



DOMESTIC/FOREIGN INSURERS BULLETIN NO. 60

**TO: ALL INSURANCE COMPANIES THAT WRITE HEALTH INSURANCE
COVERAGE**

**RE: Request for Letter of Intent to Participate in the Delaware Health Benefit
Exchange**

DATED: December 27, 2012

Introduction

The Patient Protection and Affordable Care Act of 2010 provides each state with the option to set up a state-operated health insurance Exchange, or to have a federally operated Exchange that services one or more states. An Exchange is an organized marketplace to help individuals and small businesses buy health insurance in a way that permits easy comparison of available plan options based on price, benefits, services, and quality. Consumers seeking health care coverage will be able to go to the health insurance Exchanges to obtain comprehensive information on coverage options currently available and make informed health insurance choices. By pooling consumers, reducing transaction costs, and increasing transparency, Exchanges create more efficient and competitive health insurance markets for individuals and small employers.

A key consideration of Delaware's planning activities has been whether Delaware can establish a financially self-sustaining Exchange after Federal funding ends. After months of review and exploration that included input from various stakeholders, Delaware has chosen to implement an Exchange using the Federally Facilitated Exchange Partnership Option (FFE/SPO). Under this model, and defined through a formal Memorandum of Understanding (MOU) with the federal Department of Health and Human Services (HHS), the State retains

significant responsibility for the Plan Management (PM) functions, including, but not limited to, the development and implementation of processes and standards for certification of qualified health plans (QHPs) offered through the Delaware Exchange. As part of the State's responsibilities under the FFE/SPO, the Delaware Insurance Department will conduct QHP certification review for compliance with applicable state and federal laws and standards, including:

- Licensure and good standing
 - Service area
 - Network adequacy
 - Essential community providers
 - Marketing oversight
 - Accreditation, on the timeline to be established in future rulemaking
 - Essential health benefits standards
 - Actuarial value standards, including variations for cost-sharing reductions, as well as cost-sharing limits
 - Discriminatory benefit design
 - Benefits for meaningful difference
 - Rates (new and increases), including compliance with market rating reforms
- 64513

Purpose

The purpose of this Bulletin is to provide information related to state-specific QHP standards, proposed timelines for accepting and reviewing Issuer and plan/benefit data, and to invite potential QHP Issuers to submit a letter to the Delaware Insurance Department indicating their intent to apply for participation in the Delaware Exchange.

Delaware QHP Certification Standards

As prescribed in the Patient Protection and Affordable Care Act (PPACA), all Issuers and plans participating in the Exchange must meet federal certification standards for QHPs. The Final Rule regarding federal standards for QHPs may be found on the Federal Register at the following URL:

<https://www.federalregister.gov/articles/2012/07/20/2012-17831/patient-protection-and-affordable-care-act-data-collection-to-support-standards-related-to-essential>

Additionally, Delaware will require Issuers and plans who participate in Delaware's Exchange to comply with state codes and regulations, as well as the state-specific QHP standards outlined in the table below. The State followed a number of guidelines in developing its State QHP Standards, including:

- All QHP Certification Standards will apply to both Individual and Small Group (SHOP) plans sold inside the Exchange. However, all plans, both inside and outside of the Exchange, must comply with Essential Health Benefits benchmarks established by the State, with certain exceptions for stand-alone pediatric dental plans.
- All QHPs must comply with existing federal standards and regulations, including those within the PPACA as well as other federal requirements, such as mental health parity.
- The proposed state-specific QHP Standards do not attempt to modify any federal standard, but augment federal requirements for QHP certification to include State regulations, codes and standards that promote State compliance, value to consumers and clarify State expectations for commercial plans offered to Delaware consumers through the Exchange.
- Delaware QHP Standards will not duplicate requirements clearly outlined in Federal regulation.

Delaware-specific QHP Standards

General Requirements

- Issuers are required to offer at least one QHP at the Bronze level, as well as the Silver and Gold as required by the federal standard.
- All stand-alone dental plans must be compliant with Title 18, Chapter 38 (Dental Plan Organization Act).
- Continuity of Care: A QHP issuer must have a transition plan for continuity of care for those individuals who become eligible or lose eligibility for public health programs. The Continuity of Care Transition Plan must include a transition period for prescriptions, including how the plan specifically addresses mental health pharmacy. In such instances, the new plan is responsible for executing the Transition plan. Transition plans are not applicable for individuals who **voluntarily** disenroll in a QHP; do not enroll in another QHP, but are still not eligible for Medicaid/CHIP.
- For treatment of a medical condition or diagnoses that is in progress or for which a preauthorization for treatment has been issued, the QHP issuer/plan must cover the service for a lesser of: a period of 90 days or until the treating provider releases the patient from care.
- A continuity/transition period of at least 60 days must be provided for medications prescribed by a provider. If the QHP uses a tiered formulary, the prescribed medication must be covered at tier comparable to the plan from which the individual was transitioned.
- For mental health diagnosis, a continuity/transition period of at least 90 days must be provided by the QHP for medications prescribed by the treating provider for the treatment of the specific mental health diagnosis. The prescribed medication must be covered at a tier comparable to the plan from which the individual transitioned.

- The QHP issuer must provide for reimbursement of a licensed nurse midwife subject to 16 Del.C. §122, and as outlined in 18 Del.C. §3336 and §3553.
- The QHP issuer must permit the designation of an obstetrician-gynecologist as the enrollee's primary care physician subject to the provisions of Delaware Insurance code 18 Del.C. §§3342 and 3556.
- The QHP issuer must make appropriate provider directories available to individuals with limited English proficiency and/or disabilities.
- Withdrawal from Exchange: The QHP Issuer must comply with the following state regulations in the event that it withdraws either itself or a plan(s) from the Exchange:
 - Issuers withdrawing plans for Individuals must comply with 18 Del.C. §§3608(a)(3)a, and 3608(a)(4), which states:
 - (a) An individual health benefit plan shall be renewable with respect to an enrollee or dependents at the option of the enrollee, except in the following cases:*
 - (3): A decision by the individual carrier to discontinue offering a particular type of health benefit plan in the state's individual insurance market. A type of health benefit plan may be discontinued by the carrier in the individual market only if the carrier:*
 - a. Provides notice of the decision not to renew coverage to all affected individuals and to the Commissioner in each state in which an affected insured individual is known to reside at least 90 days prior to the nonrenewal of any health benefit plans by the carrier. Notice to the Commissioner under this subparagraph shall be provided at least 3 working days prior to the notice to the affected individuals;*
 - (4) The carrier elects to discontinue offering and to nonrenew all its individual health benefit plans delivered or issued for delivery in the state. In that case, the carrier shall provide notice of its decision not to renew coverage to all enrollees and to the Commissioner in each state in which an enrollee is known to reside at least 180 days prior to the nonrenewal of the health benefit plan by the carrier. Notice to the Commissioner under this paragraph shall be provided at least 3 working days prior to the notice of the enrollees;*
 - Issuers withdrawing Small Group plans must comply with 18 Del.C. §§7206 (a)(5), 7206(a)(6) and 7206(b), Renewability of coverage, which states:
 - (a) A health benefit plan subject to this chapter shall be renewable with respect to all eligible employees or dependents, at the option of the small employer, except in any of the following cases:*
 - (5) Repeated misuse of a provider network provision;*
 - (6) The small employer carrier elects to nonrenew all of its health benefit plans delivered or issued for delivery to small employers in this State. In such a case the carrier shall:*
 - a. Provide advance notice of its decision under this paragraph to the commissioner in each state in which it is licensed; and*
 - b. Provide notice of the decision not to renew coverage to all affected small employers and to the commissioner in each state in which an affected insured individual is known to reside at least 180 days prior to the nonrenewal of any health benefit plans by the carrier.*

Notice to the commissioner under this subparagraph shall be provided at least 3 working days prior to the notice to the affected small employers;

(b) A small employer carrier that elects not to renew a health benefit plan under subsection (a)(6) of this section shall be prohibited from writing new business in the small employer market in this State for a period of 5 years from the date of notice to the Commissioner.

- Issuers must submit a withdrawal and transition plan to the Department of Insurance for review/approval.

Accreditation

The state will follow the proposed federal standards for accreditation, including requiring that those QHP issuers without existing accreditation must schedule the accreditation within the first year of participation in the exchange, and to be accredited on QHP policies and procedures by the end of the second year of certification. The state will also require in the third year of operation, that all QHP issuers must be accredited on the QHP product type. While all Issuers must comply with existing state and federal codes and regulations, Issuers of stand-alone dental plans are exempt from the state's Accreditation standard until such time as accreditation standards, entities and processes are available through federal guidance.

Network Adequacy

- QHP network arrangement must make available to every member a Primary Care Provider (PCP) whose office is located within 20 miles or no more than 30 minutes driving time from the member's place of residence.
- Each QHP that has a network arrangement must meet and require its providers to meet state standards for timely access to care and services as outlined in the table, titled **Appointment Standards**, found on page 27 of 84 in the Delaware Medicaid and Managed Care Quality Strategy 2010 document relating to General, Specialty, Maternity and Behavioral Health Services.
- Issuers must establish mechanisms to ensure compliance by providers, monitor providers regularly to determine compliance and take corrective action if there is a failure to comply with Network Standards.
- QHP networks must be comprised of hospitals, physicians, behavioral health providers, and other specialists in sufficient number to make available all covered services in a timely manner.
- Each primary care network must have at least one (1) full time equivalent Primary Care Provider for every 2,000 patients. The QHP issuer must receive approval from the Insurance Commissioner for capacity changes that exceed 2500 patients.
- The Delaware Exchange requires that each health plan, as a condition of participation in the Exchange, shall (1) offer to each Federally Qualified Health Center (as defined in Section 1905(I)(2)(B) of the Social Security Act (42 USC 1369d(I)(2)(B)) providing services in geographic areas served by the plan, the opportunity to contract with such plan

to provide to the plan’s enrollees all ambulatory services that are covered by the plan that the center offers to provide and (2) reimburse such centers for such services as provided in Section 1302(g) of the Patient Protection and Affordable Care Act (Publ. L.111-148) as added by Section 10104(b)(2) of such Act.

- Issuers of stand-alone dental plans are exempt from the state’s network adequacy standards for medical and mental health providers. However, Stand-alone dental plans must comply with SSA 1902(a)(30)(A), and assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.

Comment: The state-specific requirements for Network Adequacy are primarily those applied by Medicaid. The distance requirement is taken directly from Del.C. Title 18, Regulation 1402

Rating Area

Delaware will permit one rating area, that of the entire state.

Service Area

The entire geographic area of the State is in the service area of an Exchange, or multiple Exchanges consistent with §155.140(b). The State of Delaware will require Qualified health plan(s) offered by an issuer to be available in all three counties of Delaware.

Quality Rating Standards

Delaware will adopt the Quality Rating standards as provided in federal guidance.

Quality Improvement Standards

- Issuers will be required to participate in state quality improvement workgroups intended to standardize QHP quality improvement strategies, activities, metrics and operations, including payment structures to improve health outcomes, medical home models and technology and data analytics to support coordination and improved quality and outcomes.
- Issuers, with the exception of those who provide stand-alone dental plans only, will be required to participate in and utilize the Delaware Health Information Network (DHIN) data use services and claims data submission services, at prevailing fee structure, to support care coordination and a comprehensive health data set as a component of state quality improvement strategy.

Marketing and Benefit Design

Issuers and QHPs must comply with state laws and regulations regarding marketing by health insurance issuers, including Delaware Insurance Code Title 18§23 (Unfair Methods of

Competition and Unfair or Deceptive Acts and the requirements defined in 18 Del. Admin Code. § 1302 (Accident and Sickness Insurance Advertisements).

Proposed Timeline for Issuer/QHP Application and Certification

The table below provides a list of proposed target dates for Delaware’s QHP-related activities. Dates are subject to change based on future federal guidance and system readiness.

Activity	Target Date
Delaware Essential Health Benefits established	September 2012
Delaware QHP Certification Standards established	November 2012
Delaware issues QHP Bulletin to Issuers	December 2012
Issuers apply for HIOS ID through the federal system	January 2013
Issuer QHP Application period opens*	March 2013
Issuer QHP Application period closes	June 2013
Delaware issues final determination for initial QHP certification and submits results and plan data to CMS for ratification**	July, 2013
CMS submits Delaware QHPs to FFE for posting on the Exchange	September 2013
Open Enrollment period begins	October 1, 2013
QHP monitoring and oversight begins	October 1, 2013
Open Enrollment period ends	December 31, 2013
Issuer Accreditation deadline for those participating in the Exchange	September 30, 2014

**Delaware intends to utilize the NAIC SERFF system to support its data collection and review process associated with QHP Certification. Additional information regarding SERFF capabilities related to Exchange processing can be found on the SERFF website:*

<http://www.serff.com/hix.htm>

***Delaware will submit all recommendations for QHP certification to CMS for ratification at the same time in order to avoid adverse market advantage.*

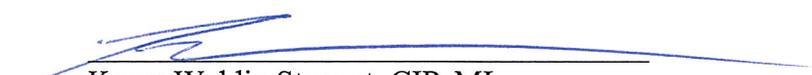
Issuer Letter of Intent

Issuers interested in applying for QHP certification on the Delaware Exchange are asked to submit electronically a Letter of Intent, using the template provided, to the Commissioner at the following email address: **DOI_Rates_Resource@state.de.us** no later than February 15, 2013. Issuers are asked to respond to all questions within the template—the content of which will be confidential and used for Delaware Exchange planning purposes only. While we encourage all Issuers interested in applying for QHP certification to submit a Letter of Intent, failure to do so will not preclude an Issuer from applying through the formal process.

List of questions/comment for Letter of Intent template

1. Issuer Contact Information (formal Company name, physical and mailing addresses, company phone, email):
 - Person authorized by the company to act on its behalf regarding the Delaware Exchange (name, title, location, phone, email).
 - Back-up contact name, title, phone and email).
2. Does the Issuer intend to participate/offer plans in:
 - Individual Exchange.
 - SHOP Exchange.
 - Both.
3. Does the Issuer currently hold a certificate of authority or is the Issuer currently licensed to write health insurance in Delaware? If no, please indicate the date the Issuer intends to apply for a certificate of authority/license.
4. Please indicate the anticipated number of distinct health plans the Issuer will submit for each of the following “Metal” levels: Bronze, Silver, Gold, Platinum, Catastrophic, Stand-alone Pediatric Dental, and Stand-alone Pediatric Vision. *(Note: all Issuers certified to participate in the Delaware Exchange are required to offer at least one (1) plan for Bronze, Silver and Gold levels.)*
5. Does the Issuer currently have health insurance products that are certified (accredited?) by URAQ and/or NCQA? If so, please provide a list of each product and which accrediting agency has certified it.
6. Does the Issuer intend to submit plans that include Pediatric Dental and/or Vision coverage?
7. Indicate when the Issuer intends to apply for HIOS ID through the federal system.

This Bulletin shall be effective immediately.



Karen Weldin Stewart, CIR-ML
Delaware Insurance Commissioner