) Should no comparable Medicare reimbursement be available, Insurers shall reimburse for services generally available under Medicare such as office visits, preventative services, chronic care management, and prolonged services, which may be further delineated by regulation and disagreements in rates arbitrated by the Department.

(c) Within a Fixed Budget and baseline measured from the [Effective Date] fiscal year, each subsequent fiscal year an Insurer must increase within its Total Cost of Care what it spends on Primary Care by at least 1% each year to at least 12% by 2025. No more than half of the increased spend may be attributed to a hospital or facility.

(d) The Total Cost of Care and compliance with this section must be shown by submission to the Insurance Commissioner using its own data, National Committee for Quality Assurance (NCQA) scoring, as well as any other relevant information including information from Delaware Health Care Claims Database codified in Chapter 103 of Title 16.

(e) Waiver Prohibited. The provisions of this section cannot be waived by contract. Any contractual arrangement in conflict with the provisions of his section or that purports to waive any requirements of this section is null and void.

Section 2. Amend Chapter 35, 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.

(a) As used in this section:

(1) “Fixed Budget” means a budget that is neither increased nor decreased by the requirements of the section, but rather effects its changes within the Total Cost of Care which may expand or contract only with other outside market forces and regulatory requirements.

(2) “Insurer” means a health insurer, health service corporation, or health maintenance organization.

(3) "Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965 [42 U.S.C. § 1395 et seq.], as then constituted or later amended.

(4) “Primary Care” means services delivered by a person licensed under Title 24 and providing services in (1) family medicine, primary care pediatrics, primary care internal medicine, and (2) primary, preventive, or screening services provided in obstetrics and gynecology and psychiatry,

(5) “Total Cost of Care” means the total expenditures for physical and mental health care an insurer reimbursed on behalf of its members, except for expenditures on prescription drugs, vision, and dental care, whether paid on a fee-for-service basis or other payment mechanism or model.

(b) No group or blanket policy or contract issued or delivered by an Insurer may reimburse for Primary Care at a rate less than Medicare reimbursement for comparable services.

(i) This shall include payment for care coordination services such as “chronic care management”, which also should not be subject to patient deductibles and copayments.

(c) Within a Fixed Budget and baseline measured from the [Effective Date] fiscal year, each subsequent fiscal year an Insurer must increase within its Total Cost of Care what it spends on Primary Care by at least 1% each year to at least 12% by 2025. No more than half of the increased spend may be attributed to a hospital or facility.

(d) The Total Cost of Care and compliance with this section must be shown by submission to the Insurance Commissioner using its own data, National Committee for Quality Assurance (NCQA) scoring, as well as any other relevant information including information from Delaware Health Care Claims Database codified in Chapter 103 of Title 16.

(e) Waiver Prohibited. The provisions of this section cannot be waived by contract. Any contractual arrangement in conflict with the provisions of his section or that purports to waive any requirements of this section is null and void.

Section 3. Amend Chapter 52, Title 29 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 5201. Definitions.

( ) “Fixed Budget” means a budget that is neither increased nor decreased by the requirements of the section, but rather effects its changes within the Total Cost of Care which may expand or contract only with other outside market forces and regulatory requirements.

( ) “Carrier” means any entity that provides health insurance under § 505(3) of this title

( ) "Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965 [42 U.S.C. § 1395 et seq.], as then constituted or later amended.

() “Primary Care” means services delivered by a person licensed under Title 24 and providing services in (1) family medicine, primary care pediatrics, primary care internal medicine, and (2) primary, preventive, or screening services provided in obstetrics and gynecology and psychiatry,

( ) “Total Cost of Care” means the total expenditures for physical and mental health care an insurer reimbursed on behalf of its members, except for expenditures on prescription drugs, vision, and dental care, whether paid on a fee-for-service basis or other payment mechanism or model.

§ 5203. Specifications of the coverage.

(a) The basic health care insurance plan for state employees shall be equivalent to the "minimum creditable coverage" as defined by applicable federal ~~law.~~ law and include coverage for Primary Care under § 5203A of this chapter.

§ 5203A. Primary Care Coverage.

(b) The plan shall reimburse for Primary Care at a rate at least that of Medicare reimbursement for comparable services.

(i) This shall include payment for care coordination services such as “chronic care management”, which also should not be subject to patient deductibles and copayments.

(c) Within a Fixed Budget and baseline measured from the [Effective Date] fiscal year, each subsequent fiscal year the plan must increase within its Total Cost of Care what it spends on Primary Care by at least 1% each year to at least 12% by 2025. No more than half of the increased spend may be attributed to a hospital or facility.

(d) The Total Cost of Care and compliance with this section must be shown by annual report to the General Assembly using its own data, National Committee for Quality Assurance (NCQA) scoring, as well as any other relevant information including information from Delaware Health Care Claims Database codified in Chapter 103 of Title 16.

Section 4. 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:

§ 526. Primary Care Access.

(a) As used in this section:

(1) “Fixed Budget” means a budget that is neither increased nor decreased by the requirements of the section, but rather effects its changes within the Total Cost of Care which may expand or contract only with other outside market forces and regulatory requirements.

(2) “Carrier” means any entity that provides health insurance under § 505(3) of this title

(3) "Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965 [42 U.S.C. § 1395 et seq.], as then constituted or later amended.

(4) “Primary Care” means services delivered by a person licensed under Title 24 and providing services in (1) family medicine, primary care pediatrics, primary care internal medicine, and (2) primary, preventive, or screening services provided in obstetrics and gynecology and psychiatry,

(5) “Total Cost of Care” means the total expenditures for physical and mental health care an insurer reimbursed on behalf of its members, except for expenditures on prescription drugs, vision, and dental care, whether paid on a fee-for-service basis or other payment mechanism or model.

(b) No Carrier may reimburse for Primary Care at a rate less than Medicare reimbursement for comparable services.

(i) This shall include payment for care coordination services such as “chronic care management”, which also should not be subject to patient deductibles and copayments.

(c) Within a Fixed Budget and baseline measured from the [Effective Date] fiscal year, each subsequent fiscal year a Carrier must increase within its Total Cost of Care what it spends on Primary Care by at least 1% each year to at least 12% by 2025. No more than half of the increased spend may be attributed to a hospital, facility, or to long-term care.

(d) The Total Cost of Care and compliance with this section must be shown by submission to the Secretary using its own data, National Committee for Quality Assurance (NCQA) scoring, as well as any other relevant information including information from Delaware Health Care Claims Database codified in Chapter 103 of Title 16.

Section 4. Effective Date. This Act shall become effective January 1 after its passage.

SYNOPSIS

Despite the demonstrated value of primary care, access to primary care for Delawareans has become increasingly difficult as reimbursement dollars have failed to support an adequate infrastructure. The national average for primary care investment for a plan is between 6 and 8% of the total medical spend. Delaware's average is between 3 and 4%. Some states such as Rhode Island and Oregon have recognized that market forces have prohibited any one plan in a competitive market to reallocate its spend and have stepped in legislatively to move the market to a 12% spend across insurance products. This legislation ensures adequate spending in primary care. First, by setting Medicare rates as a baseline for primary care reimbursement. This is a short term fix to stem additional primary care failure and consolidation in Delaware. It also requires that over a period of years that the overall spend of plans into primary care increase gradually to reach the 12% investment mark, but without increasing the total spend so that premiums rise as a result of this reallocation.

This legislation extends to individual, group, State employee, and public assistance plans.

Author: Senator Townsend