153rd GENERAL ASSEMBLY
FISCAL NOTE

BILL:	**SENATE SUBSTITUTE NO. 2 TO SENATE BILL NO. 1**
SPONSOR:	**Senator Townsend**
DESCRIPTION:	**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.**

Assumptions:

1. This Act is effective upon signature by the Governor. In addition:
    a. As it applies to the State Employee Group Health Insurance Plan (GHIP), provisions mandating certain provider costs of service are effective beginning in Fiscal Year 2030. Provisions mandating increases in primary care spending as a percentage of total medical costs are effective beginning in plan year 2029.
    b. As it applies to Medicaid, provisions mandating increases in primary care spending as a percentage of total medical costs are effective for plan year 2029.
2. This Act requires that the cost of service of carriers providing health-care insurance coverage for the GHIP conform to the following schedule of Medicare reimbursement for comparable services:
    a. Beginning July 1, 2029, non-Free-Standing Children's Hospitals will be subject to a 275 percent of the full Medicare rate for outpatient services and a 310 percent of the full Medicare rate for inpatient hospital services and emergency department services.
    b. Beginning July 1, 2031, non-Free-Standing Children's Hospitals will subject to a 250 percent of the full Medicare rate for outpatient services, and a 275 percent of the full Medicare rate for inpatient hospital services and emergency department services.
    c. Beginning July 1, 2033, non-Free-Standing Children's Hospitals will be subject to a 250 percent of the full Medicare rate for inpatient hospital services, outpatient services and emergency department services.
    d. Beginning July 1, 2029, Free-Standing Children's Hospitals will be subject to a 275 percent of the free-standing children's hospital Medicare outpatient payment rate for outpatient services, a 310 percent TEFRA rate for inpatient hospital services and 310 percent of the free-standing children's hospital Medicare outpatient payment rate for emergency department services.
    e. Beginning July 1, 2031, Free-Standing Children's Hospitals will be subject to a 250 percent of the free-standing children's hospital Medicare outpatient payment rate for outpatient services, a 275 percent TEFRA rate for inpatient services and 275 percent of the free-standing children's hospital rate for emergency department services.
    f. Beginning July 1, 2033, Free-Standing Children's Hospitals will be subject to a 250 percent of the free-standing children's hospital Medicare outpatient payment rate for outpatient services, a 250 percent TEFRA rate for inpatient services and a 250 percent of the free-standing children's hospital rate for emergency department services.
    g. If a comparable Medicare rate is not available, reimbursement for services under the State of Delaware Group Health Insurance Plan (GHIP) is to be based on Medicare rates generally applicable to similar services as reasonably determined by the Statewide Benefits Office in the Department of Human Resources.

h. The Act requires the Department of Insurance and the State Employee Benefits Office lead a process, in consultation with Delaware hospitals, to recommend an appropriate methodology to determine and apply any inflationary or other applicable adjustments to a hospital's Full Medicare Rate not otherwise captured in a hospital's annual Medicare rate update by January 1, 2027.

i. The Medicare RBP provisions of this Act beginning with the 2028 rate filing do not apply to a Medicare-Dependent Rural Hospital or Urban Medicaid DSH Hospital. In addition, Free-Standing Children's Hospitals, Medicare-Dependent Rural Hospitals and Urban Medicaid DSH Hospitals are exempted from aggregate price growth limits for the 2027 rate filing.

The Statewide Benefit Office (SBO) projects savings to the GHIP over a six-year period as a result of implementing the above Medicare-based RBPs to be $448.5 million from FY 2030 – 2035.

3. The Act also requires GHIP carriers to report data on the percentage of primary care spending as a percentage of total medical costs for plan years 2027 and 2028 and to increase spending on primary care by 1% per year starting in Fiscal Year 2029 until primary care spending reaches 11.5% of total medical costs. The current estimated primary care spending of the GHIP is 5.8%.

    a. The SBO projects the cost to the GHIP to implement the required increases in primary care spending over a seven-year period to be $264.8 million from FY 2029 – 2035.

4. The SBO projects savings from better primary care management (reduced emergency room/urgent care visits, fewer ambulatory sensitive hospital admissions, improved condition management due to integrated behavioral health and increased use of lower cost sites of service) due to the increased investment in primary care.

    a. The SBO projects the savings to the GHIP due to better primary care management to be $153.2 million from FY 2030 – 2035.

5. The Act requires carriers providing health-insurance coverage for the Medicaid program to annually report data on the percentage of primary care spending as a percentage of total medical costs for two successive plan years annually in July of the following year. Starting in the third year, which corresponds to plan year 2029, carriers are required to increase spending on primary care by 1% annually from the higher of the two prior plan years until primary care spending reaches 11.5% of total medical costs. The current estimated primary care spending of Medicaid is 6.9%.

    a. The Division of Medicaid and Medical Assistance (DMMA) estimates the cost to these programs to implement the required increases in primary care spending over a four year period to be $149 million (State and federal funds) from FY 2029 – 2032.

    b. DMMA also estimates the need for one-time funding of $25,000 to accommodate required information system updates.

6. This Act also establishes a Primary Care Fund (PCF). Administrative penalties imposed on health insurance, group health insurance, blanket health insurance, Medicare supplement and health service corporations for violations of the provisions of this Act, (however, the GHIP and Medicaid are excluded from penalties), are to be deposited to the PCF. Proceeds of the PCF are to the used by the SBO and DMMA in the performance of various functions and duties required under this Act. At the end of each fiscal year, unencumbered balances in excess of $5,000,000 are to be transferred to the Other Post-Employment Benefits (OPEB) Fund as established in 29 Del. C. §5281.

Cost:

	GHIP	Medicaid One-Time	Medicaid (State Share)
Fiscal Year 2027:	N/A	N/A	N/A
Fiscal Year 2028:	N/A	N/A	N/A
Fiscal Year 2029:	$10.1 million	$25,000	$7.4 million

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