Office of the Registrar of Regulations,
Legislative Council,
State of Delaware

DEPARTMENT OF INSURANCE

OFFICE OF THE COMMISSIONER

Statutory Authority: 18 Delaware Code, Sections 311, 334, 2503, 3342B and 3556A, and 29 Delaware Code, Chapter 101 (18 **Del.C.** §§311, 334, 2503, 3342B & 3556A; 29 **Del.C.** Ch. 101)

PROPOSED

PUBLIC NOTICE

1322 Requirements for Mandatory Minimum Payment Innovations in Health Insurance

A. Type of Regulatory Action Required

Proposal of new Regulation 1322 Requirements for Mandatory Minimum Payment Innovations in Health Insurance.

B. Synopsis of Subject Matter of the Regulation

The Office of Value Based Health Care Delivery (OVBHCD) was established within the Department of Insurance (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." *See* 18 **Del.C.** § 334(a). Senate Substitute 1 for Senate Bill 120 (SS1 for SB 120), among other things, gave the OVBHCD the regulatory authority to:

- Define "affordability standard" (*see* 18 **Del.C.** § 334(b)(1));
- Define "primary care" (*see* 18 **Del.C.** § 334(b)(3)); and
- “Establish, through regulations adopted under this section [18 **Del.C.** § 334], 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 [18 **Del.C.** § 334], to support a robust system of primary care by January 1, 2026" (*see* 18 **Del.C.** § 334(c)(2)).

In addition to and separate from the regulatory authority set forth in 18 **Del.C.** § 334, SS1 for SB 120 amended the rate filing sections of the Insurance Code by requiring that rate filings for health benefit plans may not include aggregate unit price growth for nonprofessional services that exceed the greater of:

- 3 percent or Core CPI plus 1 percent for rates filed in 2022 for the 2023 plan year;
- 2.5 percent or Core CPI plus 1 percent for rates filed in 2023 for the 2024 plan year; and
- 2 percent or Core CPI plus 1 percent for rates filed in 2024, 2025, and 2026 for the following plan years.

It also requires that rate filings by carriers with health benefit plans that cover more than 10,000 members across all fully-insured products, at a minimum, must have 50 percent 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 percent 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. *See* 18 **Del.C.** § 2503.

Lastly, SS1 for SB 120 amended 18 **Del.C.** §§ 3342B and 3556A (regarding individual and group health care coverage respectively) to mandate carrier spending on primary care as follows:

Rate Filing Year	Plan Year	Minimum % Total Cost of Medical Care Spent on Primary Care
2022	2023	7%
2023	2024	8.5%
2024	2025	10%
2025	2026	11.5%

The Department proposes to implement SS1 for SB 120 through proposed new Regulation 1322 Requirements for Mandatory Minimum Payment Innovations in Health Insurance. The Department notes that the amendments to 18 **Del.C.** § 2503 sunset on January 1, 2027. However, no such sunset date is included in those amendments to 18 **Del.C.** § 334, including the Department's authority to set affordability standards. Moreover, as detailed in the OVBHCD's February 15, 2021 Report, "Delaware Health Care Affordability Standards: An Integrated Approach to Improve Access, Quality and Value"[1], the three affordability standards set by the OVBHCD and upon which SS1 for SB 120 are based require carriers

1. The Report is available for download from the Department's website at https://insurance.delaware.gov/wp-content/uploads/sites/15/2021/03/Delaware-Health-Care-Affordability-Standards-Report-Final-03042021.pdf

to:

1. Increase primary care investment;
2. Decrease unit price growth for non-primary care services; and
3. Expand alternative payment model adoption.

Accordingly, the Department anticipates that proposed new Regulation 1322 Requirements for Mandatory Minimum Payment Innovations in Health Insurance will stand well beyond the sunset date of the amendments to the Department's rate making statute.

C. Notice and Public Comment

The proposed new regulation appears below and may also be viewed on the Department of Insurance website at http://insurance.delaware.gov/information/proposedregs/. The Department will not be holding a public hearing on the proposed new regulation.

Any person may file written comments, suggestions, briefs, and compilations of data or other materials concerning the proposed new regulation. Any written submission in response to this notice and relevant to the proposed amendments must be received by the Department of Insurance no later than 4:30 p.m. EDT, the 31st day of January 2022 and should be directed to:

Regulatory Specialist
Delaware Department of Insurance
1351 West North Street, Suite 101
Dover, DE 19904
(302) 674-7349
Email: DOI_Legal@delaware.gov

1322 Requirements for Mandatory Minimum Payment Innovations in Health Insurance

1.0 Authority

This regulation is promulgated and adopted pursuant to the authority granted in 18 **Del.C.** §§311, 334, 2503, 3342B and 3556A, and in accordance with 29 **Del.C.** Ch. 101. Subsection 9.0 is codified under the Department's express authority under 18 **Del.C.** §334 to set affordability standards, which do not include a sunset date.

2.0 Purpose

The purpose of this regulation is to establish a process through which carriers must demonstrate compliance with requirements for mandatory minimum payment innovations, including alternative payment models, provider price increases, carrier investment in primary care, and other activities deemed necessary to support a robust system of primary care by January 1, 2026 pursuant to 18 **Del.C.** §334.

3.0 Scope

This regulation applies to insurers, health service corporations, and managed care organizations that deliver or issue for delivery individual and group insurance policies or plans in this State.

4.0 Definitions

The following words and terms, when used in this regulation, shall have the following meaning unless the context clearly indicates otherwise:

"**Accountable care organization**" means an organization formed when a group or groups of doctors, hospitals, and other health care providers come together voluntarily to give coordinated high-quality care to their patients.

"**Ambulatory Payment Classification**" or "**APC**" means the classification system described in 42 CFR 419.31 that is the basis of Medicare's reimbursement system for hospital outpatient services.

"**Annual notice**" means the bulletins issued by the Commissioner that establish the format, definition, codes and supporting information that carriers must use to comply with the reporting requirements of this regulation. Such notices will be issued not later than 90 days prior to annual premium rate filing deadlines established under 18 **Del.C.** §2503.

"**Capitated Services**" means services paid through a fixed amount of money per patient per unit of time paid in advance for the delivery of health care services. The actual amount of money paid is determined by the ranges of services that are provided, the number of patients involved, and the period of time during which the services are provided.

"**Carrier**" has the meaning set forth in 18 **Del.C.** §334(b)(2).

"**Chronic care management services**" means the specific services included in the Chronic Care Management Services program, as administered by the Centers for Medicare and Medicaid Services (CMS) and includes Current Procedural Terminology ("CPT") codes 99487, 99489, and 99490.

"**Commissioner**" means the Commissioner of the Delaware Department of Insurance.

"**Comprehensive Primary Care Plus**" or "**CPC+**" means the national advanced primary care medical home model contemplated by Section 3021 of the Patient Protection and Affordable Care Act that aims to strengthen primary care through regionally-based multi-payer payment reform and care delivery transformation.

"**Comprehensive Primary Care Plus Track 1**" or "**CPC+ Track 1**" means the version of the CPC+ program in which providers are reimbursed the full Medicare Physician Fee Schedule as well as a risk-adjusted care management fee, with an opportunity to earn a performance-based incentive payment.

"**Comprehensive Primary Care Plus Track 2**" or "**CPC+ Track 2**" means the version of the CPC+ program in which providers are reimbursed less than the full Medicare Physician Fee Schedule in exchange for receiving higher non-fee-for-service payments than in CPC+ Track 1.

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

"**Delaware Health Information Network Health Care Claims Database**" or "**DHIN HCCD**" means the data base in which health care claims data that are collected from commercial and public payers under regulations promulgated pursuant to 16 **Del.C.** §10306 are stored.

"**Department**" means the Delaware Department of Insurance.

"**Diagnosis Related Groups**" or "**DRGs**" means the patient classification scheme set forth in 42 CFR 412.60.

"**Episode-based payments**" means a discounted payment or pre-determined price against which actual payments are retrospectively reconciled, that is specific to conditions for a discrete timeframe and that are initiated by combinations of diagnoses, procedures, and drugs furnished to a patient.

"**Facility**" means a place where healthcare is delivered, including by way of example only, a hospital, outpatient clinic or nursing home.

"**Health benefit plan**" has the meaning set forth in 18 **Del.C.** §§3342A(a)(3)a. and 3559(a)(3)a.

"**Inpatient hospital services**" 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.

"**Medicare Shared Savings Program Pathways to Success**" or "**MSSP Pathways**" means the CMS alternative payment model program adopted by the Federal Centers for Medicare & Medicaid Services in the "Pathways to Success" Final Rule, 83 FR 67816 (December 31, 2018), and codified in 42 CFR 425.

"**Nonprofessional services**" means services categorized as part of development of the Unified Rate Review Template as inpatient hospital, outpatient hospital, and other medical services.

"**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 professional services and categorized as such as part of development of the Unified Rate Review Template.

"**Outpatient hospital services**" 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.

"**Population-based payment**" means an arrangement in which a provider entity accepts responsibility for delivering covered services to a group of patients for a predetermined payment amount.

"**Primary Care First**" or "**PCF**" means the CMS five-year alternative payment model program established under the authority of Section 1115A of the Social Security Act that aims to reward value and quality by offering an innovative payment structure to support delivery of advanced primary care.

"**Primary Care Provider**" or "**PCP**" means an individual licensed under Title 24 of the Delaware Code to provide health care, with whom the patient has initial contact and by whom the patient may be referred to a specialist. This definition includes family practice, pediatrics, internal medicine, and geriatrics.

"**Primary care services**" or "**primary care**" means the provision of integrated, accessible health care services by primary care providers and their health care teams who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. The care is person-centered, team-based, community-aligned, and designed to achieve better health, better care, and lower costs. Services qualifying as primary care services or primary care will be determined by the Department and changes will be communicated annually to carriers by annual notice.

"**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.

"**Total cost of medical care**" means the sum of all payments by carriers, including fee-for-service and non-fee-for-service payments, for medical services paid to healthcare providers on behalf of patients and excludes spending on pharmaceutical products categorized as "pharmacy" as part of development of the Unified Rate Review Template.

"**Year**" means the calendar year in which rates are filed with the Department and applicable to the following plan year.

5.0 Coverage for Primary Care and Chronic Care Management Services

5.1 A carrier shall reimburse contracted primary care providers, their care teams and their organizations for primary care and chronic care management services furnished to Delaware residents on a fee-for-service basis according to the following:

5.1.1 The reimbursement rate shall be greater than or equal to the non-facility Delaware Medicare fee schedule that is in effect at the time the service is billed and that can be found in the Medicare Physician Fee Schedule published online at CMS.gov; and

5.1.2 A carrier shall not use business rules or any other mechanism to discount a reimbursement rate such that the resulting payment would be less than the Medicare payment that would have been made had the Medicare rate been utilized.

5.2 A carrier shall reimburse contracted primary care providers, their care teams, and organizations for primary care and chronic care management services not provided to Delaware residents on a fee-for-service basis by offering the primary care provider the opportunity to participate in one or more of the following primary care incentive programs:

5.2.1 A program in which non-fee-for-service reimbursement is greater than or equal to primary care incentive programs offered by Medicare (including by way of example only, Comprehensive Primary Care Plus (CPC+) Track 1) adjusted for the age, gender, and health status of the population, as defined by the contract. A carrier that offers a program under subsection 5.2.1 of this regulation shall ensure that the total reimbursement available to a primary care provider, the provider's care teams and organizations, is greater than or equal to the total reimbursement that would be provided according to the methodology of such program, as adjusted for the age, gender, and health status of the population;

5.2.2 A primary care incentive program (including by way of example only, the Medicare Primary Care First Program or CPC+ Track 2) in which non-fee-for-service payments comprise a larger proportion of total provider reimbursement. A carrier that offers a program under subsection 5.2.2 of this regulation shall ensure that the total reimbursement made to a participating primary care provider, the provider's care teams and organizations, is greater than or equal to the total reimbursement that would be provided according to the methodology of such program, as adjusted for the age, gender and health status of the population, as defined by the contract;

5.2.3 A carrier-designed primary care incentive program that transitions a portion of fee-for-service payment to non-fee-for-service payment, provided that:

5.2.3.1 The total PCP reimbursement under the carrier-designed program is greater than or equal to what would be paid by Medicare, adjusted for age, gender, and health status; and

5.2.3.2 The carrier has applied for approval to use the program pursuant to subsection 5.2.4 of this regulation and the Department has granted its approval; or

5.2.4 Any other qualifying primary care incentive program as may be determined by the Department and communicated annually to carriers by annual notice.

6.0 Primary Care Spending Requirements for Rate Filings

6.1 No carrier shall submit a rate filing for a health benefit plan to the Department for approval unless the rate filing reflects the following primary care spending minimums for the applicable plan year to which the rate filing pertains:

6.1.1 In 2022, at least 7.0 percent of the total cost of medical care will be expended on primary care during plan year 2023.

6.1.2 In 2023, at least 8.5 percent of the total cost of medical care will be expended on primary care during plan year 2024.

6.1.3 In 2024, at least 10 percent of the total cost of medical care will be expended on primary care during plan year 2025.

6.1.4 In 2025, at least 11.5 percent of the total cost of medical care will be expended on primary care during plan year 2026.

6.2 Each carrier rate filing shall include the following:

6.2.1 A report on eligible primary care expenses using a template supplied by the Department. The report shall include prospective and retrospective data on eligible fee-for-service and non-fee-for-service payments as well as other information as required by the Department. Definitions of eligible expenses shall be defined in an annual notice. A carrier may submit a request to the Department for a determination on whether an expense qualifies as a primary care expense for purposes of fulfilling the reporting requirements of subsection 6.2.1 of this regulation;

6.2.2 A written demonstration of the carrier's compliance with the primary care spending minimums set forth in subsection 6.1 of this regulation that is based on eligible fee-for-service and non-fee-for-service payments for Delaware residents who are attributed patients of contracted primary care providers, care teams and organizations participating in care transformation activities, and in accordance with the following:

6.2.2.1 In 2022 rate filings for the 2023 plan year, a carrier shall file a plan per instructions issued in an annual notice that describes how the carrier will make progress towards achieving 75 percent of Delaware primary care providers and care team members with attributed patients participating in eligible care transformation activities by 2026;

6.2.2.2 In 2023, 2024, and 2025 rate filings for plan years 2024, 2025, and 2026 respectively, a carrier shall include a report on progress toward achieving 75 percent of Delaware primary care providers and care team members with attributed patients participating in eligible care transformation activities by 2026. A carrier may submit a request to the Department for a determination on whether a care transformation activity meets the standards of programs in this subsection; and

6.2.2.3 Eligible activities under subsection 6.2.2 of this regulation include meeting the standards of:

6.2.2.3.1 A carrier primary care incentive program;

6.2.2.3.2 The Delaware Primary Care Model established by the Primary Care Reform Collaborative under the authority of 16 **Del.C.** §9903(a)(1);

6.2.2.3.3 The National Committee for Quality Assurance Patient-Centered Medical Home certification program as detailed at NCQA.org; or

6.2.2.3.4 Any other standards as may be added by the Department and communicated annually to carriers by annual notice.

7.0 Price Growth Limits for Non-Professional Services

7.1 No carrier shall submit a rate filing for a health benefit plan that includes aggregate unit price growth for nonprofessional services that exceeds the following:

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

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

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

7.2 Each carrier rate filing for a health benefit plan for each plan year shall be based on fee schedules and reimbursement structures that include increases that are no greater than the limits set forth in subsection 7.1 of this regulation.

7.3 The Commissioner shall annually determine the Core CPI percentage increase based on an average of the previous three years United States Department of Labor data and shall communicate this determination annually to carriers by Bulletin or other form of notice.

8.0 Alternative Payment Model Adoption

8.1 By 2023, each carrier rate filing for a health benefit plan shall reflect fee schedules and reimbursement structures for inpatient and outpatient hospital facility services delivered in Delaware that are based on a fixed payment, episode-based or population-based payment methodology (e.g., not a percent of charges), including but not limited to:

8.1.1 DRGs for inpatient facility care; and

8.1.2 APCs for outpatient facility care.

8.2 By 2023, each carrier's rate filing for a health benefit plan with more than 10,000 Delaware residents enrolled across all fully-insured products shall reflect 50 percent of total cost of care of those Delaware residents tied to an alternative payment model contract that qualifies as a Health Care Payment Learning and Action Network (HCP-LAN) Category 3 shared savings or shared savings with downside risk, with a minimum of 25 percent total cost of care of those Delaware residents covered by an alternative payment model contract that qualifies as HCP-LAN Category 3B, which includes only contracts with downside risk, and in accordance with the following:

8.2.1 For a program to qualify as HCP-LAN Category 3A in 2023 and 2024, it must offer provider organizations the ability to receive shared savings at a minimum split of 30 percent to the accountable care organizations and 70 percent to the carrier. For a program to qualify as HCP-LAN Category 3A in 2025, it must offer provider organizations the ability to receive shared savings at a minimum split of 40 percent to the accountable care organizations and 60 percent to the carrier.

8.2.2 For a program to qualify as HCP-LAN Category 3B in 2023 and 2024, it must require accountable care organizations to be responsible for at least 30 percent of losses, or 15 percent of losses if the accountable care organization would be considered low revenue by CMS. For a program to qualify as HCP-LAN Category 3B in 2025, it must require accountable care organizations to be responsible for at least 40 percent of losses, or 20 percent of losses if the accountable care organization would be considered low revenue by CMS.

8.2.3 Program design elements regarding risk corridors (i.e., minimum shared savings rate and minimum loss rate) and loss sharing limits should be consistent with the MSSP Pathways model. A carrier may submit a request to the Department for a determination on whether a program design element is consistent with the MSSP Pathways.

9.0 Affordability Standards

9.1 Each of the following affordability standards shall be included in every health benefit plan reimbursement structure and fee schedule implemented by every carrier in this state, and shall be unaffected by the sunset provisions of Senate Substitute 1 for Senate Bill 120 (SS1 for SB 120) of the 151st General Assembly:

9.1.1 For plan years through 2026, an increase in primary care spending described in Section 6.0 of this regulation at the rate set forth in Section 6.0 of this regulation for each specified plan year, and for plan years beyond 2026, an increase in primary care spending at a rate not less than the rate set forth in subsection 6.1.4 of this regulation;

9.1.2 For plan years through 2027, a limit in price growth for nonprofessional services described in Section 7.0 of this regulation at the rate set forth in Section 7.0 of this regulation for each specified plan year, and for plan years beyond 2027, a limit in price growth for nonprofessional services at the rate set forth in subsection 7.1.3 of this regulation; and

9.1.3 The adoption of an alternative payment model or models described in Section 8.0 of this regulation at the rate set forth in Section 8.0 of this regulation. For a program to continue to qualify as HCP-LAN Category 3A or HCP-LAN Category 3B beyond 2025, it must continue to satisfy the respective requirements applicable to year 2025 as set forth in subsections 8.2.1 and 8.2.2 of this regulation, respectively.

9.2 No carrier shall implement one of the affordability standards set forth in subsection 9.1 of this regulation without also implementing the other two affordability standards set forth in subsection 9.1 of this regulation.

9.3 The OVBHCD shall annually monitor carrier compliance with subsections 9.1.and 9.2 of this regulation as set forth in Section 10.0 of this regulation and may refer a non-compliant carrier to the Commissioner for disciplinary action in accordance with Section 10.0 of this regulation.

10.0 Enforcement

10.1 The Department shall monitor carrier compliance with the requirements of this regulation through an annual review of any or all of the following:

10.1.1 Carrier-specific and Medicare fee-for-service data from the DHIN HCCD;

10.1.2 Carrier-submitted templates that report information such as: fee-for-service payments, non-fee-for-service payments, and primary care incentive programs, requirements, numbers of participating providers, performance metrics, price, utilization and total cost trends and other information, as required in this regulation and as identified in annual notices. Carriers shall use templates supplied by the department to provide prospective and retrospective information to confirm carrier requirements were met; and

10.1.3 As necessary, a market conduct exam of a carrier that may include a review of carrier contracts with healthcare providers and additional information as necessary. Any market conduct exam pursuant to this regulation shall be conducted in accordance with the provisions of 18 **Del.C.** §§318-321.

10.2 The Department may report on carrier compliance with this regulation by carrier and market segment.

10.3 The Commissioner may deem carriers as non-compliant for failure to:

10.3.1 Submit a rate filing that conforms to the requirements of this regulation;

10.3.2 Timely remediate filing deficiencies; or

10.3.3 Achieve any of the requirements of this regulation and as approved in annual rate filings.

10.4 The Commissioner may elect to take one or more of the following actions for non-compliant carriers:

10.4.1 Return a rate filing to the carrier for amendments and correction of deficiencies;

10.4.2 Require the carrier to submit a corrective action plan;

10.4.3 Create carrier-specific, ongoing, additional reporting and monitoring requirements starting immediately and continuing through the following two rate years;

10.4.4 Impose administrative penalties, after notice and hearing as specified in 18 **Del.C.** Chapter 3 including but not limited to:

10.4.4.1 Daily fines of up to $10,000 per day for failure to submit initial, revised or final filing documents per established timelines or department instructions.

10.4.4.2 Fines equal to each year's value of the deficiency in reimbursement, payment and cost growth limits as set forth in Section 10.0 of this regulation.

11.0 Effective Date of Regulation

This regulation shall become effective on March 11, 2022.

25 DE Reg. 684 (01/01/22) (Prop.)