# Senate Bill 1: Putting Patients and Providers First

## Rebalancing the healthcare dollar and enhancing access to care.

**As primary care offices consolidate or close, and as health care prices and chronic conditions rise, so do the costs of health insurance, affecting patients, employers, and the State. Delaware is the #1 state struggling with primary care provider shortages, with just 16.36% of need met. Senate Bill 1 [pending filing] is supported by the Department of Insurance and the Medical Society of Delaware.**

## Evolution of Primary Care Policy

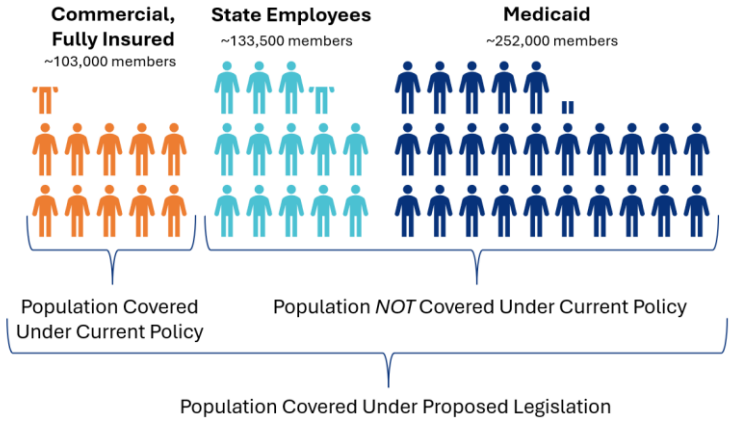
Years ago, Delaware enacted legislation (SB 120) to support primary care providers and improve access to quality preventive care, an investment that aims to improve the physical, mental, and financial health of Delawareans. This legislation more than doubled investment in primary care without meaningfully impacting insurance rates, but its impact was limited to the commercial market, **and an impending sunset stands in the way of continued progress.**

Through the Delaware Department of Insurance's implementation of SB 120, commercial insurers' investments in primary care have increased from nearly $30 million in 2022 to over $59 million in 2024, with more than 800 providers engaging in value-based care efforts that enhance patient outcomes and practice revenue. Still, provider support has been muted by the law's applicability to just 10% of residents.

### Senate Bill 1: Expanding the Primary Care Pilot

In Senate Bill 1, Medicaid and the State Group Health Plans would begin on the path toward directed primary care investment, while their issuers will offer value-based care program designs in line with those coming to the commercial market. While providing a multi-year runway for increased investment in the Medicaid and State Group Health Plan, the legislation provides for a balanced approach to ensure savings fund spending.

*Delaware Population Covered Under Current & Proposed Law*



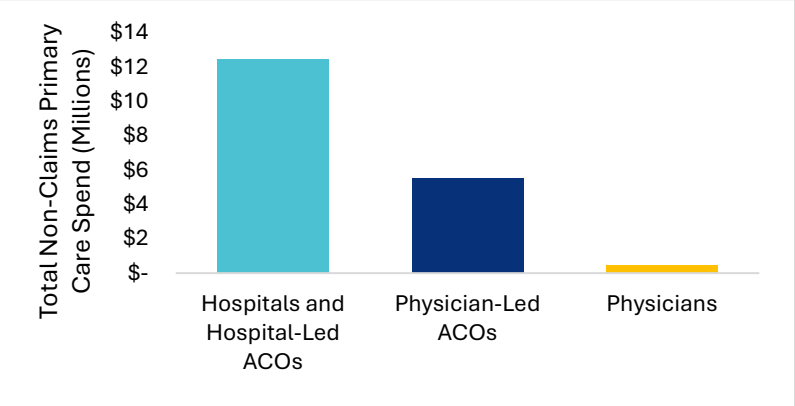

**As sunset approaches, Senate Bill 1 expands on the proven model of enhanced primary care investment to additional Delaware patients and providers while addressing the shortcomings of existing law. It also protects payers and patients from the massive financial costs of doing nothing, which include increasing issues accessing primary care and the consolidation of providers into health systems, all of which increase consumer costs, premiums, and State expenses.**

### Making Care Work for Providers

When a provider sees a patient, they just want to help. They don't check an insurance card to decide the level of care based on the quality incentives or other bonuses available. As providers are increasingly under financial pressure, Senate Bill 1 intends to support providers while protecting patients from the reduced access and high costs that system consolidation and private equity buyouts create.

In addition to including Medicaid and the State Group Health Plans, Senate Bill 1 proposes to develop standard quality program designs with similar performance metrics and reporting across plans. The

programs will provide a pathway for more practices to participate and demonstrate meaningful improvements. Senate Bill 1 also proposes requiring half of commercial primary care spending to occur in advance of care, or prospectively, to enable practices to invest in staff, systems, and technology. Contracted providers will also have access to all value-based programs offered by the insurer, so small providers cannot be excluded from incentives for high-quality care if they meet insurer requirements.




## Challenges in Current Policy Design

Without a required, standard program design, providers were subject to insurers' value-based program designs, which could be burdensome and complex to smaller providers. Insurers largely chose to contract with the larger entities to achieve the law's required levels of primary care investment most efficiently as shown here.

SB 120 required a standard value-based program design to be developed by the Primary Care Reform Collaborative, but it was not promulgated, and insurers could not be required to use it. Generating program offerings, financial incentives, and distributing investment more equitably regardless of provider size, and implementing standardized quality metrics to advance provider accountability is necessary to ensure that enhanced spending brings meaningful improvements in patient health and lower medical costs over time. Utilizing uniform program designs across the commercial, State Group Health Plan, and Medicaid markets will reduce administrative burden, enhance return on investment for quality improvements, and ensure increased primary care investment is paid more broadly across the patient population.

## Rebalancing the Healthcare Dollar

Hospital prices for inpatient and outpatient services have increased, meaningfully impacting premiums. Relative to Medicare, Delaware ranks No. 7 nationally for highest inpatient prices and No. 4 for highest outpatient hospital costs. Existing price growth limits in law, tied to inflation, have not been effective in moderating price growth. Further, the current methodology appears to further inequities in payments to health systems, whereby insurers comply with the limitation in total, but not on a per-system basis.

To require increased investment into primary care while keeping affordability top of mind, Senate Bill 1 aims to rebalance the healthcare dollar while recognizing that commercial and state plans fortify hospitals through higher-than-Medicare and Medicaid payments. The legislation adds a ceiling of 250% of Medicare to these expenses, while retaining the minimum 100% of Medicare for primary care services as specified in insurer filings and State Group Health Plan carrier selection. These savings will ensure State can develop the funds needed for gradual increases in primary care investment.

For example, research from experts at Brown University shows that, in 2022, the State Group Health Insurance Plan was charged $22M in prices above 250% of Medicare. Because the State generously limits employee's hospital out-of-pocket costs, the burden on the State and taxpayers is disproportionately high. Per the independent Brown University data, the health systems in most need of funds were not receiving the highest reimbursements: those health systems with higher Medicaid usage and charity care were receiving payments as low as 147% of Medicare for inpatient services, and 214% of Medicare for outpatient services. At the same time, other systems were far above the proposed 250% threshold: some were charging the Plan rates as high was 383% of Medicare for inpatient services, and up to 444% of

Medicare for outpatient services. Senate Bill 1's cost containment provisions will balance both primary care investment and offer improved equity in hospital contracts.

Several states have utilized such reference-based pricing models, including Montana, Oregon and Washington. Additionally, at least Colorado, Indiana, Maine, Nevada, North Carolina, Oklahoma, South Carolina, and Vermont are using or exploring similar hospital payment practices in one or more coverage environments. Programs have not been shown to limit consumer access, and states find the measure simple to administer. It is notable that Senate Bill 1 does provide Delaware hospitals with a higher multiplier of Medicare prices than other states permit, which range from 150-200% of Medicare. 250% is proposed in recognition of the current cost and coverage environment and could be lowered over time.

***Exemptions*:** Senate Bill 1 also takes steps to incentivize use of hospital global budgets, whereby a pre-determined revenue environment exists. These agreements serve to improve value and access while controlling costs. Examples include the federal AHEAD Model program which offers states $12M in funds for care transformation, or the Nemours Hospital Global Budget program with Delaware Medicaid. Hospital global budget participants would not otherwise be subject to the price limitations of the law.

## Investing Where It Matters Most

Health care in Delaware costs more. For example, Delaware commercial insurers spend nearly twice as much per member on primary care as in Virginia, the percentage of total spending is the same. In Maine, insurers spend the same as Delaware per member, per month, but it's equal to 10% of medical expense.

*Cross-State Comparison of the Commercial, Fully Insured Market, 2022*

| | Delaware | Maine | Virginia |
|---|---|---|---|
| Primary Care % of Total Medical Spend | 6% | 10% | 6% |
| Primary Care Spend Per Member, Per Month | $37 | $37 | $20 |

Due to these higher medical care costs, Senate Bill 1 proposes to maintain the minimum 11.5% primary care spend, while providing the authority to exclude high-cost claims from insurers' calculation of total medical expenses. The State Plan and Medicaid will, after multiple years of planning, increase investment by 1% per year until they meet 11.5%. Senate Bill 1 will also afford the State Plan and Medicaid access to use any funds collected by the Department of Insurance as compliance penalties related to this statute.

Investing $1 in primary care = $13 in savings, and this proactive approach can amplify State savings in additional ways. While the balanced approach in Senate Bill 1 aims to spend while saving, the longer-term outcome of improved preventative care can decrease high-cost claims, better control costly chronic conditions, and reduce hospital and emergency department utilization. These investments can also serve to improve the State's Other Post Employment Benefit (OPEB) outlook, which every rating bureau has noted as significant. Improving health outcomes and lowering health care costs strengthens the State's OPEB liability outlook, reducing the risk of a credit downgrade that would increase borrowing costs and divert taxpayer dollars away from public services.