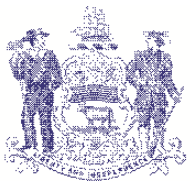
Karen Weldin Stewart, CIR-ML
Commissioner



Delaware Department of Insurance

Filing Instructions
&
Qualified Health Plan (QHP) Certification Standards

Published March 23, 2016

State of Delaware Department of Insurance

The information provided below outlines the state-specific standards for certified plans to be offered on the Delaware Individual Marketplace and FF-SHOP. More information regarding QHP standards, timelines and DOI/HHS approach to review and certification of plans may be found in the *Issuer QHP Submission Guide* document, found on DOI's website: http://www.delawareinsurance.gov/health-reform/DEMarketplace.shtml

FILING INSTRUCTIONS:

1. Filing Authority/Scope of Authority:

Forms are filed in accordance with Title 18, Del. C., Chapter 2712. See Department website for filing documents: http://www.delawareinsurance.gov/information/RatesForms.shtml#Filing

2. Filing Basis:

Delaware is a file and use state with the authority to disapprove. If you elect to DEEM a filing per Title 18, Del. C., Chapter 2712(b)**, please notify the DOI Intake Analyst at 302-674-7371.**

4. Fee Information:

a. Filing fees are **$100** per *form*, per company. *Rates* are **$100** per affected forms. *Advertising* submissions are **$100** per filing per company. Fraternal organizations do not require a filing fee.

b. Informational letters without policy forms are accepted without a fee.

c. Previously filed policy forms that are modified are considered as "new" filings and will require a fee.

d. Problem Reports not responded to within 30 days will be closed and fees will not be refunded.

5. Premium Rate Requirements & Guide per Chapter 2504 and Applicable Federal Requirements

Rates are required to be filed per Chapter 2504.

a. All Individual and Small Employer Health rate filings require an Actuarial Memorandum, Unified Rate Review Template and Preliminary Justification as outlined in the Affordable Care Act. This requirement is NOT restricted to only premium rate requests that are 10% and above.

b. **Health rate filings outsourced for actuarial review will incur additional cost to filer.**

c. Individual health rate filings must include rates and classification of risks per Chapter 33. For additional information, consult Regulation 1303, "Individual Health Loss Ratio Standards".

d. Group health rate filings - consult Regulation 1305, "Loss Ratio Filing Procedures for Health Insurers, Health Service Corporations for Medical and Hospital Expense Incurred Policies and Plans."

e. Major Medical rate filings must include: a complete filing description, rate history, rate component and base rate before and after, under Rate/Rule Schedule Tab in SERFF.

f. New Data Collection Requirement – Delaware specific data collections supplement, but do not replace the federal data collection templates. Issuers must submit complete Rate Data Table templates, Unified Rate Review templates and the Actuarial Memorandum as instructed by CMS and the DOI.

The new data collection templates, available in SERFF, have been developed in Microsoft Excel format, with the exception of the *DE Part II Preliminary Justification*, which is available in Microsoft Word format. Issuers must complete each template for each Rate Filing submitted to the DOI, regardless of whether the issuer proposes a change to premium rates from the previous plan year.

DE Data Collection Template	Individual Market	Small Group Market	Comment
DE Rate Page—Individual template	X		Allows for enhanced review of URRT data and collection of key variables
DE Rate Page—SG template		X	
DE Part II Preliminary Justification	X	X	Provides Delaware consumers with a consistent format for issuer justification of proposed rate changes
DE Actuarial Memorandum Data Set template	X	X	Allows for enhanced review of Actuarial Memorandum and collection of key variables
DE Plan Membership (Covered Lives) & Multi-Year Plan Base Rate Comparison – Individual Template	X		Facilitates collection of key variables in Excel format
DE Plan Membership (Covered Lives)— & Multi-Year Plan Base Rate Comparison – SG Template		X	

6. OFF-Market Place Plans – With the exception of SADPs, only plans being submitted for certification "On Marketplace" or indicated as "Both" are to be submitted for certification in the Rate/Form filing and in the Binder. Plans that are "Off-Marketplace only" are **NOT** to be submitted for certification.

7. Standardized Plans – Issuers are encouraged, but not required, to offer least one standardized option plan, particularly at the silver level of coverage (including the silver level cost-sharing reduction variations) for the 2017 Plan Year.

8. Identify Changes – For any issuers who are not submitting new forms, the DOI requires that any changes to the forms be clearly marked and tracked to identify the changes from the previous year's filings.

9. Individual Health Forms and Small Group– Chapters 33 and 36, Regulation 1304

1. Benefit Standards, Outline of Coverage Requirements (Regulation 1304, Sections 7 and 8)

2. Health Benefit Plan mandated benefits (Chapter 33)

10. Group & Blanket Health – Chapter 35, Forms & Rates Bulletin 17

1. Mandated health benefits of Chapter 35 apply to all health benefit plans. Please 'Bookmark' their location in Policy/Certificate for ease of review.
2. Out-of-state trusts & associations, follow Chapter 35, §3506 and §3509, and Forms & Rates Bulletin 17.

Please review the Attachments in the 2017 Issuers QHP Submission Guide for the timeline, templates and submission requirements.

Questions should be directed to:

Director Life and Health Consumer Services Investigation
Telephone: 302-674-7308

Delaware QHP Standards – Plan Year 2017

Delaware QHP Standards apply to both medical and stand-alone dental plans unless otherwise indicated.

General Standards
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. *(This standard does not apply to stand-alone dental plans)*
All stand-alone dental plans must be compliant with Title 18, Chapter 38: Dental Plan Organization Act. *(This standard does not apply to medical plans)*
The QHP issuer must make appropriate provider directories available to individuals with limited English proficiency and/or disabilities.
The QHP issuer must provide for reimbursement of a licensed nurse midwife subject to 16 Del.C§122, and as outlined in 18Del.C. §3336 and§3553. *(This standard does not apply to stand-alone dental plans)*
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 18Del.C.§§3342 and 3556. *(This standard does not apply to stand-alone dental plans)*
Issuers must submit a withdrawal and transition plan to the Department of Insurance for review/approval.
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: 1. Issuers withdrawing plans for Individuals must comply with 18 Del.C. §§3608(a)(3)a, and 3608(a)(4) 2. Issuers withdrawing Small Group plans must comply with 18 Del.C. §§7206 (a)(5),7206(a)(6) and 7206(b), Renewability of coverage. *(This standard does not apply to stand-alone dental plans)*
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. *(This standard does not apply to stand-alone dental plans)*
Continuity of Care
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** dis-enroll in a QHP, do not enroll in another QHP, but are still not eligible for Medicaid/CHIP. *(This standard does apply to stand-alone dental plans with regard to covered dental services)*

For treatment of a medical/dental 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. *(This standard does apply to stand-alone dental plans with regard to covered dental services)*

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. *(This standard does not apply to stand-alone dental plans)*

Network Adequacy

Each QHP issuer 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,** in the Delaware Medicaid and Managed Care Quality Strategy document relating to General, Specialty, Maternity and Behavioral Health Services. *(This standard does not apply to stand-alone dental plans)*

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. *(This standard does apply to stand-alone dental plans with regard to covered dental services)*

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. *(This standard does not apply to stand-alone dental plans)*

A. For QHP medical Issuers: 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 the relevant state-approved FQHC prospective payment system (PPS) rate for the items and services that the FQHC provides to the QHP enrollee, regardless of whether or not the QHP Issuer and the FQHC have previously contracted at a lower rate for the same items and services.

B. For QHP Stand-Alone Dental Issuers: The Delaware Exchange requires that each stand-alone dental 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 pediatric dental services that are covered by the plan that the center offers to provide and (2) reimburse such centers the relevant state-approved Medicaid/CHIP fee for service (FFS) rate as outlined in schedule (http://www.dmap.state.de.us/downloads/hcpcs/fee.schedule.2014.pdf) for the items and services that the FQHC provides to the QHP enrollee, regardless of whether or not the QHP Issuer and the FQHC have previously contracted at a lower rate for the same items and services.

Issuers of stand-alone dental plans are exempt from the state's network adequacy standards for medical and mental health providers unless otherwise indicated. 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.

A. Qualified Health Plan Provider Networks must meet the GEO Access Standards for the practice areas listed below for all services covered by the plan.

- If a plan's network does not have a geographically accessible provider with appropriate expertise to treat a patient's medical condition, after notifying the issuer, the patient can obtain services from an out of network provider. The health plan will work with the patient to identify a provider. The plan will pay all medically necessary covered expenses directly related to the treatment of the patient's medical condition. The patient will be responsible for the plans copayments and cost-sharing based on in network benefits. The plan may apply any case management, preauthorization protocols that would be applied to an in network provider.
- In the event that the Issuer and the out-of-network provider cannot agree upon the appropriate rate, the provider shall be entitled to those charges and rates allowed by the Insurance Commissioner or the Commissioner's designee following an arbitration of the dispute. The Issuer will pay the benefits directly to the out-of-network provider.

Practice Area	Miles from Resident Urban / Suburban*	Miles from Resident Rural*
PCP	**15**	**25**
OB/GYN	**15**	**25**
Pediatrician	**15**	**25**
Specialty Care Providers**	**35**	**45**
Behavioral Health/Mental Health/Substance Abuse Providers***	**35**	**45**
Acute-care hospitals	**15**	**25**
Psychiatric hospitals	**35**	**45**
Dental	**35**	**45**

**"Urban / Suburban" is defined as those geographic areas with greater than 1,000 residents per square mile. "Rural" is defined as those geographic areas with less than 1,000 residents per square mile.*
***Examples of Specialty Care Providers include, but are not limited to, Home Health Specialists, Cardiologists, Oncologists, OB/GYN, Pulmonologists, Endocrinologists, Chiropractors, Skilled Nursing Facilities, Rheumatologists, Ophthalmologists, Urologists, Neurologists, and telemedicine sites*
****Examples of Behavioral Health/Mental Health/Substance Abuse Providers include, but are not limited to, advanced-degree behavioral health practitioners (MD or DO in General or Pediatric Psychiatry), mid-level professionals (Licensed Psychologists, Psychiatric Nurse Specialists, Licensed Clinical Social Workers, Licensed Drug and Alcohol Counselors, Licensed Professional Counselors of Mental Health, Licensed Marriage & Family Therapists), certified peer counselors or certified alcohol and drug counselors (when supervised by an appropriately-related licensed provider or facility), in-patient and outpatient facilities, and telemedicine sites.*

B. Restricted Broad Network (i.e., HMO and EPO) and Value Network Plans must comply with the following standard for adequate and timely access to Out-of-Network Providers

- If the Plan's network is unable to provide necessary services, covered under the contract, the Issuer must adequately and timely cover these services out of network for the member, for as long as the Issuer is unable to provide them.
- Requires Issuer to coordinate with the out-of-network providers with respect to payment and ensures that cost to the member is no greater than it would be if the services were furnished within the network.
- The Issuer is responsible for making timely payment, in accordance with state regulation, to out-of -network providers for medically necessary, covered services, up to their fee maximum for contracting providers.

1. QHP Provider Directories are required to include a listing of the plan's providers including, but not limited to:
    a. Primary Care Providers (primary care physicians in pediatrics, family medicine, general internal medicine or advanced practice nurses working under Delaware's Collaborative Agreement requirement);
    b. Specialty Care Providers (including, but not limited to: Hospitals, Home Health Specialists, Cardiologists, Oncologists, OB/GYN, Pulmonologists, Endocrinologists, Chiropractors, Skilled Nursing Facilities, Rheumatologists, Ophthalmologists, Urologists, Neurologists, Psychiatric and State-licensed Psychologists,);
    c. Behavioral Health, including mental health and substance abuse disorder providers and facilities, clearly identifying specialty areas;
    d. Habilitative autism-related service providers, including applied behavioral analysis (ABA) services.
2. Issuer/Plans must update their online Provider Directory quarterly and notify members within 30 days if their PCP is no longer participating in the Plan's network.

Each plan's network must have at least one (1) full time equivalent advanced-degree behavioral health practitioner (MD or DO in General or Pediatric Psychiatry), or mid-level professional (licensed psychologists, psychiatric nurse specialists, Licensed Clinical Social Workers, Licensed Professional Counselors of Mental Health, Licensed Marriage & Family Therapists) supervised by an advanced-degree behavioral health practitioner, for every 2,000 members. The QHP issuer must receive approval from the Insurance Commissioner for capacity changes that exceed 2,500 patients.

In order to meet provider-to-patient ratios, an issuer's QHP network must include ratios calculated on a count of all patients served by the provider across all of the health plans marketed by the issuer.

For the purposes of the standard, *"**Telehealth**" means the mode of delivering health care services via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the health care provider is at a distant site. "**Telemedicine**" means a form of telehealth which is the delivery of clinical health care services by means of real time two-way audio, visual, or other telecommunications or electronic communications, including the application of secure video conferencing or store and forward transfer technology to provide or support healthcare delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, care management and self-management of a patient's health care by a health care provider practicing within his or her scope of practice as would be practiced in-person with a patient, and legally allowed to practice in the state, while such patient is at an originating site and the health care provider is at a distant site. Telemedicine facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers."*

1. An insurer, corporation, or health maintenance organization shall reimburse the treating provider or the consulting provider for the diagnosis, consultation, or treatment of the insured delivered through telemedicine services on the same basis and at least at the rate that the insurer, corporation, or health maintenance organization is responsible for coverage for the provision of the same service through in-person consultation or contact. Payment for telemedicine interactions shall include reasonable compensation to the originating or distant site for the transmission cost incurred during the delivery of health care services
2. Telehealth/medicine services covered under policies shall not be subject to deductibles, copayment or coinsurance requirements which exceed those applicable to the same services provided via face-to-face contact between a health care provider and patient.
3. In order for telehealth/medicine services to be covered, healthcare practitioners must be:
    a. Acting within their scope of practice;
    b. Licensed (in Delaware or the State in which the provider is located if exempted under Delaware State law to provide telemedicine services without a Delaware license) to provide the service for which they bill; and are
    c. Located in the United States.

Rating Area

Delaware will permit one rating area.

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 Improvement Strategy
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.
1. By January 2017, payers shall make value based payment models available to primary care providers (PCPs) or accountable care organizations, networks, or systems with which they affiliate who are eligible based on a minimum set of criteria, meant to reward those providers for the quality and efficiency of care delivered to a population of attributed members spanning their interactions with the health care system. Each QHP should offer at least one pay-for-value model (with bonus payments tied to quality and utilization management for a panel of patients) and one total cost of care model (with shared savings linked to quality and total cost management for a panel of patients). Payers shall also provide a form of funding for care coordination for chronic disease management in at least one of the programs, whether in the form of per member per month fees or payments for non-visit based care management. Provider eligibility criteria (e.g., minimum quality requirements, minimum number of attributed members, ability to pool volume across other lines of business and/or with other providers), and the approach taken to provider outreach and enrollment should allow for the adoption of these models by providers sufficient to support of at least 60 percent of members to providers, with an effective date of January 1, 2017. 2. Payers shall include incentives for quality as a part of both pay-for-value and total cost of care models. At least 75% of quality and efficiency measures tied to payment will be linked to performance on the accountable measures of the Common Scorecard and the rest linked to performance on payer-specific measures. 3. Payers shall support reporting for the Common Scorecard by providing requested data according to the timelines and format specified by DCHI and DHIN. Payers shall also provide overall program dashboard information such as payment model availability adoption levels consistent with the recommendations of the DCHI. 4. Payers shall actively participate in DCHI including through representation on the DCHI Board of Directors and Committees if invited by the Board and through support of ongoing SIM initiatives. 5. Payers are required to and shall submit claims data on all fully insured members to the Delaware Health Care Commission or its designated entity pursuant to 16 Del. Code Section 9903.
Each health plan shall establish and implement policies and processes to support integration of medical health and behavioral health services. Policies and processes for integration of care must address integration of primary care and behavioral health services, including but not limited to substance abuse disorders.
Quality Rating
The state will adopt the Quality Rating standards as provided in federal guidance.
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.

Value Network Plans
In addition to existing standards, the Delaware Exchange requires Issuers offering Value Network Plans to meet the following additional State standards: a) Issuers who wish to offer Value Network Plans must also offer at least one broad network plan that meets the State's single Service Area in each of the following metal levels—Bronze, Silver and Gold. b) Issuers must make available a Value Network Plan in each of the three counties in Delaware (New Castle, Kent and Sussex). c) Issuers' marketing materials must provide consumers with clear and easy-to-understand language regarding the benefits covered and provider network restrictions and exceptions under the plans. d) Value Network Plans must meet current network adequacy and access standards, including the requirement that Plans that do not have a skilled and experienced in-network hospital or clinician to perform a medically-necessary service are required to provide coverage for that service out-of-network, at no additional cost to the member. 1. In the event that the Issuer and the out-of-network provider cannot agree upon the appropriate rate, the provider shall be entitled to those charges and rates allowed by the Insurance Commissioner or the Commissioner's designee following an arbitration of the dispute. 2. The Issuer will pay directly to the out-of-network provider the highest allowable charge for any in-network provider for each covered service allowed by the Issuer during the full 12-month period immediately prior to the date of each medical service performed by the out-of-network provider. e) Issuers of Value Network Plans are required to provide quarterly reports to the Insurance Commissioner regarding the number of consumer complaints and appeals related to network adequacy and access. These reports must provide sufficient detail to allow the Department of Insurance to perform timely monitoring of compliance with network standards. f) Issuers of Value Networks must have policies and processes in effect for monitoring provider quality, adequacy and access to ensure that the Issuer can effectively deliver on the benefits promised under the plan. g) If an Issuer offers broad network plans in both the individual and small group markets and chooses to offer Value Network Plans, then that Issuer must offer Value Network Plans in both markets. h) Such other standards as are adopted by the Department of Insurance to address the following concerns: consumer protection; unaffordability of coverage; such other interests as are reflected in and consistent with the Insurance Code (Title 18, Delaware Code).

Contact Information:
QHP Analyst
(302) 674-7374