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Commissioner



Delaware Department of Insurance

Issuer QHP Submission Guide

For Coverage Year 2015

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1. General Information and Background

1.1 Purpose

The purpose of this document is to provide guidance to health insurance Issuers regarding the certification standards for individual and/or Small Business Health Options Program (SHOP) Qualified Health Plans (QHPs) offered through the federal Health Insurance Marketplace. This document is for informational purposes and has no legal force or effect; Issuers should refer to applicable Delaware State Code and federal statute, rules, and regulations (located in House Bill 162 as incorporated into Delaware Insurance Code), as well as state-specific QHP Certification Standards for a more comprehensive and thorough understanding of requirements related to qualified health plans offered in the Marketplace. Federal statute and regulations referenced in this document may not be final, and the citations to the same will be updated in future versions of this document when such regulations are made final. Please refer to the Federal Register for updated federal statute and regulations (<http://www.gpo.gov/fdsys/pkg/FR-2012-03-27/pdf/2012-6125.pdf>).

1.2 Background

Effective January 1, 2014, the Health Insurance Marketplace offered Issuers a state-wide marketplace to make it easier for individuals and small employers and their employees to compare plans and buy health insurance. The Marketplace is the only distributional channel through which individuals and small employers will be able to purchase coverage that will be eligible for certain affordability subsidies, including:

- Advanced premium tax credits and/or cost-sharing reductions available to households purchasing coverage in the individual market
- Affordability tax credits available to eligible employers offering coverage in the small group market

In order to comply with certain aspects of the Affordable Care Act (ACA), Delaware has chosen to implement and operate a health insurance marketplace through the Federal Facilitated Marketplace State Partnership Option (FFM/SPO). To be certified as a QHP on the Delaware Marketplace, all Issuers and their health plans must meet all pertinent federal and state statutory requirements and standards. Operating in partnership with the US Department of Health and Human Services (HHS), the Delaware Department of Insurance (DOI) will review and recommend certification of QHPs to the federal Department of Health and Human Services (HHS) for ratification of the certification recommendation, allowing for participation in the Marketplace. The ACA authorizes QHP certification as well as other operational standards for the Marketplace in following sections: 1301-1304, 1311-1312, 1321-1322, 1324, 1334, 1401-1402, 1411, and 1412. Federal standards for QHP Issuers are codified in 45 CFR 155 and 156. Furthermore, the state of Delaware has approved additional QHP certification standards to be applied to those plans sold within the Delaware Marketplace.

The Delaware Marketplace will collect data from Issuers as part of QHP certification and recertification and monitor compliance with QHP certification standards on an ongoing basis. QHP Issuer and plan data will also support additional operational activities, including the calculation of each individual's advance payment of the premium tax credit, the display of plan information on the Marketplace web site, and managing the ongoing relationships between QHP Issuers, the DOI, and the Marketplace. Much of the information collected for QHP certification purposes will support these ongoing operational activities.

An individual or SHOP health insurance plan certified as a QHP in 2014 will be offered through the Delaware Marketplace beginning November 15, 2014. Health insurance Issuers will offer certified QHPs for a term of one year beginning January 1, 2015 and ending December 31, 2015. In addition, Federal regulations allow for the offering of Multi-state Plans (MSPs) that are reviewed and approved by the federal Office of Personnel Management (OPM). The guidance contained in this document does not address these plans. Issuers who wish to submit MSPs should refer to OPM's website (<http://www.opm.gov/healthcare-insurance/multi-state-plan-program/>) and the [Multi-State Plan Program Final Rule](#). Issuers who wish to learn more about MSPs are encouraged to contact OPM or HHS directly.

1.3 General Marketplace Participation Requirements

To be certified for participation in the Marketplace, a QHP must:

- Meet the legal requirements of offering health insurance in Delaware
- Satisfy the certification criteria as established by the State
- Satisfy the minimum federal requirements of a QHP as outlined in 45 CFR Parts 155 and 156
- Receive a recommendation for certification by the DOI, have the recommendation ratified by HHS, and enter into a Certification Agreement with HHS

In addition, to participate in the Delaware Marketplace an Issuer must:

- Submit at least one silver plan and one gold plan per 45 CFR 156.200(c)(1), as well as submit at least one bronze plan per Delaware approved standards.
- Provide a child-only option for each metal tier for which the Issuer offers a QHP (45 CFR 156.200(c)(2))
- Submit three variations to each silver plan reflecting reduced cost-sharing on the essential health benefits (45 CFR 156.420(a))

1.4 Timetable

The following table provides dates for the QHP certification process in 2014. Please note that dates are subject to change based on several factors, including many beyond the control of the DOI such as delays in federal guidance, federal timelines, and SERFF enhancements. Issuers will

be kept informed of delays through regular communications by the DOI, HHS and NAIC, as well as through stakeholder meetings and other existing communication mechanisms.

Activity		Proposed Dates *
QHP Preparation	Delaware EHB Benchmarks and state QHP standards established	11/1/2012
	DOI releases Bulletin to Issuers regarding state standards and inviting them to submit a letter of intent to apply for QHP Certification	1/19/2014
	Issuers register with HIOS and receive HIOS ID	March/April 2014
QHP Application Submission and Review Process	Issuer QHP Certification Applications period begins	5/27/2014
	Deadline for submitting Form filings for all Issuers applying for QHP certification	5/31/2014
	Delaware begins review of Issuer and QHP application data and documentation	6/2/2014
	Deadline for submitting Rate filings for all Issuers applying for QHP certification	6/13/2014
	Deadline for Issuers to submit an initial and complete Issuer and QHP Application through SERFF. (QHP applications must include all required Rate and Form filings, data templates and supporting documentation in order to be considered 'complete'. <u>Any late or incomplete submissions may not be considered for certification by the State</u>)	6/27/2014
	Issuers update QHP application data and documentation through SERFF as needed or requested by Delaware	6/23/2014 – 8/7/2014
	Delaware conducts 1 st SERFF Data Transfer	8/8/2014
	FFM reviews plan data	8/11/2014 – 8/25/2014
	FFM notifies Delaware of any needed corrections to QHP data	8/26/2014
	Delaware conducts final review of Issuer and QHP Application	8/27/2014 – 9/4/2014
	Deadline for Issuer to submit final QHP Application information to the State via SERFF. (<i>Data lock-down</i>)	9/4/2014
Delaware submits recommendations for QHP certification and associated Issuer/QHP Application information to HHS via SERFF (<i>2nd SERFF-to-HIOS Data Transfer</i>)	9/5/2014 – 9/10/2014	

	FFM completes re-review of plan data and Delaware recommendations	9/22/2014
	Issuers review data on FFM web portal and address data errors. Delaware supports CMS during the Limited Data Correction Window. <i>(Data changes must be pre-approved by CMS and the State.)</i>	9/24/2014-10/6/2014
QHP Agreement / Final Certification	HHS notifies State and all Issuers of QHP Certification decision; QHP Agreement signed; QHP data finalized	10/14/2014-11/3/2014
Open Enrollment	Consumer Open Enrollment period	11/15/2014 – 2/15/2015

**Dates are subject to change based on future guidance from CMS and/or NAIC.*

1.5 Contact Information

For questions, please contact Janet Brunory, QHP Analyst, Delaware Department of Insurance, as follows:

E-mail: janet.brunory@state.de.us

Phone: 302-674-7374

Mailing Address: 841 Silver Lake Blvd., Dover, DE 19904

The DOI will notify Issuers regarding application status, findings, objections and other QHP Review-related topics through SERFF or via other existing communication mechanisms.

1.6 Document Naming Convention and Location

When submitting a QHP application, Issuers are required to adhere to the following document naming convention for all files related to a plan. This will help identify each document to a plan and binder in SERFF. Delaware is implementing the document naming convention below for all Issuers.

The document naming convention includes the following for each file:

1. A three or four letter abbreviation identifying the Issuer company name.
 - Example: ABC
2. The name of the file.
 - Examples:
 - QHP-Network-Access-Plan-Cover-Sheet
 - Plan-and-Benefits-Data-Template
3. The version number of the document (increase the file version number by one number each time the file is re-uploaded to SERFF, starting with version #1).
 - Example: v1
4. The date the file was uploaded to SERFF
 - Example: 06272014

Separate each of the four naming convention requirements with a hyphen (-). An example of a complete document name loaded to SERFF is:

- ***ABC-QHP-Network-Access-Plan-Cover-Sheet-v1-06272014.pdf***

Delaware also requires that Issuers upload and re-upload files under the appropriate section (i.e. Supporting Documentation, Templates, etc.) in the Plan Management feature in SERFF. This also applies to updated/corrected files that are uploaded and re-uploaded in response to a Note to Filer and/or Objection from Delaware DOI.

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2. Specifications for QHP Certification

This section outlines the various Issuer- and plan-level components that the DOI will require in the QHP submission. *Please note* that prior to completing a *Plans and Benefits Template*, Issuers must register their HIOS Product IDs via CCIIO's Health Insurance Oversight System (HIOS). Issuers must also have a HIOS Issuer ID issued by HHS for Rate Review. Each Product ID will come with fifty Plan IDs, each of which is made up of the Standard Component ID and a Variance ID. Issuers must also have a HIOS Issuer ID issued by HHS for Rate Review.

QHP data and information will be submitted by Issuers to the DOI in SERFF using the methods numbered below.

1. Built-in Onscreen SERFF Data Entry Fields - *E.g., Plan Binder Name, Plan Year, Market Type*
2. CCIIO Standard MS Excel Data Templates (as attachments) - *E.g., Administrative Data Template, Plan and Benefits Template, Rate Data Template, Prescription Drug Template*
 - At the time of publication this guide, the CCIIO MS Excel Data Templates can be found at the following location:
http://www.serff.com/plan_management_data_templates_2015.htm
3. Supporting Documentation (as attachments) - *E.g., QHP Network Access Plan Cover Sheet template, QHP Issuer Compliance Plan and Organizational Chart Cover Sheet, Continuity of Care Plan, Actuarial Memorandum*
4. Attestations (as PDF attachments under Supporting Documentation in the Plan Management tab) - *E.g., "Issuer will adhere to all requirements contained in 45 CFR 156, applicable law and applicable guidance"*
 - State-specific attestations:
 - *Delaware Marketplace QHP Attestations & Compliance Form template*
 - Federal attestations
 - *Program Attestations for SPM/FFM Issuers template*
 - *Statement of Detailed Attestation Responses* (only required if Issuer does not fully attest to all attestations in the Program Attestations)

For each QHP certification requirement included in this section, the primary proposed method Issuers will use to submit supporting data information is listed. However, this may change prior to the opening of the QHP submission window subject to new guidance and information from CCIIO and the NAIC. As permitted by the ACA, Issuer and plan data and information required for QHP certification and ongoing monitoring will be forwarded by the DOI securely and directly to HHS through SERFF.

Additional instructions and helpful information can be found at the following link:

http://www.serff.com/plan_management_instructions_2015.htm

2.1 Data Submission Templates

The 2015 QHP data templates can be found on SERFF at the following link:

http://www.serff.com/plan_management_data_templates_2015.htm

Questions and comments about the templates should be directed to CMS per their comment procedures.

2.2 Uniform Modification of Coverage

The Delaware Department of Insurance (DOI) has elected to adopt the federal standards for uniform modifications to certify plans, as referenced in **45 CFR 147 Proposed Rule**:

<http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/CMS-9949-P.pdf>

Adoption will be subject to release of the Final Rule.

2.3 Issuer Administrative Information

This information will be Issuer-specific and will only need to be submitted once, per Issuer, for all related initial QHP application submissions. This section also applies to stand-alone dental plans.

Statutory/Regulatory Standard

Not applicable

DOI/HHS Approach to Certification

The QHP filing process requires submission of certain general administrative data that will be utilized for operational purposes. This basic information is required to identify Issuers and the markets they intend to serve, and to facilitate communications with and payment to Issuers. The data elements may include Issuer contact information and banking information.

(See 508 Appendices A1 and A4 of Paperwork Reduction Act package, CMS Form Number CMS-10433, for additional information.)

Each Issuer submitting QHP applications must also submit the *QHP Issuer Compliance and Organizational Chart Cover Sheet*, which can be found under Supporting Documentation in the Plan Management Tab in SERFF.

Please see the *Administrative Data Template* for detail on the data elements to be collected and complete all fields indicated with a red asterisk.

Primary data submission method(s): CCIIO MS Excel Data Templates, Supporting Documentation

2.4 *Licensure, Solvency, and Standing*

This information will be Issuer-specific and will only need to be submitted once, per Issuer, for all related initial QHP application submissions. This section also applies to stand-alone dental plans.

Statutory/Regulatory Standard

An Issuer must be licensed, meet State solvency requirements, and have unrestricted authority to write its authorized lines of business in the State of Delaware in order to be considered “in good standing” and to offer a QHP through the Exchange. Good standing means that the Issuer has no outstanding sanctions imposed by the DOI (45 CFR 156.200(b)(4)).

DOI/HHS Approach to Certification

The DOI’s Bureau of Examination, Rehabilitation & Guaranty (BERG) will review and confirm Issuers submitting QHPs meet these standards, leveraging existing information and data sources to review the status of an Issuer’s license, solvency, and standing. Consequently, Issuers licensed in Delaware will not be required to submit supporting documentation for this certification standard initially unless concerns are identified and additional review is required. Issuers that are not currently licensed will be required to complete the Delaware licensing process, which is handled by the DOI’s BERG unit. Delaware is a NAIC Uniform Certificate of Authority Application (UCAA) participant state; therefore, Delaware accepts the UCAA Primary and Expansion Applications. To obtain a license in Delaware, insurers and stand-alone dental plans must follow the procedures outlined in the UCAA Primary and Expansion Applications.

Primary data submission method(s): Attestations

2.5 *Benefit Standards and Product Offerings*

This information will be QHP-specific and will need to be included for each submitted QHP in the Issuer’s application. With the exception of Section 2.4.5 (Mental Health Parity and Addiction Equity Act), this section also applies to stand-alone dental plans.

Plan-specific information not captured in other sections will be collected in the *Plan and Benefits Template*, including data elements such as Plan ID, whether or not the plan is offered in the individual or SHOP market and/or off of the Marketplace, and plan effective date.

Additionally, Issuers must submit benefits information for each QHP. QHP Issuers must ensure that each QHP complies with the benefit design standards (specified in the ACA and subsequent rules (45 CFR §156.200(3)), including:

- Federally approved State-specific essential health benefits (EHB)
- Federally approved State-specific QHP standards, *as applicable*
- Cost-sharing limits
- Actuarial value (AV) requirements

- Non-discriminatory benefit design
- Mental health parity

QHP offerings must also reflect meaningful differences amongst products to ensure that a manageable number of distinct plan options are offered.

Sections 2.5.1 – 2.5.5 provide additional requirements related to Benefit Design standards.

2.5.1 Essential Health Benefits

Statutory/Regulatory Standard

All small group and individual health benefit plans sold inside and outside of the Exchange must cover a core set of “essential health benefits” as defined by HHS. Coverage must be substantially equal to the coverage offered by a benchmark plan, and the plan must cover at least the greater of one drug in every USP category and class or the same number of drugs in each category and class as benchmark plan (45 CFR 156.110, 156.115, 156.1207).

Delaware has selected the state’s Small Group Blue Cross/Blue Shield (BCBS) EPO as its Essential Health Benefit benchmark. At the time of approval, the BCBS EPO plan had the largest enrollment in the Small Group plan currently available in Delaware. The state has also selected to include the following supplements for pediatric dental and vision and habilitative services to augment the BCBS EPO plan.

Pediatric Dental

- Delaware has selected the state’s Medicaid/CHIP Dental Plan as a supplement to its EHB benchmark plan to cover pediatric dental benefits.

Pediatric Vision

- Delaware has selected the Federal Employee Program Blue Vision Plan (FED Blue Vision) as a supplement to its EHB benchmark plan to cover pediatric vision benefits.

Habilitative Services

- As provided under existing federal guidance, Delaware will require that coverage for habilitative services be on parity with those for rehabilitative services as outlined in the state’s Essential Health Benefit (EHB) benchmark. As it relates to habilitative devices and services for the State’s EHB, the DOI interprets “parity” to mean both separate and equal to rehabilitative devices and services.

Delaware requests that Issuers include information indicating how frequently the Issuer updates its formularies, as well as information on the Issuer’s process for providing the state with advance notification of such updates.

Delaware EHB Benchmark Plan: <http://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/delaware-ehb-benchmark-plan.pdf>

Delaware State-Required Benefits: <http://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/de-state-required-benefits.pdf>

DOI/HHS Approach to Certification

In its review, the DOI and its third party Actuary will confirm the following:

- Issuer offers coverage that is substantially equal to the benchmark plan
- Issuer has demonstrated actuarial equivalence of substituted benefits if the Issuer is substituting benefits
- Issuer provides required number of drugs per category and class

EHB substitutions will require an actuarial certification to support that the substitutions are compliant and actuarially equivalent substitutions (45 CFR 156.115(b)(2)). Data will be collected on health benefits, including covered drugs, and Issuers will submit Summary of Benefits and Coverage (SBC) Scenario results. Please see the *Plans and Benefits Template* and *Prescription Drug Template* for additional detail on the data elements to be collected. The *CMS Drug Tool* will be used as part of this review by DOI.

If the plan includes substitutions of any essential health benefit included in Delaware's benchmark plan, the Issuer must submit an *EHB-Substituted Benefit (Actuarial Equivalent) Supporting Documentation and Justification*. Issuers may also be required to complete and submit a *Formulary – Inadequate Category/Class Count Supporting Documentation and Justification*. Both of these documents can be found under Supporting Documentation in the Plan Management tab in SERFF.

The issuer must also complete and submit a *Delaware Issuer Essential Health Benefits (EHB) Crosswalk and Certification for Plan Year 2015* template as part of their filing. This template can be found at the end of this Issuer Submission Guide in **Attachment 3**.

2.5.2 Annual Cost-Sharing Limitations

Statutory/Regulatory Standard

All small group and individual health benefit plans sold inside and outside of the Exchange must meet the following annual cost-sharing limits in 2015 (45 CFR 156.130):

- **Out-of-Pocket Limits:** The cost-sharing incurred under a health plan with respect to self-only coverage or coverage other than self-only coverage for a plan year beginning in 2015 shall not exceed the dollar amounts in effect under section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986 for self-only and family coverage, respectively, for taxable years beginning in 2015. The annual limitation on cost sharing (commonly referred to as a maximum out-of-pocket limit) for 2015 is \$6,600 for self-only coverage and \$13,200 for other than self-only coverage. This affects the allowable maximum out-of-pocket value for Essential Health

Benefits for all plans submitted in a QHP application. It also affects the allowable deductible value for catastrophic plans.

- Deductibles: Employer-sponsored plans may not have a deductible in excess of \$2,050 for a plan covering a single individual or \$4,100 for other coverage. The deductible limit may be increased by the maximum amount of reimbursement reasonably available to an employee under a flexible spending arrangement.

Beginning in 2015, all of the cost-sharing limits will be indexed to per-capita growth in premiums in the United States as determined by HHS.

While the annual limitation on cost-sharing for a QHP must be consistent with 45 CFR 156.130, final rule 45 CFR 156.150 indicates the annual limitation on cost-sharing for a stand-alone dental plan would be considered separately. The plan must have an annual limit on cost sharing that is at or below \$350 for a plan with one child enrollee or \$700 for a plan with two or more child enrollees.

DOI/HHS Approach to Certification

The DOI will review plan data for compliance with ACA cost-sharing limitations. Benefit cost-sharing (e.g., quantitative limits, co-payments, and co-insurance by benefit), plan cost-sharing (e.g., in-network and out-of-network deductibles), and pharmacy benefit cost-sharing data elements will be collected; please see the *Plans and Benefits Template* and *Prescription Drug Template* for additional detail on required data elements. DOI will conduct this review using the *CMS Cost Sharing Tool*.

If the Issuer is seeking advanced payment, the Issuer must complete and submit the *Limited Cost Sharing Plan Variation – Estimated Advance Payment Supporting Documentation and Justification* template which can be found under Supporting Documentation in the Plan Management tab in SERFF.

Primary data submission method(s): CCHIO MS Excel Data Templates, Attestations, Supporting Documentation

2.5.3 Actuarial Value

Statutory/Regulatory Standard

Except for the impact of cost-sharing reduction subsidies and a *de minimis* variation of +/- 2 percentage points, each plan in a metal tier must meet the specified AV requirements based on the cost-sharing features of the plan (45 CFR 156.140):

- Bronze plan – AV of 60 percent
- Silver plan – AV of 70 percent
- Gold plan – AV of 80 percent
- Platinum plan – AV of 90 percent

- Catastrophic plan – N/A8 (*Please see ACA §1302(e) for details on catastrophic plans and individuals eligible for them.*)

Additionally, Delaware requires that 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.

With exceptions for unique plan designs, Issuers must use an actuarial value calculator, provided by HHS for use within the SERFF application, to produce computations of a QHP’s metallic level based upon benefit design features. The AV calculator *may* also be used by Issuers informally for plan design. For unique plan designs for which the calculator does not provide an accurate summary of plan generosity, an actuarial certification is required from the Issuer indicating compliance with one of the calculation methods described in 45 CFR 156.135(b)(2).

Per final rule 45 CFR 156.150, stand-alone dental plans may not use the HHS-developed AV calculator. Instead, any stand-alone dental plan certified to meet a 70 percent AV, with a *de minimis* range of +/- 2 percentage points, be considered a “low” plan and anything with an AV of 85 percent, with a *de minimis* range of +/- 2 percentage points, be considered a “high” plan. The “high/low” actuarial value standard would apply to the pediatric dental EHB only in a stand-alone dental plan; when the pediatric dental EHB is included in a health plan, the AV calculator would apply to the pediatric dental EHB.

In addition, Delaware requires that all stand-alone dental plans must be compliant with Delaware code, Title 18, Chapter 38: Dental Plan Organization Act.

DOI/HHS Approach to Certification

The DOI and its third party Actuary will review and confirm that the AV for each QHP meets specified levels and review unique plan designs and the accompanying actuarial certification, if applicable.

If the QHP Application indicates the plan includes a unique benefit design that cannot be supported by the AV Tool, the Issuer must complete and submit the *Unique Plan Design Supporting Documentation and Justification* template which can be found under Supporting Documentation in the Plan Management tab in SERFF.

Primary data submission method(s): CCIIO MS Excel Data Templates, Attestations, Supporting Documentation

2.5.4 Non-Discrimination

Statutory/Regulatory Standard

An Issuer cannot discriminate based on an individual’s age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions (45

CFR 156.125). In addition, QHPs must not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation (45 CFR 156.200(e)) and must not have benefit designs that have the effect of discouraging the enrollment of individuals with significant health needs (45 CFR 156.225(b)).

DOI/HHS Approach to Certification

Issuers will be required to attest to non-discrimination on these factors for both federal and state standards. In addition, the DOI will conduct outlier tests to identify potentially discriminatory benefit designs using the *CMS Non-Discrimination Tool*.

Primary data submission method(s): CCIIO MS Excel Data Templates, Attestations

2.5.5 Mental Health Parity and Addiction Equity Act

This requirement *does not apply* to Stand-alone Dental Plans.

Statutory/Regulatory Standard

All individual and small group plans sold inside and outside of the Exchange are required to comply with the Mental Health Parity and Addiction Equity Act (ACA § 1311(j)).

Additionally, Issuers are reminded that the state requires plans offered in the Individual Exchange market to comply with Delaware Insurance code 18Del.C §3343, and plans offered in the small group market to comply with 18 Del.C §3578.

DOI/HHS Approach to Certification

The DOI will review benefits and cost-sharing for compliance with this standard, including ensuring that financial requirements (such as co-pays and deductibles) and treatment limitations (such as visit limits) applicable to mental health or substance use disorder (MH/SUD) benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits.

The issuer must also complete and submit a *Delaware Mental Health Parity and Addiction Equity Act Issuer Checklist and Certification – Plan Year 2015* template as part of their filing. This template can be found at the end of this Issuer Submission Guide in **Attachment 4**.

Primary data submission method(s): CCIIO MS Excel Data Templates, Attestations, Supporting Documentation

2.5.6 Continuity of Care

Delaware QHP Certification Standards

Delaware specific certification standards regarding Continuity of Care include:

- 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.

Issuers must submit a Continuity of Care Plan to the Department of Insurance for review/approval.

DOI/HHS Approach to Certification

The DOI will review Issuer transition plans for compliance with continuity of care standards, as well as Issuer attestations.

Primary data submission method(s): Attestations, Supporting Documentation

2.5.7 Withdrawal from the Marketplace

Delaware QHP Certification Standards

Delaware specific certification standards regarding withdrawal from the marketplace include:

- 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 Transition Plan to the Department of Insurance for review/approval.

DOI/HHS Approach to Certification

The DOI will review Issuer transition plans for compliance with QHP certification standards, as well as Issuer attestations.

Primary data submission method(s): Attestations, Supporting Documentation

2.6 Rating Factors and Rate Increases

This information will be QHP-specific and will need to be included for each submitted QHP in the Issuer's application.

For the purposes of completing the application for certification of stand-alone dental plans in the FFM, stand-alone dental plans must complete the rates table and associated business rules table according to the rating rules. Stand-alone dental plans, as excepted benefits, have additional flexibility to adjust premiums based on other rating factors. The modified dental plan and benefits template will have a data field in which dental issuers will indicate whether they are committing to the rates in the template, and thereby voluntarily complying with the rating rules, or whether the issuer reserves the right to make further premium adjustments. The plan display will indicate to consumers whether the premium displayed for stand-alone dental plans is a guaranteed rate or an estimated rate. In the 2014 Letter to Issuers, CMS outlined a process for SADPs to complete the rating template portion of the QHP Application. SADP issuers were instructed to complete the rating templates in accordance with the associated rating and business rules and to indicate in the 2014 Plan and Benefits Template whether they were committing to charging that rate ("guaranteed" rates) or retaining flexibility to change the rate ("estimated" rates). As noted in the proposed 2015 QHP information request, CMS proposes to collect the average premium actually charged for those SAPD issuers that indicated estimated rates in their template to determine the average difference using the 2015 Plan and Benefits Template. Please refer to the March 14, 2014 CMS Letter to Issuers for Plan Year 2015 for additional information. <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-final-issuer-letter-3-14-2014.pdf>

Statutory/Regulatory Standard

Issuers offering non-grandfathered health insurance coverage in the individual and small group markets starting in 2014, and the large group market if such coverage is available through an Exchange starting in 2017, must limit variation in plan premiums to age, tobacco use (subject to wellness program requirements in the small group market), family size, and geography (45 CFR 147.102; 45 CFR 156.255). The Federal rule prohibits the use of other rating factors such as health status, medical history, gender, and industry of employment to set premium rates.

Federal rules related to rate-setting are listed below:

Standards are contained in Federal rules.

- *Tobacco Use.* Rates based on tobacco use may vary by up to 1.5:1.
- *Family Composition.* Issuers must add up the premium rate of each family member to arrive at a family rate. However, the rates of no more than the three oldest family members who are under age 21 would be used in computing the family premium.
- *Geography.* A state is to have a maximum of seven rating areas. The rating area factor is required to be actuarially justified for each area.
- *Age.* Issuers must use a uniform age rating curve that specifies the distribution of relative rates across all age bands and is applicable to the entire market. The federal government's proposed age curve anchors the premium amount to age 21, and is expressed as a ratio, for all ages between ages 0 and 64, inclusive, subject to the following:
 - Children: single age band covering children 0 to 20 years of age, where all premium rates are the same
 - Adults: one-year age bands starting at age 21 and ending at age 63
 - Older adults: a single age band covering individuals 64 years of age and older, where all premium rates are the same
 - Rates for adults age 21 and older may vary within a ratio of 3:1

In addition, Delaware has established, as part of its QHP Standards, *a single rating area* to be applied to the entire state.

Furthermore, Issuers must:

- Set rates for an entire benefit year, or for the SHOP, plan year;
- Charge the same premium rate without regard to whether the plan is offered through the FFE or directly from the Issuer through an agent and is sold inside or outside of the Exchange;
- Submit rate information to the Exchange at least annually;
- Submit a justification for a rate increase prior to the implementation of the increase; and
- Prominently post the justification on its Web site (45 CFR 156.210).

Rate increases for QHPs are subject to the reporting and review requirements in 45 CFR 154.215 related to the submission of a Rate Filing Justification, inclusive of:

- An HHS standardized Unified Rate Review data template
- A Consumer Narrative Justification (for increases subject to the review threshold)
- An actuarial memorandum providing the reasoning and assumptions that support the data submitted in the data template and an actuarial attestation

DOI/HHS Approach to Certification

The DOI and its third party Actuary will review rates for compliance with rating standards, as well as Issuer attestations. For rate increases, a review of the Rate Filing Justification, including Actuarial Memorandum, will be performed. Please see the *Rate Data Template*, *Unified Rate Review Template*, and *Rating Business Rules Template* for detail on the data elements to be collected.

The DOI may conduct an outlier test on QHP rates to identify rates that are relatively high and low compared to other QHP rates in the same rating area.

Primary data submission method(s): CCIIO MS Excel Data Templates, Attestation, Supporting Documentation

2.7 Accreditation Standards

This information will be Issuer-specific and will only need to be submitted once, per Issuer, for all related initial QHP application submissions. This section does not apply to stand-alone dental plans.

Statutory/Regulatory Standard

During an Issuer's initial year of QHP certification (e.g., in 2013 for the 2014 coverage year), a QHP Issuer must have an existing commercial, Medicaid, or Exchange health plan accreditation in Delaware granted by a HHS recognized accrediting entity or must have scheduled, or plan to schedule, a review of QHP policies and procedures with a recognized accrediting entity (45 CFR 155.1045).

Per 45 CFR 155.1045, prior to a QHP Issuer's second and third year of QHP certification (e.g. in 2014 for the 2015 coverage year), a QHP Issuer must be accredited by a recognized accrediting entity on the policies and procedures that are applicable to their Exchange products or must have commercial or Medicaid plan accreditation granted by a recognized accrediting entity for the same state in which the Issuer is offering Exchange coverage and the administrative policies and procedures underlying that accreditation must be the same or similar to the administrative policies and procedures used in connection with the QHP.

Delaware will follow the final 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.

Accreditation must be on the basis of local performance in the following categories (45 CFR 156.275):

- Clinical quality measures, such as the HEDIS
- Patient experience ratings on a standardized CAHPS survey
- Consumer access
- Utilization management
- Quality assurance
- Provider credentialing

- Complaints and appeals
- Network adequacy and access
- Patient information programs

DOI/HHS Approach to Certification

Data verifying accreditation status is received directly in SERFF from the NCQA, URAC and AAAHC. Issuers meeting accreditation standards in the initial year must authorize the release of accreditation survey data to the DOI and Marketplace. An accreditation data file will be received by the NAIC from accrediting entities, loaded into SERFF, and made available for display as part of the plan submission (data will also be sent to HHS). In addition, Issuers, regardless of accreditation status, must provide attestations including acknowledgment that, prior to 2016, CAHPS® data may be used on the Marketplace Internet website and the website may display that a QHP Issuer is accredited if that Issuer is accredited on its commercial, Medicaid or Marketplace product lines.

For plans applying for re-certification the deadline to be fully accredited is September 30, 2015. For plans applying for initial certification the deadline to be fully accredited is September 30, 2016.

Primary data submission method(s): Built-in SERFF Fields, Attestations

2.8 Network Adequacy and Provider Data

This information may be Issuer or QHP-specific. If the provider network within the service area is consistent across all products and plans sold by the Issuer, the Issuer may provide required information and attestations only once. If there is any variation in the provider networks across QHPs, information will need to be provided for each product and/or plan. With the exception of 2.7.3, Mental Health and Substance Abuse providers, this section also applies to stand-alone dental plans.

2.8.1 General

Statutory/Regulatory Standard

Per 45 CFR 155.1050, the Exchange must ensure that enrollees of QHPs have a sufficient choice of providers. A QHP's provider network must include a sufficient number and type of providers, including providers that specialize in mental health and substance abuse, to assure that all services will be available without unreasonable delay (45 CFR 156.230(a)(2)).

Issuers and QHPs must meet the following certification standards for Network Adequacy as specified in CFR 156.230, which state that a *QHP Issuer must ensure that the provider network of each of its QHPs is available to all enrollees and meets the following standards-*

- Includes essential community providers in accordance with §156.235;
- Maintains a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay; and,

- Is consistent with the network adequacy provisions of section 2702© of the PHS Act,
- (b) Access to provider directory. A QHP Issuer must make its provider directory for a QHP available to the Exchange for publication online in accordance with guidance from the Exchange and to potential enrollees in hard copy upon request. In the provider directory, a QHP Issuer must identify providers that are not accepting new patients.

Issuers must have sufficient number of and geographic distribution of essential community providers where available to ensure reasonable and timely access to a broad range of such providers for low income and medically underserved individuals in QHP service area.

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. If available, please provide justification or demographic information to verify compliance with requirement that every member can access 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 have providers in the plan network that cover services in all ten essential health benefits or must submit justification for access to care at in-network rates and without balanced billing.
- 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.
- 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.
- 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.

DOI/HHS Approach to Certification

To fulfill the network adequacy requirement, an Issuer must be accredited with respect to network adequacy by an HHS-recognized accrediting entity and attest to complying with the following standards to demonstrate it has an adequate range of providers for the intended service areas:

- Issuer will maintain a provider network that is sufficient in number and types of providers to assure that all services are accessible without unreasonable delay, as specified in 45 CFR 156.230(a)(2)
- Issuer's network meets applicable Delaware network adequacy requirements as defined above.
- Issuer's network reflects executed contracts for the year in which the Issuer is applying.

If the Issuer is not accredited or is accredited but cannot respond affirmatively to each of the attestations, a network access plan must be submitted. In general, the access plan may include, but is not limited to, the following types of information based on the NAIC Model Act #47 requirements:

- Standards for network composition
- Referral policy
- Needs of special populations
- Health needs assessment
- Communication with members
- Coordination activities
- Continuity of care

The DOI will monitor network adequacy, for example, via complaint tracking and/or gathering network data from any QHP Issuer at any time to determine whether the QHP's network(s) continues to meet federal and state certification requirements.

Issuers are required to complete and submit the *Delaware QHP Network Access Plan Cover Sheet Template*. This template can be found at the end of this Issuer Submission Guide in **Attachment 5**.

Primary data submission method(s): Attestations, Supporting Documentation

2.8.2 Essential Community Providers

Statutory/Regulatory Standard

Issuers must ensure that the provider network for a QHP has a sufficient number and geographic distribution of Essential Community Providers (ECPs), where available, to ensure reasonable and

timely access to a broad range of such providers for low-income, medically underserved individuals in the QHP's service area (45 CFR 156.235).

ECPs are defined in section 340B(a)(4) of the Public Health Service Act; and 1927(c)(1)(D)(i)(IV) of the Social Security Act. ECPs are provider organizations that by legal obligation, organizational mission, or geographic location serve a patient population that has been at risk for inadequate access to care.

Additionally, 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 Medicaid 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.

DOI/HHS Approach to Certification

In this section, Issuers must denote the ECP's with which they have contracts for each network in which they plan to provide coverage.

Based on an HHS-developed ECP list, the DOI will verify one of the following:

- For certification year 2015 to utilize a general ECP standard whereby the application would first have to demonstrate that at least 30 percent of available ECPs in each plan's service area participate in the provider network. In addition to achieving a level of 30 percent participation of available ECPs, the issuer would have to offer contracts in good faith prior to the benefit year to:
 - All available Indian health providers in the service area, using the model QHP Addendum for Indian health providers developed by CMS; and
 - At least one ECP in each ECP category in each county in the service area, where an ECP in that category is available.
- Issuer complies with additional Delaware standards regarding Federally Qualified Health Centers as defined above
- Issuer fails to achieve either standard but submits a satisfactory narrative justification as part of its submission.

Justifications submitted by Issuers that fail to achieve any standard will undergo stricter review by the DOI.

Issuers that provide a majority of covered services through employed physicians or a single contracted medical group must comply with the alternate standard established by the Exchange (45 CFR 156.235(b)), as follows:

- Issuer has at least the same number of providers located in designated low-income areas
- Issuer has at least the same number of providers located in designated low-income areas as the equivalent of at least 10% of available ECPs in the service area, and submits a satisfactory narrative justification as part of its QHP submission
- Issuer fails to achieve either standard but submits a satisfactory narrative justification as part of its submission

Both HHS and the State anticipate that it will be difficult for Issuers that do not meet the state and federal regulatory standards and state-specific QHP standards. Failure to achieve compliance with these standards will be a basis for not certifying a plan as a QHP. To assist Issuers in identifying these providers, CMS is publishing a non-exhaustive list of available ECPs based on data maintained by CMS and other federal agencies, and will include identifying and contact information for each provider.

Issuers will indicate which ECPs are included in their provider network(s) by populating a template as part of the QHP application. Please see the *Essential Community Providers Template* for more detail on the data elements to be collected. Issuers will be permitted to write in ECPs not on the CMS-developed list for consideration as part of the DOI's review. DOI will use the *CMS ECP Tool* as part of this review.

If applicable, the Issuer must complete and submit the *ECP Supplemental Response* template, which can be found under Supporting Documentation in the Plan Management tab in SERFF.

Primary data submission method(s): Attestation, CCHIO MS Excel Data Templates, Supporting Documentation

2.8.3 Mental Health and Substance Abuse Services

This requirement does not apply to stand-alone dental plans.

Statutory/Regulatory Standard

Issuers must ensure that the provider network for the QHP has a sufficient number and type of providers that specialize in mental health and substance abuse services to assure that mental health and substance abuse services will be accessible without unreasonable delay (45 CFR 156.230(a)(2)).

Additionally, Issuers are reminded that the state requires plans offered in the Individual Exchange market to comply with Delaware Insurance code 18Del.C §3343, and plans offered in the small group market to comply with 18 Del.C §3578.

DOI/HHS Approach to Certification

Issuers must establish a standard to assure that the QHP network complies with the Federal standard. A copy of this standard must be included in this application, and the Issuer must certify that the provider network for this QHP meets this standard.

Primary data submission method(s): Attestation, Supporting Documentation

2.8.4 Service Area

Statutory/Regulatory Standard

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.

Delaware does not allow plans with Partial Services Areas.

DOI/HHS Approach to Certification

Data elements such as service area ID and name will be collected from Issuers using the CCIIO standard data template and reviewed by the DOI for compliance with the State standard. Please note that the standard SERFF template used includes a field to indicate whether or not the service area is a partial county; this does not apply in Delaware. Please see the *Service Area Template* for additional detail on the data elements to be collected.

Primary data submission method(s): CCIIO MS Excel Data Template, Attestation

2.8.5 Provider Directory

Statutory/Regulatory Standard

A QHP Issuer must make its health plan provider directory available to the Exchange electronically and to potential enrollees and current enrollees in hard copy upon request (45 CFR 156.230 (b)).

DOI/HHS Approach to Certification

Issuers will be asked to provide their network names, IDs, and active URL in the *Network Template*.

Primary data submission method(s): CCIIO MS Excel Data Templates

2.9 Marketing, Applications, and Notices

This information may be Issuer-specific or QHP-specific. This section also applies to stand-alone dental plans.

Statutory/Regulatory Standard

Issuers must not employ marketing practices that will have the effect of discouraging the enrollment of individuals with significant health needs in their QHP (45 CFR 156.225). In addition, all QHP

enrollee applications and notices must comply with Federal standards in 45 CFR 155.230 and 156.250, including being provided in plain language and language that is accessible to people with Limited English Proficiency and disabilities.

Issuers must also comply with Delaware 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.

DOI/HHS Approach to Certification

Issuers will be asked to attest to compliance with the ACA requirements related to non-discrimination in marketing practices. Issuers must also submit a copy of all marketing materials, application, and notices for DOI review and approval as either a URL in the *Plan and Benefits Template* or as Supporting Documentation in the Plan Management tab in SERFF.

Primary data submission method(s): Attestation; Supporting Documentation

2.10 Quality Standards

This information may be Issuer-specific or QHP-specific. This section also applies to stand-alone dental plans, unless otherwise indicated.

Statutory/Regulatory Standard

By 2016, HHS will develop a rating system that will rate QHPs offered through an Exchange in each benefits level on the basis of the relative quality and price (ACA § 1311(c)(3)) and an enrollee satisfaction survey system (ACA § 1311(c)(4)). In addition, Issuers must implement a Quality Improvement Strategy (QIS) that complies with the description in ACA § 1311(g)(1), i.e., uses provider reimbursement or other incentives to improve health outcomes, prevent hospital readmissions, improve patient safety, and implement wellness programs.

Additionally, per federal regulation 45 CFR, §156.20, Issuers must:

- Implement and report on a quality improvement strategy or strategies consistent with standards of section 1311(g) of the Affordable Care Act, disclose and report information on healthcare quality and outcomes described in sections 1311(C) (1) (H) and (I) of the Affordable Care Act, and implement appropriate enrollee satisfaction surveys consistent with section 1311(c)(4) of the Affordable care Act; Strategies in ACA Section 1311(g)
- A payment structure that provides increased reimbursement or other incentives for improving health outcomes through the implementation of activities that shall include quality reporting, effective case management, care coordination, chronic disease management, medication and care compliance initiatives, including through the use of the medical home model, for treatment or services under the plan or coverage;

- The implementation of activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and cost discharge reinforcement by an appropriate health care professional. (not applicable to Stand-alone Dental Plans);
- The implementation of activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage;
- The implementation of wellness and health promotion activities; and
- The implementation of activities to reduce health and health care disparities, including through the use of language services, community outreach, and cultural competency trainings.

HHS intends to propose in future rulemaking that quality reporting requirements related to all QHP Issuers (other than accreditation reporting) become a condition of QHP certification, beginning in 2016, based on the 2015 coverage year; such regulatory proposals would be part of the implementation of Affordable Care Act § 1311(c)(1)(E), 1311(c)(3), 1311(c)(4), 1311(g), and 1311(h).

Delaware will also apply the following state-specific QHP Certification Standards with regard to Quality Improvement Strategy.

- Issuers will be required to participate in a state quality improvement workgroup 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.

DOI/HHS Approach to Certification

Issuers will be required to attest to compliance with various Federal and State quality requirements. Future quality and quality improvement standards will be developed for 2016.

Medical Issuers seeking re-certification in 2015 must attest that they have entered into a formal agreement with the DHIN.

Issuers will also be required to complete and submit a *Delaware Quality Improvement Strategy Workgroup Designation Form*. This template can be found at the end of this Issuer Submission Guide in **Attachment 6**.

Primary data submission method(s): Attestation, Supporting Documentation

2.11 Meaningful Difference to Support Informed Consumer Choice

QHP offerings must reflect meaningful differences amongst products to ensure that a manageable number of distinct plan options are offered.

DOI/HHS Approach to Certification

Delaware intends to ensure that consumers can make an informed selection among plan choices that the consumer can readily differentiate and compare, and that one Issuer does not impede competition by submitting a number of very similar QHPs that monopolize virtual “shelf space.”

To balance these priorities, DOI will conduct a benefit package review for all QHPs offered by an Issuer. The goal of this review is to identify QHPs that are not meaningfully different from other QHPs offered by the same Issuer and with the same plan characteristics. DOI will conduct this review using the *CMS Meaningful Difference Tool*. As in other areas, DOI will use this review to target QHPs for additional review and discussion with the Issuer.

2.12 Segregation of Funds for Abortion Services

This information is QHP-specific. This section does not apply to stand-alone dental plans.

Statutory/Regulatory Standard

In the case of Issuers that cover abortions for which federal funding is prohibited, the ACA bars the use of federal funds "attributable" to either the advance refundable tax credit or cost-sharing reduction under the Act for those abortions. The ACA requires Issuers to create allocation accounts that separate the portion of premiums/tax credits/cost-sharing subsidies for covered services *other* than non-expected abortions from the premium amount equal to the actuarial value of the coverage of abortion services. Issuers must exclusively use funds from these separate accounts to pay for the services for which the funds were allocated (e.g., funds for services other than non-expected abortions cannot be used to pay for non-expected abortions).

Additionally, the ACA requires Issuers to provide a notice to enrollees of abortion coverage as part of the summary of benefits and coverage explanation at the time of enrollment; specifies that notices provided to enrollees, advertisements about qualified plans, information provided by Exchanges, and any other information specified by the Secretary, must provide information with respect to the total amount of the combined premium/tax credit/cost sharing subsidy payments for services covered by the plan and in connection with abortions for which federal funding is prohibited; and prohibits qualified health plans from discriminating against any health care provider or any health care facility because of its unwillingness to provide, pay for, provide coverage of, or refer for abortion.

Issuers offering coverage for non-expected abortion services must submit a segregation plan that details its process and methodology for meeting the requirements of Section 1303(b)(2)(C), (D), and (E) of the ACA. The segregation plan must describe the health plan’s financial accounting systems,

including appropriate accounting documentation and internal controls¹⁷, which would ensure the segregation of funds required by the ACA. The plan should address items including the following:

- The financial accounting systems, including accounting documentation and internal controls, that would ensure the appropriate segregation of payments received for coverage of non-excepted abortion services from those received for coverage of all other services, which may be supported by Federal premium tax credits and cost-sharing reduction payments
- The financial accounting systems, including accounting documentation and internal controls that would ensure that all expenditures for non-excepted abortion services are reimbursed from the appropriate account
- An explanation of how the health plan’s systems, accounting documentation, and controls meet the requirements for segregation accounts under the law

DOI/HHS Approach to Certification

Issuers will be asked to annually attest that they will comply with Federal requirements related to segregation of funds for abortion services, as well as provide a segregation plan. The DOI will perform periodic financial audits of each QHP to assure compliance with Section 1303 of the ACA.

Primary data submission method(s): Attestation, Supporting Documentation

2.13 Past Complaints/Compliance

This review may be Issuer-specific or QHP-specific. This section also applies to stand-alone dental plans.

Statutory/Regulatory Standard

The Exchange may certify a health plan as a QHP if it determines it is in the interest of qualified individuals and qualified employers in the State to do so (155.1000 (c)(2)).

DOI/HHS Approach to Certification

As part of the “interest” standard, the DOI may perform an analysis of past compliance and complaints for existing insurers. Existing data sources will be used for this analysis, therefore Issuers are not required to complete or upload any specific data for this standard.

Primary data submission method(s): None

3. SHOP-specific Requirements

This information is QHP-specific. This section also applies to stand-alone dental plans.

Statutory/Regulatory Standard

SHOP QHPs will be required to comply with SHOP-specific criteria as outlined in 45 CFR §156.285 of the final federal rule.

SHOP QHPs will also be required to comply with the following federal and state regulations and standards:

- Federal regulation 45 CFR §155.725 describing Employer-defined contribution approach
- Delaware Insurance code 18 Del.C. §7205(4) regarding restrictions relating to premium rates
- Delaware Insurance code 13 Del.C. §201 regarding Civil Unions
- Delaware Insurance code 18 Del.C. §3513 regarding grace period for premium payment
- Delaware Insurance code 18 Del.C. §7206(a)(6)(a and b) regarding noticing requirements related to non-renewal of all its health benefit plans

The DOI also reminds Issuers and brokers/producers that, within the Individual Exchange and FF-SHOP, Issuers are required to pay the same commissions offered in the state outside the exchange for similar product offerings.

DOI/HHS Approach to Certification

Reviews of SHOP plans will be conducted through the same process, timelines and criteria as for Individual plans with the exception that SHOP plans will also be reviewed for compliance with the standards mentioned above.

Issuers participating in both the Individual and SHOP marketplaces are required to complete and submit the *SHOP Tying Provision Justification for the Individual Market template*, which can be found under Supporting Documentation in the Plan Management tab in SERFF.

Primary data submission method(s): Attestation, Supporting Documentation

4. Standards Specific to Stand Alone Dental Plans

Delaware will accept Stand Alone Dental Plans offered both inside and outside the Marketplace through the SERFF Plan Management Functionality. However, Stand Alone Dental Plans intended to be utilized outside the Marketplace only for use to supplement medical plans such that the medical plans will comply with federal requirement of offering all 10 EHBs outside the Marketplace as required under the Public Health Services Act must follow the Marketplace certification filing process.

- Issuers of Stand Alone Dental Plans and Stand Alone Dental Plans must meet QHP certification standards, except for any certification requirement that cannot be met because the plan only covers dental benefits.
- Stand Alone Dental Plans are required to comply with other QHP certification standards, including: Essential Health Benefits (Dental), maximum out-of-pocket limits, network adequacy, marketing, non-discrimination, actuarial value, licensure, and service area. In addition:
- Stand Alone Dental Plans are not subject to the insurance market reform provisions of the Affordable Care Act such as guaranteed availability and renewability of coverage. Dental carriers will be able to make premium adjustments upon consumer enrollment, but must indicate that rates are not guaranteed for QHPs offered on the Delaware Marketplace.
- Under 45 CFR 155.1065 (a)(2), the pediatric dental EHB offered by stand-alone dental plans must be offered without annual and lifetime limits. Such limits may be used for benefits in addition to the pediatric dental essential health benefits and for adult dental.
- Stand Alone Dental Plans are excluded from cost-sharing reduction (CSR) requirements.
- Stand Alone Dental Plans must have an annual limit on cost sharing that is at or below \$350 for a plan with one child enrollee or \$700 for a plan with two or more child enrollees.
- For plan year 2015, Stand Alone Dental Plans are not required to be accredited or submit accreditation information.
- Stand Alone Dental Plans are not required to submit the Unified Rate Review Template for rate increase.
- Stand Alone Dental Plans are subject to network adequacy standards, including standards for Essential Community Providers (ECPs).
- 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
- Issuers must submit supporting documentation that provides the time/distance measures for each QHP network
- Issuers must submit supporting documentation for Essential Community Providers listed
- Stand Alone Dental Plans are required to offer child-only coverage.
- Stand Alone Dental Plans may not use the AV Calculator. Instead, they must demonstrate that the Stand Alone Dental Plans offers the pediatric dental EHB at either a low level of coverage with an AV of 70% or a high level of coverage with an AV of 85%, and with a de

minis variation of +/-2%. This must be certified by a member of the American Academy of Actuaries.

- Issuers are allowed to include 24-month waiting periods for orthodontia services for both Stand Alone pediatric dental and embedded medical product that includes pediatric dental.
- No additional age rating may be included for pediatric dental.
- Issuers of Stand Alone Dental Plans and Stand Alone Dental Plans must comply with 18 Del.C.§38 Dental Plan Organization Act.
- The ACA requirement to cover children to age 26 does not apply to stand-alone dental plans. Pediatric dental plan is up to age 19.

In summary, as displayed in the 2015 Letter to Issuers in the FFM, below are the certification standards applicable to Stand Alone Dental Plans:

Certification Standard Applies <i>(* denotes modified standard)</i>		Certification Standard Does Not Apply
Essential Health Benefits*	Actuarial Value*	Accreditation
Annual Limits on Cost Sharing*	Licensure	Cost-sharing Reduction Plan Variations
Network Adequacy	Inclusion of ECPs	Unified Rate Review Template
Marketing	Service Area	Meaningful Difference
Non-discrimination		

Primary data submission method(s): CCHIO MS Excel Data Templates, Attestations, Supporting Documentation

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5. Summary of Submission Requirements

Delaware Health Plan Submission Requirements Plan Year 2015

Templates, Forms and Other Certifications Required for Plans Offered in the Delaware Marketplace and Outside Market

	Form or Template	<u>Marketplace Plan</u> <i>(including plans also offered outside the Marketplace)</i>		<u>Plans Offered Only Outside the Marketplace</u>
		Medical	Stand Alone Dental <i>(Pediatric)</i>	SADP <i>(Non-EHB)*</i>
General Requirements	Program Attestation Form	Required	Required	Not Required
	Compliance Plan	Required	Required	Not Required
	Administrative	Required	Required	Required
	Essential Community Providers	Required	Required	Not Required
	List of School-Based Providers	Required	Required (if applicable)	Not Required
	Actuarial Value Calculator	Required	Not Required	Not Required
	Plan/Benefit Data	Required	Required	Required
	Plan/Benefit Add In	Required	Required	Required
	Service Area	Required	Required	Not Required
	Network	Required	Required	Not Required
	Prescription Drug Formulary	Required	Not Required	Not Required
	Rate Data	Required	Required	Required

	Form or Template	<u>Marketplace Plan</u> <i>(including plans also offered outside the Marketplace)</i>		<u>Plans Offered Only</u> <u>Outside the Marketplace</u>
		Medical	Stand Alone Dental <i>(Pediatric)</i>	SADP <i>(Non-EHB)*</i>
	Business Rules	Required	Required	Required
	Accreditation	Required	Not Required	Not Required
	Unified Rate Review Form	Required	Not Required	Not Required
	Part II Consumer Justification Narrative	If applicable	Not Required	Not Required
	Part III Actuarial Memorandum	If applicable	Not Required	Not Required
	SADP Disclosure of Attribution and Allocation Methods	Not Required	If applicable	Not Required
	SADP Actuarial Value Form	Not Required	Required	Required
	PPACA Uniform Compliance Summary	Required	Required	Required
Supplemental Justification Forms	Unique Actuarial Value Plan Justification Form	Required for unique plan design	Not Required	Not Required
	EHB Benefit Substitution Form	Required for EHB substitution	Required for EHB substitution	Required for EHB substitution
	Drug Formulary Inadequate Category / Class Count Supporting Documentation and Justification	If applicable	Not Required	Not Required
	SHOP Tying Provision Form	Required for Individual Market	Required for Individual Market	Not Required
	Essential Community Provider Supplemental Response Form	If applicable	If applicable	Not Required
	Limited Cost Sharing Plan Variation -- Estimated Advance Payment Supporting Documentation and Justification	Required	Not Required	Not Required
	Discrimination -- Cost Sharing Outlier Justification	If requested	If requested	Not Required

	Form or Template	Marketplace Plan <i>(including plans also offered outside the Marketplace)</i>		Plans Offered Only <u>Outside the Marketplace</u>
		Medical	Stand Alone Dental <i>(Pediatric)</i>	SADP <i>(Non-EHB)*</i>
	Marketing Language Justification	If requested	If requested	Not Required
	Discrimination Drug Utilization Management Outlier Justification	If requested	Not Required	Not Required
	Meaningful Difference Justification	If requested	If requested	Not Required
	Cost Sharing -- Supporting Documentation and Justification for Exceeding Annual Limitation on Small Group Deductibles	If applicable	Not Required	Not Required
	Cost Sharing -- Supporting Documentation and Justification for Exceeding Annual Limitation on Out of Pocket Expenses ("Nesting" Justification)	If applicable	Not Required	Not Required
	Cost Sharing -- Supporting Documentation and Justification for Exceeding Annual Limitation on Small Group Out of Pocket Maximums	If applicable	If applicable	If applicable
Delaware-Specific Requirements	Delaware Issuer EHB Crosswalk and Certification Form	Required	Required	Required
	Delaware Issuer MHPEA Checklist and Certification Form	Required	Required	Not Required
	Delaware Marketplace QHP Attestation and Compliance Form for Medical Issuers	Required	Not Required	Not Required
	Delaware Marketplace QHP Attestation and Compliance Form for SADP Issuers	Not Required	Required	If applicable
	Continuity of Care Plan	Required	Required	Not Required
	Withdrawal Transition Plan	Required	Required	Not Required
	Delaware QHP Network Access Plan (Cover Sheet, Plan and supporting documentation)	Required	Required	Not Required
	Delaware Quality Improvement Strategy Workgroup Member Designation	Required	Required	Not Required

6. Issuer Attestations

Documents including all attestations along with instructions will be available for download by Issuers in SERFF. Issuers will review, complete, provide an electronic signature, and upload back into SERFF. Issuers must comply with both Federal Program Attestations that were developed by HHS (6.1) and Delaware state-specific Attestations (6.2).

6.1 HHS Requirements

HHS requires Issuers seeking certification and/or recertification of qualified health plans to complete and submit a *Program Attestations for SPM/FFM Issuers template*. CCIIO and the NAIC have indicated Issuers will be able to download a PDF document with the attestations in SERFF, provide an electronic signature, and upload back into SERFF for submission to the State and HHS. Similar to last year, Delaware anticipates that if an Issuer does not fully attest to all attestations in the Program Attestations, an Issuer will be required to submit the *Statement of Detailed Attestation Responses* document, which allows Issuers to provide an explanation on non-compliance with an attestation. Detailed instructions regarding both documents will be available in the SERFF application prior to the opening of the submission window.

6.2 Delaware Requirements

See Attachment 1: *Delaware Marketplace QHP Attestations & Compliance Form – Medical Issuers* for attestations to support Delaware-specific laws, regulations and standards for Medical Issuers.

See Attachment 2: *Delaware Marketplace QHP Attestations & Compliance Form – Stand-Alone Dental Issuers* for attestations to support Delaware-specific laws, regulations and standards for Dental Issuers.

Attachment 1: Delaware Marketplace QHP Attestations & Compliance Form – Medical Issuers

All Medical QHP Issuers are required to complete and submit the following Attestations sheet indicating compliance with Delaware rules, regulations and state-specific QHP Certification Standards

I, _____ of _____
 (Name) (Title)
 _____, attest that the plan submission (_____)
 (Company / NAIC Co-Code) (HIOS Plan ID Number)

is in compliance with all of the laws, regulations, rules, guidance, and standards outlined below.

Check (v) “Y”, “N”, or “NA” for each of the items below to indicate that the plan complies with each item. If supporting documentation is included, please indicate the appropriate the page number.

Y	N	N/A	Pg #	
				1. Compliance with State Rules & Regulations
				a. Plan complies with Delaware Insurance Law - Chapters 33 and 36, Regulation 1304 - Individual Health Forms
				b. Plan complies with Delaware Insurance Law - Chapter 72, Regulation 1308; Forms & Rates Bulletins Nos. 11-13 - Small Employer
				c. Plan complies with Delaware Insurance Law - Chapter 35, Forms & Rates Bulletin 17 - Group & Blanket Health
				2. Accreditation
				a. Plan complies with federal and state accreditation standards, including provisions in 45 CFR §156.275; 45 CFR §155.1045, and the additional Delaware requirement that all QHP Issuers must be accredited on the QHP product type by the third year of operation.
				Note: The state will follow the final 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. <u>The state will also require in the third year of operation, that all QHP Issuers must be accredited on the QHP product type.</u> 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.
				3. Network Adequacy
				a. Plan complies with requirement that 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.
				b. Plan complies with requirement that plan network arrangement must meet and require it provides 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.
				c. Plan complies with requirement that 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 including oversight process regarding timely access to care and services.
				d. Plan, as a condition of participation in the Exchange, shall (1) offer to each Federally Qualified Health Center (as defined in Section 1905(l)(2)(B) of the Social Security Act (42 USC 1369d(l)(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 Medicaid 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.
				4. Rating Areas Attestation
				a. Plan rates do not vary by geographical rating area, as the state of Delaware permits only one rating area.
				5. Service Area Attestation
				a. Plan complies with requirement that 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.
				6. DHIN Quality Improvement Standards
				a. Plan Issuer will 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 improve health outcomes, medical home models and technology and data analytics to support coordination and improved quality and outcomes.
				b. Plan Issuer has entered into a formal agreement with the Delaware Health Information Network (DHIN), and will participate in and utilize the DHIN data use services and claims data submission services for all plans offered on the Delaware Marketplace, at prevailing fee structure, to support care coordination and a comprehensive health data set as a component of state quality improvement strategy, unless plan is a stand-alone dental plan.
				7. Marketing and Benefit Design
				a. Plan marketing and benefit design complies with and will continue to 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.
				8. Dental Compliance with Title 18, Chapter 38 (if applicable)
				a. Plan complies with Delaware Title 18, Chapter 38 (Dental Plan Organization Act) if plan is offering dental coverage, including embedded dental coverage. (If plan does not offer dental coverage, mark this item as N/A.)
				9. Actuarial Value
				a. Plan Issuer has separately offered or plans to offer in the same plan year at least one QHP at the Bronze level, as well as the Silver and Gold as required by the federal standard 45 CFR §156.225.
				10. Marketing Regulations and Transparency
				a. Plan complies with state and federal marketing and transparency regulations, including the Unfair or Deceptive Acts and Unfair Methods of Competition Act (Delaware Insurance Code Title 18§23; 18 Del Admin Code§ 1302) as well as federal regulations including, but not limited to, 45 CFR §156.220 which requires the publication of cost-sharing data on Issuer Internet web site.
				11. Market Reform Rules
				a. Plan complies with all state and Federal Market Reform rules including, but not limited to PHS 2701; PHS 2702; PHS 2703; PPACA §1302(e); PPACA §1312(c); PPACA §1402; 43 CFR §156; 42 CFR §147.
				12. Compliance with Essential Health Benefits
				a. Plan includes pediatric dental benefits that are substantially equal to benefits offered in the Delaware pediatric dental benchmark plan (CHIP). Note: If plan does not include dental benefits, mark this item as N/A.
				b. Plan includes medical benefits that are substantially equal to the benefits offered in the Delaware benchmark plan (BCBS EPO).
				c. Plan includes coverage of habilitative devices and services that are separate and equal to those offered for rehabilitative devices and services.
				d. Plan includes pediatric vision benefits that are substantially equal to the benefits offered in the Delaware vision benchmark plan (FEDVIP)
				13. Continuity of Care
				a. Plan Issuer has 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 includes a transition period for prescriptions, including how the plan specifically addresses mental health pharmacy. Plan Issuer is responsible for executing the Transition plan.
				b. Plan Issuer agrees to comply with withdrawal and transition plan requirements as stated in Del.c. 18 subsection §3608 for Individual plans.
				c. Plan Issuer agrees to comply with withdrawal and transition plan requirements as stated in Del.c. 18 subsection §7207 for Small Group plans.
				d. Plan Issuer has submitted a withdrawal and transition plan to the Department of Insurance for review/approval.

				e. For treatment of a medical condition or diagnoses that is in progress or for which a preauthorization for treatment has been issued, plan Issuer agrees to cover the service for a lesser of: a period of 90 days or until the treating provider releases the patient from care.
				f. Plan Issuer agrees to provide a continuity/transition period of at least 60 days for medications prescribed by a provider and agrees to cover the prescribed medication at a tier comparable to the plan from which the individual was transitioned.
				g. Plan Issuer agrees to provide a continuity/transition period of at least 90 for a mental health diagnosis and agrees to cover medications prescribed by the treating provider for the treatment of the specific mental health diagnosis for at least 90 days. Issuer agrees that the prescribed medication must be covered at a tier comparable to the plan from which the individual transitioned.
				14. Transparency
				a. Plan Issuer agrees to ensure that cost-sharing data is published on Internet Web Site, clearly and in plain language.
				15. Broker/Producer Compensation
				a. Plan Issuer agrees to ensure that commissions paid to brokers/producers for QHPs sold through the Individual Marketplace and FF-SHOP are the same as those paid in the outside market.

Printed Name/Title

Signature/Date

Attachment 2: Delaware Marketplace QHP Attestations & Compliance Form – Stand Alone Dental Issuers

Stand Alone Dental Plan (SADP) Issuers are required to complete and submit the following Attestations sheet indicating compliance with Delaware rules, regulations and state-specific QHP Certification Standard.

I, _____ of _____
 (Name) (Title)
 _____, attest that the plan submission (_____)
 (Company / NAIC Co-Code) (HIOS Plan ID Number)

is in compliance with all of the laws, regulations, rules, guidance, and standards outlined below.

Check (v) “Y”, “N”, or “NA” for each of the items below to indicate that the plan complies with each item. If supporting documentation is included, please indicate the appropriate the page number.

Y	N	N/A	Pg #	
				1. Compliance with State Rules & Regulations
				a. Plan complies with Delaware Insurance Law - Chapters 33 and 36, Regulation 1304 - Individual Health Forms
				b. Plan complies with Delaware Insurance Law - Chapter 72, Regulation 1308; Forms & Rates Bulletins Nos. 11-13 - Small Employer
				c. Plan complies with Delaware Insurance Law - Chapter 35, Forms & Rates Bulletin 17 - Group & Blanket Health
				2. Network Adequacy
				a. Plan complies with requirement that 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 including oversight process regarding timely access to care and services.
				b. 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.
				3. Rating Areas Attestation

				a. Plan rates do not vary by geographical rating area, as the state of Delaware permits only one rating area.
				4. Service Area Attestation
				a. Plan complies with requirement that 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.
				5. DHIN Quality Improvement Standards
				a. Plan Issuer will 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 improve health outcomes, medical home models and technology and data analytics to support coordination and improved quality and outcomes.
				6. Marketing and Benefit Design
				a. Plan marketing and benefit design complies with and will continue to 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.
				7. Dental Compliance with Title 18, Chapter 38 (if applicable)
				a. Plan complies with Delaware Title 18, Chapter 38 (Dental Plan Organization Act) if plan is offering dental coverage, including embedded dental or stand-alone dental coverage.
				8. Marketing Regulations and Transparency
				a. Plan complies with state and federal marketing and transparency regulations, including the Unfair or Deceptive Acts and Unfair Methods of Competition Act (Delaware Insurance Code Title 18§23; 18 Del Admin Code§ 1302) as well as federal regulations including, but not limited to, 45 CFR §156.220 which requires the publication of cost-sharing data on Issuer Internet web site.
				9. Market Reform Rules
				a. Plan complies with all Federal Market Reform rules including, but not limited to PHS 2701; PHS 2702; PHS 2703; PPACA §1302(e); PPACA §1312(c); PPACA §1402; 43 CFR §156; 42 CFR §147. (Note: There are no Delaware-specific market reform rules).
				10. Compliance with Essential Health Benefits
				a. Plan pediatric dental benefits offered are substantially equal to benefits offered in the Delaware dental supplemental benchmark plan (CHIP).
				11. Continuity of Care
				a. Plan Issuer has a transition plan for continuity of care for those individuals who become eligible or lose eligibility for public health programs. Plan Issuer is responsible for executing the Transition plan.
				b. Plan Issuer agrees to comply with withdrawal and transition plan requirements as stated in

				Del.c. 18 subsection §3608 for Individual plans.
				c. Plan Issuer agrees to comply with withdrawal and transition plan requirements as stated in Del.c. 18 subsection §7207 for Small Group plans.
				d. Plan Issuer has submitted a withdrawal and transition plan to the Department of Insurance for review/approval.
				12. Broker/Producer Compensation
				a. Plan Issuer agrees to ensure that commissions paid to brokers/producers for QHPs sold through the Individual Marketplace and FF-SHOP are the same as those paid in the outside market.

Printed Name/Title

Signature/Date

7. Additional Attachments

Attachment 3: Delaware Issuer EHB Crosswalk and Certification Template

Issuer Essential Health Benefits (EHB) Crosswalk and Certification For Plan Year 2015				
[INSERT ISSUER'S NAME]				
<p>The benefits included in the State of Delaware's Benchmark, Including applicable supplements for pediatric vision and dental and habilitative devices and services, are Essential Health Benefits and must be included in all policies and plans offered in the individual and small group markets pursuant to 45 C.F.R. §§147.150 & 156.100 et. Seq., unless otherwise noted. As allowed for in federal regulation, all Delaware state-mandated benefits enacted prior to January 1, 2012 are included in the State's Essential Health Benefit benchmark.</p>				
<p>The Issuer must complete and submit this EHB Crosswalk and Certification as a supplement to its Form Filings for each plan.</p>				
	Benefit	Covered (Required): Is Benefit Covered or Not Covered?	Quantitative Limits on Service? (Required if Quantitative Limit is "Yes"): Enter Limit Quantity	Description and Location of Benefit in Issuer's Policy Form
	Primary Care Visit to Treat an Injury or Illness	Covered		See Page ____ of ____.
	Specialist Visit	Covered		See Page ____ of ____.
	Other Practitioner Office Visit (Nurse, Physician Assistant)	Covered		See Page ____ of ____.
	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Covered		See Page ____ of ____.
	Outpatient Surgery Physician/Surgical Services	Covered		See Page ____ of ____.
	Hospice Services	Covered	240 Days	See Page ____ of ____.
	Non-Emergency Care when Traveling Outside of the U.S.	Covered		See Page ____ of ____.
	Private-Duty Nursing (Inpatient)	Covered	Outpatient PDN is not covered. Inpatient PDN is covered for up to 240 Hours in a 12 month period	See Page ____ of ____.
	Routine Eye Exam (Adult)	Covered	1 Every 24 Months	See Page ____ of ____.
	Urgent Care Centers or Facilities	Covered		See Page ____ of ____.
	Home Health Care Services	Covered	100 Visits Per Year	See Page ____ of ____.
	Emergency Room Services	Covered		See Page ____ of ____.

Emergency transportation/Ambulance	Covered		See Page ____ of ____.
Inpatient Hospital Services (e.g., hospital Stay)	Covered		See Page ____ of ____.
Inpatient Physical and Surgical Services	Covered		See Page ____ of ____.
Bariatric Surgery	Covered		See Page ____ of ____.
Skilled Nursing Facility	Covered	120 Days Per Confinement. Benefits renew after 180 days without care	See Page ____ of ____.
Prenatal and Postnatal Care	Covered		See Page ____ of ____.
Delivery and All Inpatient Services for Maternity Care	Covered		See Page ____ of ____.
Mental/ Behavioral Health Outpatient Services	Covered	20 Visits Per Year. Limits do not include serious mental illness which is covered as any other illness.	See Page ____ of ____.
Mental/Behavioral Health Inpatient Services	Covered	31 Days Per Year. Covered for up to 31 inpatient days and 62 partial hospital days per calendar year. On inpatient day reduces partial hospital days by two days. Two days of partial hospital care reduce inpatient days by one day. Limits do not include serious mental illness which is covered as any other illness.	See Page ____ of ____.
Substance Abuse Disorder Outpatient Services	Covered		See Page ____ of ____.
Substance Abuse Disorder Inpatient Services	Covered		See Page ____ of ____.
Generic Drugs	Covered		See Page ____ of ____.
Preferred Brand Drugs	Covered		See Page ____ of ____.
Non-Preferred Brand Drugs	Covered		See Page ____ of ____.
Specialty Drugs	Covered		See Page ____ of ____.
Outpatient Rehabilitation Services: Physical Therapy & Occupational Therapy	Covered	30 Visits Per Year.	See Page ____ of ____.
Outpatient Rehabilitation Services: Speech Therapy	Covered	30 Visits Per Year.	See Page ____ of ____.
Outpatient Rehabilitation Services: Cognitive Therapy	Covered	30 Consecutive days beginning on the first day of treatment	See Page ____ of ____.
Outpatient Rehabilitation Services: Cardiac Therapy	Covered	3 Sessions per week and 3 months of treatment	See Page ____ of ____.
Outpatient Habilitative Services: Physical Therapy & Occupational Therapy	Covered	30 Visits Per Year.	See Page ____ of ____.
Outpatient Habilitative Services: Speech Therapy	Covered	30 Visits Per Year.	See Page ____ of ____.

Outpatient Habilitative Services: Cognitive Therapy	Covered	30 Consecutive days beginning on the first day of treatment	See Page ____ of ____.
Outpatient Habilitative Services: Cardiac Therapy	Covered	3 Sessions per week and 3 months of treatment	See Page ____ of ____.
Chiropractic Care	Covered	30 Visits Per Year. Three Modalities per visit. One visit per day.	See Page ____ of ____.
Durable Medical Equipment	Covered		See Page ____ of ____.
Dialysis	Covered		See Page ____ of ____.
Hearing Aids	Covered	2 Hearing Aids -- One hearing aid per ear every three years for children less than 24 years of age	See Page ____ of ____.
Diagnostic Test (X-Ray and Lab Work)	Covered		See Page ____ of ____.
Imaging (CT/PET Scans, MRIs)	Covered		See Page ____ of ____.
Preventive Care/Screening/Immunization, including newborn and infant hearing screening, lead poisoning screening and screening of infants and toddlers for developmental delays	Covered		See Page ____ of ____.
Contraceptive drugs and Devices	Covered		See Page ____ of ____.
Radiation Treatment	Covered		See Page ____ of ____.
Chemotherapy	Covered		See Page ____ of ____.
Organ Transplant	Covered		See Page ____ of ____.
Routine Eye Exam for Children	Covered	1 Visit Per Year. Supplemented using FEDVIP.	See Page ____ of ____.
Eye Glasses for Children	Covered	1 Pair of Glasses (lenses and frames per year). Supplemented using FEDVIP.	See Page ____ of ____.
Dental Check-up for Children	Covered	1 Every 6 Months. Supplemented using Delaware CHIP.	See Page ____ of ____.
Basic Dental Care for Children	Covered	Please Reference Delaware CHIP Pediatric Dental Benefits.	See Page ____ of ____.
Orthodontia Care for Children	Covered	Please Reference Delaware CHIP Pediatric Dental Benefits.	See Page ____ of ____.
Major Dental Care for Children	Covered	Please Reference Delaware CHIP Pediatric Dental Benefits.	See Page ____ of ____.
Routine patient care for individuals engaged in clinical trials 18 Del.C. §3351 and §3567	Covered		See Page ____ of ____.
Reconstructive Surgery following Mastectomies 18 Del.C. §3347 and §3563	Covered		See Page ____ of ____.
Monitoring ovarian cancer following treatment 18 Del.C. §3338 and §3552	Covered		See Page ____ of ____.

Midwife Services Reimbursement 18 Del.C. §3336 §3553	Covered		See Page ____ of ____.
Obstetrical and Gynecological Coverage including Pap Smear and Mammography--18 Del.C. §3345 §3552	Covered		See Page ____ of ____.
Colorectal Screening 18 Del.C. §3346 §3562	Covered		See Page ____ of ____.
Infant and toddler screening for developmental delay 18 Del.C. §3360 and §3571(d)	Covered		See Page ____ of ____.
Diabetes Care Management 18 Del.C. §3344 and §3560	Covered		See Page ____ of ____.
Reversible contraceptives 18 Del.C. §3559	Covered		See Page ____ of ____.
Prescription Medication 18 Del.C. §3350 §3566	Covered		See Page ____ of ____.
Formulas and foods for the treatment of inherited metabolic diseases such as PKU 18 Del.C. §3355 and §3571	Covered		See Page ____ of ____.
Scalp hair prosthesis for hair loss suffered as a result of alopecia areata, resulting from an autoimmune disease 18 Del.C. §3356 and §3571(b)	Covered		See Page ____ of ____.
Dental services for children with severe disabilities 18 Del.C. §3358 and §3571(c)	Covered		See Page ____ of ____.
Equal reimbursement for oral and intravenous anticancer medication 18 Del.C. §3338A and §3555A	Covered		See Page ____ of ____.
Delaware State-Required Non-EHB Benefits Included within plans			
Autism Spectrum Disorders Coverage (includes screening, diagnosis and treatment for individuals less than 21 years of age) 18 Del.C. §3361 and §3570(a)	Covered	No limitations on the number of visits an individual may make to an autism services provider or that a provider may make to an individual regardless of the locatin in which services are provided. Maximum benefit of \$36K per twelve-month period per person for applied behavior analysis (ABA) services.	See Page ____ of ____.
Prescription Drug Specialty Tier 18 Del.C. §3364 and §3580	Covered		See Page ____ of ____.
School-based Health Centers 18 Del. C. §3365 and §3571(f)	Covered		See Page ____ of ____.

			See Page ____ of ____.
			See Page ____ of ____.
	Additional Benefits covered <i>(Issuers are encouraged to list any additional benefits that the plans cover and provide a page reference)</i>		
			See Page ____ of ____.
			See Page ____ of ____.
			See Page ____ of ____.
			See Page ____ of ____.

Attachment 4: Delaware Mental Health Parity Addiction and Equity Act Issuer Checklist and Certification Template

Delaware Mental Health Parity and Addiction Equity Act Issuer Checklist and Certification – (Plan Year 2015)

Company Name:	
Product Name:	
Plan:	
<input type="checkbox"/>	Individual
<input type="checkbox"/>	Small Group
<input type="checkbox"/>	Large Group

YES: The plan should check this box if it meets the requirements.

NO: The plan should check this box if it does not meet requirements. The plan should provide detailed explanations for any “No” boxes that are checked.

Requirement	Yes	No
<i>Federal Law</i>		
Aggregate lifetime and annual dollar limit requirements for mental health and substance use disorder benefits <input type="checkbox"/> The plan complies with the aggregate lifetime and annual dollar limit requirements set forth in 45 CFR §146.136(b).	<input type="checkbox"/>	<input type="checkbox"/>
<i>Explanation (if necessary):</i>		
Financial requirements and quantitative and nonquantitative treatment limitation requirements for mental health and substance use disorder benefits <input type="checkbox"/> The plan complies with the financial requirements and quantitative and nonquantitative treatment limitation requirements set forth in 45 CFR §146.136(c).	<input type="checkbox"/>	<input type="checkbox"/>
<i>Explanation (if necessary):</i>		

Requirement	Yes	No
Availability of medical necessity criteria for mental health and substance use disorder benefits <input type="checkbox"/> The plan makes the criteria for medical necessity determinations with respect to mental health or substance use disorder benefits available to any current or potential participant, beneficiary, or contracting provider upon request in accordance with 45 CFR §146.136(d).	<input type="checkbox"/>	<input type="checkbox"/>
<i>Explanation (if necessary):</i>		
State Law		
<input type="checkbox"/> The plan (if offered in the individual market) complies with 18 Del.C §3343.	<input type="checkbox"/>	<input type="checkbox"/>
<i>Explanation (if necessary):</i>		
<input type="checkbox"/> The plan (if offered in the small group market) complies with 18 Del.C §3578.	<input type="checkbox"/>	<input type="checkbox"/>
<i>Explanation (if necessary):</i>		

I, on behalf of [INSERT ISSUER] (“Company”), hereby certify, based on information and belief formed after reasonable inquiry, that (i) the statements and information contained herein are true, accurate and complete and (ii) Company complies with, and will continue to comply with, the Mental Health Parity and Addiction Equity Act and 45 C.F.R. § 146.136 et. seq.

Signature

Title

Date

Attachment 5: Delaware QHP Network Access Plan Cover Sheet Template

Delaware QHP Network Access Plan Cover Sheet Template

Overview

As part of the Delaware QHP Application process, the Delaware Department of Insurance will conduct a review and analysis of Plan Provider Networks to ensure compliance with State and federal regulations, standards, and to confirm there is adequate access to all providers and facilities without unreasonable delay or the need to travel an unreasonable distance. The process also accounts for differences in provider availability, capacity to treat patients, provider types (specialties, including mental health and substance abuse providers), facilities, practice referral patterns, continuity of care, among others.

In addition to federal QHP submission requirements, Issuers applying for certification of health plans on the Delaware Marketplace for Plan Year 2015 are required to submit for review by the Delaware DOI a Network Access Plan, including a completed Cover Sheet template, and supporting documentation as described below. Issuers must also document that their proposed network meets additional Delaware-specific QHP Standards. These standards may be found at the following URL:

<http://www.delawareinsurance.gov/departments/documents/bulletins/DomesticForeignInsurersBulletin60.pdf>.

The Delaware benchmark plan includes coverage of mental health and substance abuse (MHSA) services. Federal law requires that these services be offered at parity with medical and surgical services. Final rules for the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) went into effect on January 13, 2014 and the interim final rule went into effect starting in 2010. As such, the DOI will review each Issuer's Network Access Plan to ensure parity related of mental health providers with other specialty provider types with respect to adequacy, access and referral procedures.

Instructions for Submitting Network Access Plan Information

Please describe the Network's Access Plan using this Cover Sheet Template as follows:

If the issuer's access plan addresses an element, mark 'Yes' in the Included in Access Plan column. Then, in the Page Number for Supporting Documentation column, provide a reference to the applicable page number in the issuer's access plan that addresses the specific element. If the issuer has multiple networks, reference the pages that are applicable to each network, or indicate whether the particular page is applicable to multiple networks. *(If the information is referenced within an additional supporting document other than the Issuer's Network Access Plan, the Issuer should include the name of the document and applicable page numbers.)*

Documentation that the network(s) meet these standards should include a detailed Network Accessibility Analysis (preferably in Excel format) must include provider's name, location and County and include information that addresses both Network Adequacy (provider/member ratios) and Network Access (time/distance) for the following:

❖ **Primary Care Providers**

- ✓ General/Family Practitioners or Internal Medicine
- ✓ Family Practitioners and Pediatricians

❖ **Specialty Care Providers**

- ✓ Hospitals
- ✓ Home Health Agencies
- ✓ Cardiologists
- ✓ Oncologists
- ✓ Obstetricians
- ✓ Pulmonologists
- ✓ Endocrinologists
- ✓ Skilled Nursing Facilities
- ✓ Rheumatologists
- ✓ Ophthalmologists
- ✓ Urologists
- ✓ Psychiatric and State Licensed Clinical Psychologists
- ✓ Dental Providers (for compliance with pediatric EHB service requirements)

❖ **Mental Health / Behavioral Health / Substance Abuse Providers**

- ✓ Psychiatric and State Licensed Clinical Psychologists
- ✓ Other (include provider / facility type)

❖ **Essential Community Provider**

- ✓ FQHC
- ✓ Ryan White Provider
- ✓ Family Planning Provider
- ✓ Hospital
- ✓ Other ECP (including School-Based Provider)

Required Network Access Plan Elements

1. Standards for Network Composition:

Describe how the issuer establishes standards for the composition of its network to ensure that networks are sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services and pediatric dental (if applicable), to ensure that all services will be accessible without unreasonable delay. Standards must be specific, quantifiable, and measurable based on the anticipated needs of their membership. The standards must address provider-to-enrollee ratios and time and distance standards.

Evaluation Criteria	Included in Access Plan (Y/N)	Page number for supporting documentation
Does the issuer have a documented process to establish standards for network composition?		
Does the issuer's standard address how the network will be sufficient in number and type of providers, including mental health and substance abuse services?		
Is the issuer's standard quantifiable and measurable?		
Does the issuer provide documentation or evidence that its proposed network meets its standard?		

2. Referral Policy

Describe the issuer's procedures for making referrals within and outside of its network.

Evaluation Criteria	Included in Access Plan (Y/N)	Page number for supporting documentation
Does the issuer have a documented process for making referrals inside and outside the network?		
Does the process allow members to access services outside the network when necessary?		
Do the issuer's policies and procedures regarding referrals for mental health, behavioral health and substance abuse services align with those for medical/surgical referrals, including access to services outside the network when necessary?		

3. Ongoing Monitoring

Describe the issuer’s process for monitoring and ensuring, on an ongoing basis, the sufficiency of the network to meet the health care needs of the population enrolled.

Evaluation Criteria	Included in Access Plan (Y/N)	Page number for supporting documentation
Does the issuer have a documented process for monitoring, on an ongoing basis, the sufficiency of the network to meet the needs of its members?		
Does the issuer include a both quantifiable and measurable approach to monitoring ongoing sufficiency of its network?		

4. Needs of Special Populations

Describe the issuer’s efforts to address the needs of covered persons with limited English proficiency and illiteracy, with diverse cultural or ethnic backgrounds, or with physical and mental disabilities.

Evaluation Criteria	Included in Access Plan (Y/N)	Page number for supporting documentation
Does the issuer have a documented process to address the needs of covered persons with limited English proficiency and illiteracy, with diverse cultural and ethnic backgrounds, and with physical and mental disabilities?		
Does the issuer s process identify the potential needs of special populations?		
Does the issuer s response describe how its process supports access and accessibility of services for special populations?		
If the issuers plans include the pediatric dental benefit, does the issuers response address compliance with Delaware regulations regarding access to all required provider services for severely handicapped children?		

5. Health Needs Assessment

Describe the issuer's methods for assessing the needs of covered persons and their satisfaction with services.

Evaluation Criteria	Included in Access Plan (Y/N)	Page number for supporting documentation
Does the issuer have a documented method for assessing the needs of covered persons?		
Does the proposed method include a review of quantitative information?		
Does the proposed method assess needs on an ongoing basis?		
Does the proposed method assess the needs of diverse populations?		

6. Communication with Members

Describe the issuer's method for informing covered persons of the plan's services and features, including, but not limited to, the plan's grievance procedures, its process for choosing and changing providers, and its procedures for providing and approving emergency and specialty care.

Evaluation Criteria	Included in Access Plan (Y/N)	Page number for supporting documentation
Does the issuer have a documented method for informing covered persons of the plan's services and features, including, but not limited to, the plan's grievance procedures, its process for choosing and changing providers, and its procedures for providing and approving emergency and specialty care?		
Does the method address the process for choosing or changing providers and access to emergency or specialty services?		
Does the process describe how it supports member access to care?		

7. Coordination Activities

Describe the issuer’s system for ensuring the coordination and continuity of care for covered persons referred to specialty physicians; for covered persons using ancillary services, including social services and other community resources; and for ensuring appropriate discharge planning.

Evaluation Criteria	Included in Access Plan (Y/N)	Page number for supporting documentation
Does the issuer have a documented process for ensuring coordination and continuity of care?		
Does the proposed process address specialty care referrals; ancillary services, including social services and community resources; and discharge planning?		
Does the response describe how the process supports member access to care?		

8. Continuity of Care

Describe the issuer’s proposed plan for providing continuity of care in the event of contract termination between the health issuer and any of its participating providers or in the event of the issuer’s insolvency or other inability to continue operations. The description must explain how covered persons will be notified of the contract termination, issuer’s insolvency, or other cessation of operations and how they will be transferred to other providers in a timely manner.

Evaluation Criteria	Included in Access Plan (Y/N)	Page number for supporting documentation
Does the issuer have a documented plan for ensuring continuity of care in compliance with federal and state QHP Standards?		
Does the issuer have a hold harmless provision in its provider contracts, prohibiting contracting providers from balance-billing enrollees in the event of the issuer’s insolvency or other inability to continue operations?		

Attachment 6: Delaware Quality Improvement Strategy Workgroup Designation Form

Delaware Quality Improvement Strategy Workgroup Designation Form

Designation Information	
Company Name:	Date:

Primary Contact			
Name:	Title:		
Address:	City:	State:	Zip:
Phone Number:	Email Address:		

Primary Contact Signature
Date

Alternate Contact			
Name:	Title:		
Address:	City:	State:	Zip:
Phone Number:	Email Address:		

Alternate Contact Signature
Date