Karen Weldin Stewart, CIR-ML
Commissioner

Delaware Department of Insurance

General Filing Instructions

Life and Health

Revised July 2, 2014

State of Delaware Insurance Department
General Filing Instructions Document
Life & Health

All rate filings must include a thorough Filing Description, which includes an explanation as to why a rate increase or decrease is warranted. The Filing Description is located under the General Information tab on the SERFF database.

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/formapps.htm#Life.

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 analyst at 302-674-7385.**

3. **Status in Domicile:**
   Approval from state of domicile is not required, but status may be requested.

4. **Fee information:**
   a. Filing fees are **$100** per *form*, per company, per LOB. *Rates* are **$100** per affected forms. *Advertising* submissions are **$100** per filing per company. Fraternal organizations do not require a filing fee.
   b. For Med Supp., **$100** per Rate Plan is required.
   c. Filings outsourced for actuarial review per Title 18 Del. C. Chapter 7 §714 will incur additional cost.
   d. Informational letters without policy forms are accepted without a fee.
   e. Previously filed policy forms that are modified are considered as "new" filings and will require a fee.
   f. Problem Reports not responded to within 30 days will be closed and fees will not be refunded.

5. **Required Filing Documents and Information:**
   Long Term Care (LTC): Cost Disclosure Form is required.

6. **Attachment information and file formats for SERFF filings:**
   a. Funding agreements and indexed life and annuity products must be clearly identified under the "General Information" tab and on the filing fee form.
   b. **As health rate filings, indexed life or annuity products, and funding agreements may be outsourced for actuarial review, notify analyst (see #2 above) when these type filings are submitted.**

7. **Contact Information:**
   Laura Wilcox
   Rates and Forms
   (302) 674-7371
   laura.wilcox@state.de.us

DELAWARE LIFE & HEALTH PRODUCT GUIDELINES

All citations refer to Title 18, Delaware Code, unless otherwise indicated. Please follow specific guidelines within laws and regulations cited. Note: The Delaware Department has adopted the NAIC position on Terrorism Exclusions for Life and Health products. At this time the Delaware Department is not accepting filings that contain terrorism exclusions that provide no benefit for any loss due to terrorism.

LIFE

Comprising: All Life and Annuity Products

Forms: Indexed life and annuity, and funding agreement products must be identified. **As these products may be outsourced for actuarial review per §714, please notify analyst at 302-674-7385 upon submission of filing. Outsourced filings will incur additional cost to filer.**

Rates: Not required for life products. § 2502(b).

Equity Indexed Products - Please provide the following:

1. Marketing and cost disclosure brochures
2. Specifications Page with available options
3. Actuarial Memorandum indicating surrender charges and minimum values
4. Guaranteed minimum and maximum rates, including, but not limited to participation, caps and spread
5. Reserve basis and compliance with appropriate actuarial guidelines
6. Hedging strategy including counterparties and NAIC, Moody's and S & P rating
7. Guidelines on determining actual subsequent rates
8. Quarterly reports providing details on new business, any changes to minimum/maximum rates, surrenders (account value and net amount actually paid)

For items involving calculations, e.g. minimum guaranteed values, compliance with reserve sample/actuarial guidelines, retrospective and prospective demonstrations, please provide in an Excel file.

Guaranteed Living Benefits-Please provide the following:

1. Copy of affected form (if not with filing)
2. Actuarial memorandum signed by qualified actuary
3. Actuarial memorandum must describe reserve methodology for guaranteed living benefit
4. Copy or description of investment/risk management strategy to support living benefits signed by an actuarial or investment professional with relevant experience
5. Signed Opinion by company's appointed actuary that investments for living benefits are appropriate to cover liabilities
6. Copy of Prospectus
7. Copy of marketing and sales materials

Life, Annuity - Chapter 29: Variable Life - Regulations 1201 and 1205

1. Actuarial memorandum
2. For applicable products, per Regulation 1210 Section 5A, indicate if policies will be illustrated. If not illustrated, provide a Summary of Cost & Benefit.

2001 CSO Mortality Table Compliance

1. New policy form (endorsements are not acceptable)
2. Specification Page
3. Actuarial Memorandum which indicates reserve basis and compliance with standard valuation and non-forfeiture laws, appropriate actuarial guidelines, and IRS Section 7702/7702A
4. Policy forms should contain new Standard Non-Forfeiture Law (SNFL) tables if they are to be included in the policy

Actuarial Memorandum should specifically include tables of surrender charges or minimum cash values and no-lapse premiums. An example (calculation) for issue age, say 35, showing minimum cash values, SNFL values and algorithms for Whole Life/ Interest Sensitive Whole Life (WL/ISWL) policies should be provided.

For non-forfeiture, compliance for Universal Life (UL) surrender charges and WL/ISWL minimum cash values should be verified. Guaranteed Cost of Insurance (COI) charges should be verified to ensure they do not exceed the 2001 valuation table.

Group Life – Chapter 31

Must meet group requirements of §3102 through §3109.

Accelerated Benefits

Individual Life products accelerating benefits for Long-Term Care must comply with Chapter 7105(i) through (k).

Riders

Cost for Rider should be captioned. Include actuarial memorandum and rates, if applicable.

Credit Life and Health - Chapter 37, Regulation 1701

Level/decreasing life and disability rates per Regulation 1701, Section II, A and B. Contracts should contain disclosure and other requirements of §3706.

Applications - Life and Health

Where medical questions concerning HIV/AIDS are included in the Application and the Company will perform testing, an HIV Consent Form is required to be filed with the Department following guidelines of Chapter 74 and Forms & Rates Bulletin No. 4. The HIV Consent Form is a one-time filing. Amendments to the Form must be re-filed.

HEALTH

Comprising: All health insurance products

Premium Rate Requirements & Guide per Chaper 2504

Rates are required to be filed per Chapter 2504.

1. Health rate filings require an actuarial memorandum, Unified Rate Review Template and Preliminary Justification form as attached.
2. **Health rate filings outsourced for actuarial review will incur additional cost to filer.**
3. Individual health rate filings must include rates and classification of risks per Chapter 33. Consult Regulation 1303, "Individual Health Loss Ratio Standards".

4. 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."
5. Actuarial Certification is required for Small Employer rate filings. See rating guidelines for Small Employer below. All medical premium rate filings that request an increase must contain the Parts I and II Rate Justification (bringing info over) that is outlined in the Affordable Care Act. This requirement is not restricted to premium rate requests that are 10% and above.
6. 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.

Individual Health Forms - 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)

Medicare Supplement - Chapter 34, Regulation 1501

1. Rates per Chapters 25 and 34; Regulation 1501 Section 15.3
2. Advertising, approval for use, per Regulation 1501 Section 19
3. ALL other requirements as contained in Chapter 34 and Regulation 1501

Long Term Care - Chapter 71, Regulation 1404

Delaware has adopted the NAIC Model Regulation, with variations thereto.

1. Advertising, approval for use, per Regulation 1404 Section 23
2. Rates per Regulation 1404 Section 20. Filed rates must correspond with Cost Disclosure requirements of Regulation 1404 Section 6.1.4
3. ALL other requirements of the Regulation must be in compliance

Small Employer - Chapter 72, Regulation 1308; Forms & Rates Bulletins Nos. 11-13

1. Follow prescribed format in Regulation for Schedule of Benefits and Exclusions for Basic and Standard Plans per Appendices A & B
2. Health mandates of Chapter 35 for Large Group & Blanket Health are applicable to Small Employer Standard Plan (see §7213), and for all other Small Employer Plans
3. Rate Restrictions - Regulation 1308 Section 6 and §7205

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

Contact Information:

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Delaware-specific Qualified Health Plans (QHP) Certification Standards

The information provided below outlines the state-specific standards for certified plans to be offered on the Delaware Individual Exchange 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.

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 18Del.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

Additional Delaware specific certification standards regarding Network Adequacy include:

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 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,** 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.

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 Rating Standards

The state 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 outcome.

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 18Del. C.23 Unfair Methods of Competition and Unfair or Deceptive Acts and the requirements defined in 18 Del. C.,§1302 Accident and Sickness Insurance Advertisements.

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Insurer's explanation of the rate increase

Summary

pdating its rates for Small Group PPO plans in Delaware to adjust for several changing factors. Our new filing proposes to raise average premium rates

Who This Change Will Affect

The proposed rates would apply to policies that renew or start from through . Approximate members currently are enrolled in plans to which the new rates will apply.

Why We Are Asking to Increase Premiums

Medical costs are going up and we are changing our rates to reflect this increase. We expect medical costs to go up 9.2%, excluding the effect of benefit changes described below. Medical costs go up mainly for two reasons providers raise their prices and members get more medical care. We expect 40% of the medical cost increase to come from providers raising prices and to come from members getting more care.

Some examples of increases we have experienced in the last 12 months in Delaware include:

- Costs for pharmacy prescriptions have gone up
- Costs for medical pharmacy prescriptions have gone up
- Expenses for emergency treatment have increased

What Else Affects Our Request to Increase Premiums

We offer Delaware small businesses a variety of plans to choose from. In August 2012, we changed some benefits for these plans, including enhanced coverage for Womans Preventive Health Services. On average, the changes increased expected medical costs approximately 3%. We took that change into account in this rate filing.

Will Premiums for All Small Groups Increase

No, the is an average. Some plans premiums will increase by less or even go down; others will increase by more than the average. The exact rate change will depend on what benefit plan the group chooses, when the groups plan starts or renews, and the subscribers ages, and the number of dependents covered under the contract.

How Does This Request Match up with Minimum Loss Ratio Requirements (MLR)?

We expect these rates will produce an MLR equal to or above the required 80% requirement for small group business meaning that we expect at least 80% of the premiums we collect to pay for medical care and activities that improve health care quality for our members. If our actual MLR turns out to be less than 80% -- for instance, if doctors and hospitals raise prices less than we expect -- we will issue rebates as the law requires.

In addition to paying for medical claims and quality improvement activities, a portion of every member's premium goes toward covering administrative expenses such as customer service, claims and billing, and quality activities like disease management programs. Premium also includes premium taxes and Federal income tax.

What is Doing to Keep Premiums Affordable?

Our goal is to deliver competitive pricing that allows our customers and members to get the greatest value out of their health benefits. also is taking a number of steps to try to keep our products as affordable as possible, such as:

- Developing new relationships with health care providers that compensate them for the quality of care they provide, and not the quantity.
- Creating medical management programs which address potential health issues for members earlier, improving health outcomes and reducing the need for high-cost health care services.

We are also dedicated to increasing transparency within the health care system, as well as helping our members best utilize the plans that they have. Members can access our secure member website, which allows them to research their specific plan benefits, health care providers in a given area, and in some locations, the cost of certain health care services. Additionally, for Your Health website aims to educate all consumersnot just memberson how to take advantage of their health care benefits.

Back to top

What kinds of Medical Services are causing this rate increase?

Medical Service	Per Member Per Month Increase	Portion of Increase
Hospital Inpatient - Care in a Hospital		
Outpatient - Care in a hospital or other facility that doesn't require an overnight stay		
Professional Services - Payments to doctors and other healthcare professionals		
Prescription Drugs - Medicines you need a prescription to buy		
Ancillary Services - Medical supplies, ambulance fees, etc.		
Capitation - A fixed per person payment the insurer pays to a provider to cover a person's medical costs		
Cost Sharing - Changes in deductibles, copayments, benefits, etc.		
Current Medical Cost Adjustment - The difference between what your insurer thought it was going to pay for medical services and what it actually paid during the current year		
Total Medical Service Cost Changes		

Back to top

How would my insurance company use my premium?

	How Premium Dollars Will be Spent If the Requested Rate Is used	
Type of Cost	**Per Member Per Month**	**Portion of Rate**
Medical Services - Cost of providing healthcare services to policyholders		
Administrative Expenses - Marketing, claims processing, and other costs to the company		
Underwriting Gain/Loss - Amount the company keeps after paying claims and administrative expenses		
Total Request Rate		

Back to top

Last three rate increases for this product:

Year	Requested	Got
2011		
2010		
2009		

Back to top

Who is reviewing this rate increase?

The rate increase request is being reviewed by the State.

State laws either:

- Allow the insurance regulator to review rate filings, but do not allow the regulator to stop a rate from being used, or
- Allow the insurance regulator to both review rate filings *and* stop an unreasonable rate from being used.

If a state's laws do not allow the insurance regulator to perform effective rate reviews, the federal government* will review any rate increases at or above 10% in the individual or small group market.

***If the federal government is reviewing, click here to see the filing.**

Back to top