



DISABILITIES LAW PROGRAM

COMMUNITY LEGAL AID SOCIETY, INC.

100 W. 10th Street, Suite 801
Wilmington, Delaware 19801
(302) 575-0660 TTY (302) 575-0696 Fax (302) 575-0840
www.declasi.org

To: GACEC; SCPD; DDC
From: Disabilities Law Program
Date: April 15, 2020
Re: April 2020 Policy and Law Memo

Proposed DDOE Regulation on Certifications for Special Education Teachers of Students with Disabilities, 23 Del. Register of Regulations 810 (April 1, 2020)

The Delaware Department of Education (“DDOE”) proposes to amend 14 Del. Admin. C. 1571, which describes requirements for a special education teacher of students with disabilities standard certificate pursuant to 14 Del. C. § 1220. DDOE, in cooperation with the Professional Standards Board (hereinafter “The Board”), is proposing to amend this regulation to clarify changes made in Section 1.0, add definitions to Section 2.0, clarify the requirements for issuing a special education teacher of students with disabilities certificate, clarify disciplinary procedures, and adding two new sections which (1) allow for the Secretary of Education to review applications and (2) recognize past certifications.

Much of the proposed changes do not warrant much discussion or concern, so they will be mentioned only briefly. Proposed § 1571.2 reprints, nearly verbatim, a number of definitions that are found in 14 Del. Admin. C. § 1505. These definitions replace the language which had incorporated the definitions from § 1505.

In proposed § 1571.3.2, DDOE proposes to include a provision that it will not act on an application under this section if the applicant is under official investigation by any local, state, or national authority with the power to issue educator licenses. It goes on to list alleged conduct where DDOE will not act. It is unclear whether the list describes the *only* investigations where DDOE will not act, or if they represent examples. Councils may wish to recommend DDOE clarify this section.

In proposed § 1571.4.1.1, DDOE is proposing to include additional ways in which to satisfy the education requirement to apply for a certificate under this section. Those additional routes include (1) having “[o]btained and currently maintain an Exceptional Needs Specialist certificate from the National Board for Professional Teaching Standards”; “[s]atisfactorily completed an alternative routes for licensure or certification program to teach students with disabilities as

provided in 14 Del.C. §§1260 – 1266; or [s]atisfactorily completed a Department-approved educator preparation program in special education.”

Proposed § 1571.5 includes requirements for the actual application for the certificate under this section. It lists the documentation needed in order for DDOE to process the application, which are standard documents and include items such as official college transcripts, evidence of an acceptable score on the *Praxis* exam, and an official copy of an educator license or certificate from another jurisdiction for educators wishing to teach in Delaware.

Proposed § 1571.7 outlines the disciplinary actions that could befall an educator with a certificate under this section. The proposed language incorporates requirements and actions in other current Delaware law and regulations including 14 Del. Admin. C. § 1514 (Limitation, Suspension, and Revocation of Licenses, Certificates, and Permits), 14 Del. C. § 1222 (Revocation of a Certificate), and 14 Del. Admin. C. § 1515 (Hearing Procedures and Rules).

The two proposed sections which require the most scrutiny and consideration are § 1571.6 and § 1571.8.

Proposed § 1571.6 establishes that an educator with a certificate under this section is not required to *renew* the certificate *as long as* their educator’s license is valid and current. For background, an educator’s initial license is valid for four (4) years at which point they can apply for a continuing license which is valid for five (5) years. After five (5) years, the educator can apply to renew their license. That renewal requires a certain number of professional development hours along with other requirements. The purpose of these professional development hours is to ensure that Delaware educators are continuing to learn and develop their practice, just as other professions are required to do.

The Board does not prescribe specific professional development for educators. This is true for educators possessing one of the many standard certifications that are available, including the certification under proposed § 1571. The only requirements for professional development, found at 14 Del. Admin. C. § 1511.6, are that it should include at least ninety (90) “Clock Hours” which are related to 14 Del. Admin. C. § 1597 (Delaware Professional Teaching Standards), 14 Del. Admin. C. § 1590 (Delaware Administrator Standards), or “appropriate specialty organization standards.” Therefore, it is possible that an educator with this certificate will not actually participate in any professional development related to their certification.

Councils may wish to recommend that DDOE consider whether including requirements for renewal of this certificate is warranted, especially given the vulnerability of the population served. For ease, the renewal of this certificate could coincide with the date of renewal for the educator’s license. Proposed requirements for renewal could include activities such as participation in a mandated number of hours (out of the ninety (90) required) of professional development related to this certificate or additional mentoring on top of the current mentoring requirements.

Proposed § 1571.8 establishes an additional route to obtaining a certificate under this section. Specifically, it allows DDOE’s Secretary of Education to review and grant certification where the educator does not meet the requirements necessary. This review would be prompted at the

request of a local school or school district and would need to be supplemented with documentation showing the educator's effectiveness.

Proposed § 1571.8 mirrors similar language found in 14 Del. C. § 1224, which allows the Secretary to “review licensure and certification credentials on an individual basis and to act upon same at the request of the local school district or charter school provided that the local school district or charter school is able to document the effectiveness of the applicant.” The regulations implementing this part, found at 14 Del. Admin. C. § 1505.9, use the same language as that found in the proposed regulation. Although proposed § 1571.8 is aligned with current regulations concerning standard certificates, DDOE cannot forget that students with disabilities require Delaware's most capable educators. Given that educators under this certificate are responsible for educating our most vulnerable students and those most in need of exceptional teachers, Councils may wish recommend that DDOE remove proposed § 1571.8. Alternatively, Councils may wish to recommend DDOE remove the language allowing for a review by the Secretary where an applicant does not meet the listed requirements.

In conclusion, Councils may wish to support the proposed amendment with the included recommendations and suggestions.

Proposed DHCQ Regulation 3340 on Free Standing Emergency Departments, 23 Del. Register of Regulations 817 (April 1, 2020)

The proposed regulation by the Department of Health and Social Services (DHSS), Division of Health Care Quality (DHCQ), abrogates the existing one (4404) and re-numbers it 3340. The proposed regulation changes the name of the facility from Free Standing Emergency Center to Free Standing Emergency Department (FSED).

DHSS originally published proposed regulations for FSED's in the July 1st 2019 issue of the Delaware register of Regulations. The regulations are being republished as the Department made significant substantive changes to the previous proposed regulations.

This author reviewed the July 2019 proposed regulation and was asked to specifically address the regulation for accessibility issues for individuals with disabilities. One of the criticisms of the regulation made by the author was that it did not specifically mention the Americans with Disabilities Act of 1990 (ADA) or Section 504 of the Rehabilitation Act of 1973 (Section 504). The ADA requires access to medical care services and the facilities where the services are provided. Private FSED's are covered by Title III of the ADA. Section 504 covers any FSED that received federal financial assistance (including Medicare and Medicaid reimbursements). This author stated that it would be better if the regulation specifically mentioned that the FSED must comply with the ADA and Section 504, so that its application to persons with disabilities would be readily apparent (and not by inference).

Section 4.23 of the proposed regulation now requires FSED's to comply with the ADA and incorporates the act into the regulation. Likewise, section 4.24 requires FSED's to comply with Section 504 and incorporates the act into the regulation.

Another criticism of the July 2019 regulation was that although it mandated preparation of a written disaster preparedness plan for dealing with medical and non-medical emergencies, there was no specific language setting forth any requirements for dealing with patients with

disabilities during an emergency. Section 15.2 of the proposed regulation now requires FSED's to "maintain a **disability inclusive** written disaster preparedness plan for natural and other disasters specific to the facility." (bold print added).

A third criticism of the July 2019 regulation was that although it required FSED's to comply with the rules and regulations of the Fire Prevention Commission and be inspected annually by the fire marshal, there was no specific language dealing with how patients with disabilities would be evacuated. Further, the regulation did not require that employees receive training in procedures to be followed for patients with disabilities. This author opined that it would be better if the regulation had requirements that specified an evacuation route for patients with disabilities, including the width of any route and removal of any obstructions. Unfortunately, this issue was not addressed in the proposed regulation.

The proposed regulation adds a host of new definitions, including abuse, medication diversion, adverse incident, and emergency care. However, if a FSED is owned and operated by a hospital and is accredited by an organization approved by the Centers for Medicare and Medicaid Services, it is exempt from licensure and this regulation.

The regulation sets up a comprehensive licensing procedure, which includes an initial license (3.3.1), a provisional license (3.3.2), and an annual license (3.3.3). The regulation vests the Department of Health and Social Services with the authority to impose disciplinary action, including immediately suspending a license where there is an "immediate jeopardy or imminent danger to the public health, welfare and safety requiring emergency action." (3.5).

The regulation also sets up a comprehensive scheme of authority and responsibility. Every FSED must have a governing body that is responsible for the management, control, and operation of the facility. (5.0). There must be a director who is a full-time physician board certified in emergency medicine. He or she is responsible for the day to day operation and management of the FSED. (6.1.1; 6.1.2). The director is responsible for providing quality medical care. (6.1.3).

There must be a clinical director appointed by the director who is a registered nurse with substantial education, experience, and competence in emergency nursing. (6.2.1; 6.2.3.1). He or she must be a competent manager, administrator, and supervisor since the person provides general supervision and direction of the services offered by the FSED. (6.2.3.2; 6.2.3.3).

There are requirements for physicians (6.7) and nurses (6.8). There must be at least one (1) physician and one (1) registered nurse with training "in advanced cardiac life support and pediatric advanced life support in the FSED at all times." (6.9).

The regulations requires FSED's to have an infection prevention and control program based upon nationally recognized guidelines and standards such as the Centers for Disease Control and Prevention. (8.1).

The FSED must be properly built, equipped, and maintained to protect the health and safety of patients and employees. (10.1). A facility must have an adequate supply of linen that is processed in accordance with national standards for healthcare laundry. (10.2.1; 10.2.8). An FSED must have housekeeping services to ensure a clean, sanitary, and safe environment. (10.3.1). Waste must be properly stored and disposed of to prevent the transmission of disease

(10.4.3), and the regulation adopts and incorporates as requirements for FSED's the provisions of the Department of Natural Resources and Environmental Control, Regulation Governing Solid Waste. (10.4.4).

FSED's have to collect, maintain, and store patient medical records (while protecting confidentiality), and must be able to retrieve, authenticate, and distribute a patient's medical records. Records can be kept in hard copy, electronically, or a combination of both. (11.0).

Drugs, controlled substances, and biologicals must be properly stored, accessible only to authorized employees, and prepared and dispensed "according to acceptable standards of practice." (12.1; 12.4). FSED's must comply with all state and federal laws, regulations, and guidelines pertaining to pharmaceutical services (12.2), and must be registered under state and federal controlled substance acts. (12.3).

An FSED must provide a patient or patient's representative with verbal and written notice of the patient's rights (14.1) and also post the patient's rights in the waiting room. (14.2). The notice must include the contact information of the DHSS to which patients may report complaints. (14.2). The patient's rights are broad and include treatment with respect and dignity; safety; privacy; care free from abuse, neglect, and exploitation; provision of appropriate information concerning the diagnosis, treatment and prognosis to the patient, patient's designee, or legally authorized person; participation in decisions involving care and treatment except "when the patient's participation is contradicted for medical reasons;" and the ability to complain about treatment and care that is or is not provided. (14.0 *et. seq.*) Information shall also be provided to patients and employees about patient conduct and responsibilities; services that the FSED provides; the fees and payment policies for the available services; and ways to express complaints and suggestions to the FSED. (14.4 *et. seq.*).

This regulation is a major effort to protect the state's citizens and ensure they receive proper care from Free Standing Emergency Departments. The regulation is comprehensive and applies equally to all patients, including those with disabilities. The regulation specifically incorporates the ADA and Section 504. The regulation also requires a disability inclusive written disaster preparedness plan. That being said, language should be added to the fire safety section to more adequately address the needs of individuals with disabilities. This is a laudable attempt by DHSS to ensure the quality of care and to regulate the provision of services patients receive from FSED's and should be endorsed by councils.

Proposed DHCQ Regulation 4469 on Personal Assistance Services Agencies, 23 Del. Register of Regulations 818 (April 1, 2020)

The Division of Health Care Quality proposes to amend existing regulations pertaining to personal assistance services agencies, which are currently found at 16 Del. Admin. C. § 4469. Personal assistance services are defined by the regulations as "services for compensation that do not require the judgment and skills of a licensed nurse or other professional," which are limited to "individual assistance with/or supervision of activities of daily living, companion services, transportation services, homemaker services, reporting changes in consumer's condition, and completing reports" (see existing regulations at subsection 1.1).

The amendments implement the terms of the “Share the Care Act” (SB 27) which was passed by the General Assembly in April 2019 and signed into law by Governor Carney on June 13, 2019. The “Share the Care Act,” codified at 24 Del. C. § 1921 (17), allows the employee of a personal assistance services agency to administer medication to service recipients in certain circumstances. The stated reasons in the bill were the time and resource constraints that many family caregivers may face, and that contracting for nursing care solely for the purposes of medication administration could be prohibitively expensive and may discourage individuals from continuing to live independently in the community.

The proposed amendments to the regulations expand the defined scope of personal assistance services to include “medication reminders” as well as “medication administration” if certain conditions are met (see subsection 1.1 of the proposed regulations). As laid out in subsection 5.4.3 of the proposed regulations, the administration of medication must be authorized by “a responsible caregiver with appropriate capacity.” There must be an agreement between the caregiver and the personal assistance services provider which includes the caregiver’s confirmation that the medication and administration method are both “safe and appropriate.” The caregiver must pre-package and label the medication to be administered, including the date and time it is to be administered, and provide written instructions for administering the medication. These provisions specifically exclude administration of medication by injection, intravenously, through the rectum or vagina, through a catheter, or through a feeding tube. All of these requirements mirror the language in the statute. The proposed regulations also include requirements for the documentation of medication administration at subsection 5.5.2.5, and make clear at 5.5.12 that a medication diversion, error or omission is a major adverse event that must be reported to the Department within forty-eight (48) hours.

In addition to implementing the changes created by the “Share the Care Act” the proposed amendments clarify the distinction between a “complaint” and a “grievance” and explicitly requires provider agencies to create a formalized grievance procedure for consumers of personal assistance services and their representatives (see subsection 6.4 of the proposed regulations). This process must include a procedure for submission of written or verbal grievances, a set timeline for reviewing and responding to grievances, and a written notice of decision to be issued in response to every grievance. Having such a mechanism seems necessary to meaningfully enforce the consumer rights established in subsection 6.0 of the existing regulations.

The proposed regulations also add a requirement at subsection 8.0 that each provider agency develop a “comprehensive emergency management plan” for disaster preparedness. This plan must include “provisions for continuing personal assistance services during an emergency that interrupts consumer care or services in the consumer’s home,” and must be disseminated to both staff and service recipients. In light of the recent COVID-19 pandemic, such a requirement seems more than reasonable and would hopefully help to prevent service disruptions in future disasters.

Per the terms of the “Share the Care Act,” the Act is to be implemented a year after the date of enactment, or after the promulgation of final regulations by DHSS, whichever is earliest. The DLP suggests that the Councils support the proposed regulations, as they implement existing

law and also add additional protections for consumers in the form of requiring providers to implement grievance procedures and disaster preparedness plans.

Proposed Dept of Insurance Regulation 903 on Prompt Payment of Workers Compensation Claims, 23 Del. Register of Regulations 831 (April 1, 2020)

Regulation 903 amends the existing regulation dealing with payment of settled claims other than those pertaining to Workers Compensation (an agreement on compensation or benefits is controlled by 19 *Del. C.* section 2344). The regulation is promulgated by the Department of Insurance and required by 18 *Del. C.* section 2304(16).

The new regulation contains the same provisions as the current regulation. There is some change in the language used but the meaning remains the same. For example, both regulations provide that once a claim has settled, whether because of litigation or negotiation, the insurance carrier must make payment within thirty (30) days. The thirty (30) days run from the date the settlement agreement is signed by both parties; the date the final court order is issued; or the last day on which an arbitration can be appealed, when neither party appeals.

If an insurance carrier has failed to promptly pay a settled claim in bad faith, the insurance commissioner can, after a hearing take several steps: award interest equal to the prime rate plus three percent (3%) to the claimant; fine the insurance carrier; and fine any person(s) involved with the claim and settlement.

A rebuttable presumption that an insurance carrier violates section 2304(16)(f) arises if the carrier fails to make a payment three (3) times within a thirty-six (36) month period. This period is measured by the same standards in which the claim is to be paid (namely the date the settlement agreement is signed by both parties; the date the final court order is issued; or the last day on which an arbitration can be appealed, when neither party appeals).

Only the insurance commissioner can enforce this regulation against an insurance carrier or its employees; there is no private cause of action granted to the affected claimant.

The major change is that the amendments allow the claimant to receive payment by check or electronic payment. If electronic payment is selected, the payment cannot be to a prepaid card or other method where any transaction fees are incurred.

This regulation continues to recognize that settled claims with an insurance carrier were not always being paid in a timely manner. This regulation continues to impose an obligation on the insurance carrier to pay settled claims within thirty (30) days with the threat of penalties if non-payment or delayed payment occurs more than three (3) times in a three (3) year period.

The major feature of the amendments, however, is that it allows payment by electronic means (with some restrictions). The electronic payment feature is new and keeps up with the technology that has evolved in the way payments can be made.

The effective date of the regulation is thirty (30) days after publication in the register of regulations. The amendments to the regulation become effective on the 11th day after publication of the final order signed by the Insurance Commissioner adopting the amendments.

This is a laudable attempt by the Department of Insurance to regulate the manner in which settled claims are paid and the timeliness of those payments and should be endorsed by councils.

Proposed Dept of Insurance Regulation 1411 on Registration of Pharmacy Benefit Managers, 23 Del. Register of Regulations 834 (April 1, 2020)

Pharmacy benefit manager (“PBM”) contracts typically cover administration of the retail prescription drug benefit. These private entities process claims help create the plans’ drug benefit and negotiate with drug companies to obtain discounts, rebates, or other price concessions. Although the primary function of a PBM initially was to create networks and process pharmaceutical claims, they have been criticized for exploiting a lack of regulation and transparency and have been accused by consumer groups of creating conflicts of interest which have significantly distorted competition, reduced choices for consumers and ultimately increased the cost of drugs. States have historically had little defined oversight authority over PBM operations, leaving pharmacies, patients, and plan sponsors with little to no recourse against PBM abuses. To combat the lack of transparency, states are beginning to require PBMs become licensed or registered with the state department of insurance or board of pharmacy to provide the state with more oversight authority over PBMs.

House Bill 194 as amended by House Amendment 1 (HB 194/HA1) added a new Subchapter V to Chapter 33A of the Insurance Code. *See* 82 Del. Laws, c. 115 (2019). Entitled “Registration of Pharmacy Benefits Managers,” the legislation: (1) Requires PBMs to register with the Insurance Commissioner; (2) Permits the Insurance Commissioner to issue cease and desist orders to PBMs who commit fraudulent acts or violations of Title 18, Chapter 33A; (3) Requires PBMs to maintain certain records; (4) Permits the Insurance Commissioner to examine the affairs of PBMs; (5) Grants the Insurance Commissioner the authority to enforce Chapter 33A of Title 18 by imposing fines, requiring PBMs to take affirmative actions, and suspending, denying, or revoking a PBM’s registration; and (6) Updates existing law regarding maximum allowable cost lists and establishes a more transparent appeals process on which a pharmacy may rely if a PBM does not reimburse the pharmacy the amount owed under their contract or pursuant to the maximum allowable cost list.

DOI is proposing Regulation 1411 to implement the registration requirements of HB 194/HA 1. All PBMs are required to register with the Insurance Commissioner before providing pharmacy benefits management services in Delaware to an insurance company, health service corporation, health maintenance organization, managed care organization, and any other entity that: (1) provides prescription drug coverage or benefits in Delaware, and (2) enters into agreement with a pharmacy benefits manager for the provision of pharmacy benefits management services. The regulation provides broad grounds for the DOI Commissioner to deny, suspend, or revoke an application or registration certificate and includes a record keeping provision to give the Commissioner access to a PBM’s practices.

Councils should support legislative and regulatory efforts to promote transparency in drug pricing and in the drug distribution system. However, increased transparency and registration requirements are not enough. As an example of an even more aggressive effort to control PBMs, Nevada passed legislation specifying that a PBM has a fiduciary duty to a third party with which it has entered into a contract to manage that party’s pharmacy benefits plan.

This means that the PBM must act in the best interest of the pharmacies or consumers it serves. While Regulation 1411 includes strict licensing requirements and provides important oversight of PBMs that will help provide insight and information on how PBMs conduct business, Councils should advocate for even stronger legislation to keep PBMs accountable and actually promote savings as they were intended to do.

Bills:

HB 175, An Act To Amend Title 15 Of The Delaware Code Relating To Voting By Mail

This bill would permit voting by mail. Specifically, the bill would allow any qualified voter the option to vote by mail in primary, general, and special federal elections. The heart of the bill describes the process for voting by mail. The bill tasks the State Elections Commission (Commission) to create an application for a mail ballot, which must be released at least 45 days prior to the election. This application can then be filed by mail or in person with the Commission by any qualified voter who wants to vote by mail. A voter does not have to file the specific application, rather they can file any written request “evidencing a desire to vote by mail” with the Commission. The bill further requires the Commission to establish procedures that must allow processing and scanning of mail ballots sent by mail ahead of Election Day without tabulation until Election Day, dropping off mail ballots at any polling place on Election Day and dropping off mail ballots in a secure drop box of each county Department of Elections on Election Day and before Election Day.

“Five states currently conduct all elections entirely by mail: Colorado, Hawaii, Oregon, Washington and Utah. At least 21 other states have laws that allow certain smaller elections, such as school board contests, to be conducted by mail.” All-Mail Elections (aka Vote-By-Mail) Ncsl.org, <https://www.ncsl.org/research/elections-and-campaigns/all-mail-elections.aspx> (last visited Apr 13, 2020). Voting by mail has many possible advantages including convenience and accessibility. The process could allow more access to the electoral process for those who find it difficult to vote in person. Since citizens would be voting at home they can have the time they need to study the issues. Voting by mail could help protect the health and safety of voters and elections personnel during times of emergencies, such as the current Covid-19 outbreak, where “the closure of polling places due to contamination, travel restrictions, or voters’ reluctance to enter crowded environments could all restrict the ability to vote in-person.” VOTE AT HOME SCALE PLAN (National Vote at Home Institute) (2020), https://www.voteathome.org/wp-content/uploads/2020/03/VAHScale_StrategyPlan.pdf (last visited Apr 13, 2020).

Currently, the Department of Elections has a secure system in place that allows certain absentee voters the option to receive their absentee ballots electronically and submit them via a secure online platform. As of now, the system is only available to absentee voters who choose either of the following reasons for voting absentee: they are sick, or temporarily or permanently physically disabled; they are in public service of the U.S. or the State of Delaware; or they are a spouse or dependent residing with or accompanying him or her (this reason also applies to members of the Uniformed Services). Expanding the use of this system for all mail in voters would provide voters with another option of returning their ballots and provide greater accessibility. .

Councils should consider endorsing this bill but seek the addition of electronic transmission and submission of mail in ballots in order to improve accessibility.

HB 307 – Annual Behavioral Health Well Check

HB 307 proposes to add language to various chapters of the Delaware Code to mandate health insurance coverage for an “annual behavioral health well check,” which is defined as “an annual visit with a licensed mental health clinician with at minimum a masters level degree.” The bill refers to the Mental Health Parity and Addiction Equity Act, which was passed by the U.S. Congress in 2008. The Act as passed in 2008 only applied to group health plans and insurance coverage, but was expanded by the 2010 Affordable Care Act to include individual health insurance coverage (see, e.g., “The Mental Health Parity and Addiction Equity Act (MHPAEA),” available at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet).

HB 307 would add identical language to the chapters of the Delaware Code referring to health insurance contracts (Title 18, Chapter 33), group and blanket health insurance (Title 81, Chapter 35), the State Public Assistance Code (Title 31, Chapter 5) and health care insurance for state public officers and employees (Title 29, Chapter 52). This language requires that health plans cover an annual behavioral health well check, which “must include but not be limited to a review of medical history; evaluation of adverse childhood experiences; use of appropriate battery of validated mental health screening tools” and “may include anticipatory behavioral health guidance congruent with stage of life using the diagnosis of “annual behavioral health well check.” In addition to provisions for how providers shall be reimbursed, the language in the bill makes clear that this check may be “incorporated into and reimbursed within any type of integrated primary care service delivery method,” meaning it would presumably not necessarily require patients to schedule a separate appointment for an annual behavioral health well check.

The DLP suggests that the Councils support this bill, as expanded coverage for preventative care and early intervention will benefit individuals with mental health conditions or who are at risk of developing mental health conditions later in life.

HB 315: Delaware Resident Low Income Tax Credit for Automobile Purchase Document Fees

House Bill 315 (“HB 315”) seeks to amend Chapter 11, Subchapter II of Title 30 of the Delaware Code relating to Personal Income Tax Credits for Delaware residents by adding § 1118, which creates a personal income tax credit for certain low income Delaware residents for incurred motor vehicle document fees. The stated purpose is to “assist the working poor in obtaining a new or used motor vehicle.” The bill was introduced in the Delaware House of Representatives on March 12, 2020, sponsored by Representative Yearick and Senator Delcollo, and co-sponsored by Senator Hocker and Representatives Bush, Gray, Vanderwende, and Michael Smith. It was subsequently assigned to the House Revenue and Finance Committee where a hearing will be held once the General Assembly is back in session.

The § 1118 personal income tax credit would apply to residents who have claimed income between \$18,000 and \$30,000 and would allow for a credit in an amount equal to the amount of

motor vehicle document fees required by 30 Del. Admin. C. § 3002(c)(3) which are paid by the resident for one (1) new or used motor vehicle purchased during that tax year. For Delaware resident spouses filing jointly, their claimed income must be between \$36,000 and \$60,000 and are allowed the credit for one (1) *or* two (2) motor vehicles purchased during that tax year. If Delaware resident spouses file a federal joint tax return, but file separately in Delaware, the rules for a single Delaware resident apply to this tax credit; however, only one spouse will be able to claim the tax credit for any motor vehicle (meaning each spouse cannot claim the tax credit for the same motor vehicle document fees).

The motor vehicle document fees required under § 3002(c)(3) are imposed on the sale, transfer, or registration of any new or used motor vehicle, truck tractor, trailer, or motorcycle within the state of Delaware. These document fees begin at \$8.00 for a motor vehicle purchased for less than \$400 and increase to \$13.75 for a purchase price between \$400 and \$500. Any purchase price above \$500 increases the document fees by \$4.25 for every \$100. This bill would allow a Delaware resident meeting the income requirements, to receive a tax credit in an amount equal to the amount of motor vehicle document fees paid by that individual.

This bill will undoubtedly put money back into the hands of Delawareans with low income who were able to afford the purchase of a new or used motor vehicle; however, its ultimate impact is unclear. Many individuals seeking to purchase a vehicle, especially those with low income, tend to need the assistance on the front end when purchasing the vehicle, rather than on the back end. Therefore, it is hard to determine whether this bill will actually meet its intended purpose of assisting low-income Delawareans with obtaining a new or used vehicle.

Although its impact is currently unclear – this reviewer found it difficult to locate other states who had introduced or implemented something similar – Councils may wish to support this bill given its potential for providing financial security and assistance for low-income Delawareans. However, Councils may wish to recommend that the bill be amended to include additional tax credits for low-income residents related to the purchase or ownership of a motor vehicle, such as additional credits for registration and inspection fees past the year of purchase. Councils may also wish to recommend that the bill be amended to include credits for excise taxes paid on gasoline for the vehicle.

HB 316: Delaware Resident Low Income Tax Credit

House Bill 316 (“HB 316”) seeks to amend Chapter 11, Subchapter II of Title 30 of the Delaware Code relating to Personal Income Tax Credits for Delaware residents by adding § 1119, which creates a personal income tax credit for certain low income Delaware residents. The bill was introduced in the Delaware House of Representatives on March 12, 2020, sponsored by Representatives Yearick and Ramone and Senators Lawson and Wilson, and co-sponsored by Representative Michael Smith. It was subsequently assigned to the House Revenue and Finance Committee where a hearing will be held once the General Assembly is back in session.

The § 1119 personal income tax credit would apply to residents who have claimed income between \$18,000 and \$30,000 and would allow for a credit in the amount of \$250 against the tax imposed under Chapter 11 of Title 30. For Delaware resident spouses filing jointly, their

claimed income must be between \$36,000 and \$60,000 and are allowed a credit in the amount of \$500.

If Delaware resident spouses file a federal joint tax return, but file separately in Delaware, the rules for a single Delaware resident apply to this tax credit; however, each spouse will only be eligible for the tax credit if he or she meets the income requirements. For example: if Spouse 1 claims more than \$30,000 in income and Spouse 2 claims between \$18,000 and \$30,000, only Spouse 2 is eligible for the tax credit and will receive \$250. However, if both Spouse 1 and Spouse 2 claim between \$18,000 and \$30,000 in income, both spouses would be eligible for the \$250 tax credit, for a total of \$500.

Although it is clear that this bill is aimed at easing the tax burden for low-income residents, this reviewer believes it will not provide the assistance imagined. Instead, it will likely provide only a minute level of assistance. While the bill *is* a step in the right direction, Councils may wish to urge the Legislature to consider alternative proposals that will likely make a greater impact and provide even more assistance to Delawareans who need it the most.

The Institute on Taxation and Economic Policy (“ITEP”) published a report identifying state tax codes that *actually* help fight poverty with recommendations to consider. [<https://itep.org/state-tax-codes-as-poverty-fighting-tools/>]. They identify four effective strategies including the state Earned Income Tax Credit (“EITC”) (which Delaware has already enacted), property tax circuit breakers, targeted low-income credits (which this bill aims to enact), and child-related tax credits. Regarding the EITC, ITEP notes that states vary wildly in their credits allowed under EITC. The report notes that Delaware is only one of six states which allow *only* a non-refundable EITC credit, which limits the ability of the credit to “offset regressive state and local taxes.” The Delaware legislature has previously tried to convert the EITC to be refundable, however it was vetoed by Governor Carney in 2018.

[<https://www.delawarepublic.org/post/governor-supports-renewed-effort-make-earned-income-tax-credit-refundable>]. House Bill 80, which was introduced in January of 2020 and has Governor Carney’s support, represents another effort to make the EITC refundable – it would give residents the option of a non-refundable 20% credit or refundable 4.5% credit.

What HB 316 represents is a targeted low-income credit, which complements EITCs. ITEP notes that there are several states whose targeted low-income tax credit essentially “zeroes out” families’ personal income tax contributions. [<https://itep.org/state-tax-codes-as-poverty-fighting-tools/>]. In Ohio, the enacted legislation ensures that families with an income below \$10,000 are not subject to the income tax. In Kentucky, low-income families of a certain size are not subject to state income taxes. In other states, low-income families are offered income tax credits to offset sales and excise taxes. While the former would not be applicable because Delaware does not have sales tax, the latter *is* applicable. Excise taxes are taxes directly levied on certain goods by the state or federal government and are generally passed to the consumers via higher prices. Delaware collects excise taxes on gasoline, cigarettes, and alcoholic beverages. In Idaho, each resident receives a credit to offset their grocery taxes, even if they are not subject to the income tax.

As stated previously, this bill represents a step in the right direction for providing assistance to low-income Delawareans; however, this reviewer does not believe it goes far enough nor will it accomplish the level of assistance contemplated or needed. Instead, the Delaware legislature

should consider enacting legislation that will provide the greatest impact. Councils may wish to support this bill with a recommendation to increase the amount of the credit to at least \$500 and / or with a recommendation to consider other proposals to make more substantial changes, especially making the tax credit refundable.

Final Regulations:

1. DHSS Regulation on Community Spouse (Councils endorsed without comment), Page 871.
2. DSS Regulation SNAP Definitions (page 873). Comments noted and ignored, DSS indicating that these were definitions and didn't matter, and that "good cause" is under revision (which they have said for a year now).
3. DSS Child Care (p. 878). DSS revised final regulation per Council suggestion to allow exceptions to five day rule for parents or children with disabilities who may miss more than five days in a month due to disability or sickness.

Policies:

Delaware Division of Motor Vehicles Testing Procedures for Non-English Speaking and Deaf or Hard of Hearing Driver License Applicants

The Delaware Division of Motor Vehicles (DMV), created procedures to address the use of translators for driver license applicants who cannot read or speak English and the use of interpreters for the deaf and hard of hearing. Under federal law, 28 C.F.R. §36.303(c), "a public accommodation shall furnish appropriate auxiliary aids and services where necessary to ensure effective communication with individuals with disabilities", which includes the deaf and hard of hearing. The goal of the procedures is to outline "exactly how a translator/interpreter may assist an applicant during the Division of Motor Vehicle's... written and road tests." The procedures are currently in use by the DMV.

The testing procedures are divided based on non-English speaking/reading driver license applicants and deaf and hard of hearing driver license applicants. The use of a translator and/or interpreter for both groups of applicants during the road test portions is largely similar and does not appear to raise issues. Along with the road tests, driver license applicants are required to successfully complete an automated written test.

The DMV policy regarding the use of interpreters for deaf and hard of hearing driver license applicants during the automated written test appears to be problematic. Non-English speaking/reading driver license applicants who need translation assistance to take an automated written test may have a translator read the questions and multiple choice answers to them as shown on the DMV automated test system. The use of an interpreter by a deaf or hard of hearing driver license applicant during the automated written test is limited.

In comparison, “Unlike a translator for a non-English speaking/reading driver license applicant, *a deaf and hard of hearing interpreter shall not sign the questions and multiple choice answers for the applicant. In these situations the applicant will be able to read the questions and answers from the automated testing system him/herself.*” An interpreter can only be used during the written test if the applicant has a question or needs to communicate with the DMV employee proctoring the test. The procedures further state that “If a deaf or hard of hearing driver license applicant is also a non-English speaking applicant, then the interpreter may sign the questions and multiple choice answers on the automated testing system.”

The DMV procedures are making an incorrect assumption that all people who communicate via sign language are able to read written English text. “American Sign Language (ASL) is its own unique language, complete with its own grammar and structure that is unrelated to English.” Differences between ASL and English, <http://signaphasiatests.salk.edu/appendix/langdiff.html> (last visited Apr 13, 2020). The procedures do not offer any clear justification as to why an interpreter cannot sign the questions and multiple choice answers for the applicant on the automated written test. Perhaps, it could be argued that the DMV’s justification was to curtail cheating that could result from an interpreter providing answers to applicants but that would defy common sense since translators/interpreters are allowed to be used by non-English speaking applicants on the automated written test and present an equal risk of cheating.

The DMV has also put procedures in place to monitor and punish cheating by translators/interpreters. The procedures allow the division to use video and audio devices to monitor translators/interpreters during the written and road tests to ensure translators/interpreters are not providing answers to the applicant. The procedures address non-compliance by stating “Any applicant whose translator/interpreter is found speaking or signing during a written or road test at any time other than when permissible under these written procedures will automatically fail the test. Translators/interpreters who assist applicants by providing answers to questions or by pointing out the correct answers will be prohibited from providing future translation/interpretation services in division facilities.”

Furthermore, the National Association of the Deaf (NAD) and the Registry of Interpreters for the Deaf, Inc. (RID) have their own Code of Professional Conduct that must be followed. If interpreters violate this Code they are subject to the RID Ethical Practices System (EPS), whose goal is to uphold the integrity of ethical standards among interpreters. “In keeping with that goal, the system includes a comprehensive process whereby complaints of ethical violations can be thoroughly reviewed and resolved through complaint review or mediation.” Enforcement Procedures, <https://rid.org/ethics/enforcement-procedures/> (last visited Apr 13, 2020).

Many other states allow for a deaf and hard of hearing interpreter to sign the questions and multiple choice answers for the applicant during a written test portion. Some states, like Virginia, implemented ASL in to their actual testing system for the written exam portion. The Virginia DMV created a testing system called SecuriTest, which allows customers the option to complete knowledge exams in 16 different languages, including ASL. This system was created because “For many individuals who are deaf or hard of hearing, ASL is their first language, so offering DMV tests in ASL, as opposed to just reading the questions, allows them to receive the information in the language they prefer.” Virginia DMV Offering ASL Version of Written Tests

for Driver Licenses, <https://nvrc.org/vddhh-dmv-offering-asl-version-of-written-tests-for-licenses-press-release/> (last visited Apr 13, 2020).

Councils should strenuously advocate for change in the procedures to allow for deaf and hard of hearing applicants to have the option of an interpreter to sign the questions and multiple choice answers during the automated written test.