Issuer Workshop

Delaware Health Benefit Exchange

February 21, 2013

Introductions

Project Leads

- Crystal English, DHSS/DMMA—Senior Administrator for the Exchange
- Linda Nemes, DOI—Assistant Director, Market Regulation

Introductions (cont)

DOI Plan Management Team

- Janet Brunory, DOI—QHP Analyst
- Sandy Brown, DOI—QHP Administrative Support
- Linda Long, DOI—Producer Licensing and Market Conduct Investigator
- Jennifer Stinson, DOI –Rates and Forms Analyst
- Laura Wilcox, DOI—Administrative Support
- Carol Jones, DOI—Director of Information Systems

Introductions (cont)

Public Consulting Group

- Alicia Holmes, Senior Consultant
- Bernadette Schad, Senior Consultant
- Ashley Odom, Consultant

Agenda

1. Brief overview of Delaware Partnership Exchange
   - Partnership functions retained by the state
   - Delaware's Exchange organization and the DOI Plan Management Team
   - Proposed Plan Management Timeline
2. Overview of the QHP Certification Process
3. Review of State-specific Standards
   - Essential Health Benefit benchmark
   - Delaware QHP Certification Standards
4. NAIC Training
5. Key Contacts for the Delaware Exchange

1. Overview of Delaware Partnership Exchange

Exchange Senior Leadership

- Health Reform Committee (HCR) – This steering committee provides strategic and policy-level leadership to the DE HBE Program. The HCR ensures efficient and appropriate integration among state agencies and programs to support overall success of the Exchange. Committee members include cabinet and senior management representatives from the state Departments of Insurance, Health and Social Services, Technology and Information, as well as the Governor's office and the Executive Director of the Health Care Commission (HCC)
- Secretary of Health and Social Services – Voting member of the HCC and Chair of the HCR, the Secretary has been designated as the primary point of contact for the HHS regarding the Exchange, and is authorized to enter into agreement with CMS and the federal exchange on behalf of the state.
- Insurance Commissioner – Voting member of the HCC and member of the HCR, the Commissioner will oversee activities related to insurance regulation and DOI responsibilities for Plan Management functions, including supporting efficient and appropriate integration with other state agencies and programs to support overall success of the Exchange.
- Delaware Health Care Commission– Created by the State General Assembly in June 1990 to develop a path to basic affordable health care, and is comprised of members from executive and legislative government and individuals representing the public and private sector. The HCC reviews and approves Exchange-related policies and ensures that the Exchange aligns and supports the state's overall health reform goals and objectives.

Partnership Exchange

- Originally, the Delaware Health Care Commission (HCC) carried a motion to recommend a State-based Exchange for Delaware.
  - At the time of the vote, the alternatives were to cede all functionality to the Federally-Facilitated Exchange or find other States with which to create a regional Exchange.
  - Of these options, the most viable choice was to pursue a State-based model
- In late 2011, the Federal government released new options for States to consider in establishing a Health Benefit Exchange (Exchange)
  - These new options allowed States to enter into a partnership with the Federal government and choose to retain Plan Management functions, Consumer Assistance functions, or both. Under the partnership model, the Federal government would administer all other functionality, most notably the large technical infrastructure to support Exchange operations.
- Following the release of the Partnership model, Delaware re-assessed the viability of all available options and determined that the State-Federal Partnership is the most appropriate choice.

Delaware Fast Facts

- **Population[1] -** 897,934
- **Medicaid Recipients[1] –** 193,276 (As of January 2011)
- **Anticipated Medicaid Expansion –** 25,423 in 2014; 8,474 annually 2015/2016
- **Uninsured Population** – 100,000; approx. 30,000 currently eligible for Medical Assistance
- **Anticipated Exchange Population[2]** – 35,000 Individuals/Covered Lives

[1] Source: University of Delaware, "Delaware and the Patient Protection Affordable Care Act (ACA)"; revised July 2011
[2] Source: PCG, "Delaware HBE Project – Feasibility Study", revised February 2012

Goals of the Delaware HBE Project

The State has identified specific goals and objectives that inform the critical decisions made regarding Exchange-related policies, processes and implementation approach, as well as provide a marker for Exchange performance measurement.

Goals:

1. Improve access to affordable health insurance for Delawareans.
2. Achieve financial sustainability that does not adversely impact the Delaware insurance market (carrier selection and cost of coverage).
3. Assist small employers with the purchase of insurance for their employees.
4. Implement a model that harmonizes with the broker community.
5. Comply with federal regulations and guidelines for a State Partnership Model for Plan Management and Consumer Assistance.

Delaware's Partnership Exchange

Under the Partnership model, Delaware:

- Will implement both Plan Management & Consumer Assistance functions
- Will conduct final eligibility determination for Medicaid/CHIP for individuals who apply through the FFE portal
- Will defer Reinsurance program administration to federal government
- Will establish state-specific Essential Health Benefits (EHB) benchmark
- Will establish state-specific QHP certification standards in addition to federal QHP requirements
- Will retain separation between the Individual and Small Group markets

Federal Responsibilities in the Partnership Exchange

Key Exchange functions and responsibilities retained by HHS in the FFE State Partnership Exchange model include:

- Final certification of QHPs
- Development and operations of the Exchange Website
- Eligibility determinations for premium subsidies (APTCs and CSRs)
- 'Shop and Compare' and Enrollment in QHPs
- Operation of the SHOP to support small group employers/employees
- Financial management, including premium aggregation, billing, audits, etc.
- Reinsurance and Risk Adjustment
- Call Center Customer Support functions

DE Exchange Organization

Governor Markell designated DHSS as the lead agency for the Partnership. Responsibilities include:

- Overall program management and oversight
- Coordination with CMS/CCIIO regarding Exchange activities, timelines and oversight reviews
- Financial Monitoring and federal Grant administration
- Program communication and stakeholder engagement
- Exchange/Medicaid integration, including the business process and technical integration related to eligibility processing

DE Exchange Organization (cont)

The DOI will leverage its existing operational structure and staff to support Plan Management activities

- Collect and review Issuer and plan data to support QHP certification,
- Collect and transmit necessary data to HHS
- Conduct QHP Issuer Account Management activities in coordination with HHS
- Perform QHP oversight and monitoring
- Collect additional Issuer data as required to support oversight and quality reporting
- Verify accreditation status
- Track and resolve consumer complaints and inquiries
- Coordinate with HHS on quality rating and enrollee satisfaction survey

DOI Divisions will support PM activities

- **Market Regulations**: responsible for monitoring the market conduct of insurers operating in Delaware; reviewing and regulating insurance contracts and rate filings, including approval and contest of rate filing; and ensures competency and ethical conduct by insurance agents, brokers, limited agents, adjusters, appraisers, and consultants
- **Bureau of Company Examination, Rehabilitation & Guaranty:** The Bureau reviews applications to do business in Delaware; monitors the financial operations of the domestic insurers licensed in Delaware; and rehabilitates or liquidates financially impaired insurers
- **Consumer Services & Investigations Division:** This division provides information on how to make decisions that can lower the cost of insurance and increase the value the consumer receives; assists consumers in resolving conflicts with insurance companies, health coverage providers, and agents; provides arbitration hearings as a low-cost alternative to civil litigation to resolve disputed consumer claims; and investigates concerns regarding all types of insurance and utilizes consumer input to review market trends, statute and rule violations, and to develop changes to the insurance law
- **Fraud Prevention Bureau:** The Bureau investigates property and casualty, auto, life, health, workers compensation, provider and agent insurance fraud; and provides a focal point for the anti-fraud efforts

DOI resources dedicated to Plan Management

QHP Analyst

- Develop content for QHP-related bulletins
- Perform role of State Issuer Account Manager, including receiving and tracking inquiries from Issuers regarding QHP standards and processes and resolving Issuer-generated complaints
- Lead QHP Application Review process, including ongoing communication with Issuers regarding submission and inquiries
- Collect and analyze data to support the Quality Reporting process
- Lead activities related to the QHP recertification, decertification, withdrawal, and appeals of decertification

QHP Administrative Support

- Receive and track Issuer QHP applications
- Provide administrative support to the QHP Analyst regarding QHP application review, Issuer communication, data validation and verification of Issuer and plan data, tracking of QHP agreements, Issuer Account Management
- Assist in collecting and analyzing data to produce periodic performance reports and market conduct reviews

Proposed Delaware QHP Timeline

Activity	Date *
Delaware EHB Benchmarks and state QHP standards established	November 1, 2012
DOI releases Bulletin to Issuers regarding state standards and inviting them to submit a letter of intent to apply for QHP Certification	December 2012
Issuers register with HIOS and receive HIOS ID	March 2013
Issuer QHP Certification Applications period begins	March 28, 2013
Issuer QHP Application period closes	June 30, 2013
Delaware recommendations for QHP certification provided to HHS** SERFF transmits Issuer data for all recommended QHPs to HIOS	July 31, 2013
Issuers review data on FFE web portal during Plan Preview period and address data errors	1 week late August 2013
HHS notifies State and all Issuers of QHP Certification decision; QHP Agreement signed	Early September 2013
Consumer Open Enrollment Period begins; QHP monitoring activities begin	October 1, 2013
Consumer Open Enrollment period ends	December 31, 2013
Issuer Accreditation deadline for QHPs in the Exchange	September 30, 2014

**future dates based on existing guidance from CMS and NAIC*

***Delaware will submit all recommendations for QHP certification concurrently in order to avoid adverse market advantage*

2. Overview of Delaware QHP Certification Process

QHP Application Submission

- Issuers access HIOS and obtain user IDs

- QHP Application Submission
  - Issuers access QHP Application on SERFF
  - Provide data on-screen and through Issuer-level and plan-level data templates
  - Complete and submit QHP Application to SERFF

Review and Notification

- State reviews submitted QHP Applications for compliance with federal and state laws, and QHP Standards

- Deficiency notices sent
  - State will notify Issuers of any deficiencies found
    - Notification will identify specific issues such as standards not met, complete data, etc. and will provide detail on the changes that should be resubmitted.

Resubmission and Re-Review

- Issuer QHP Application Resubmission
  - Issuers will submit corrections or clarifications into SERFF in response to State's deficiency notices.
  - Issuers will only be able to alter data and provide supplemental justifications or documentation when explicitly identified as deficient.

- Review of Resubmission
  - State will complete final reviews of resubmitted Issuer- and plan-level data.

State Findings and Compiling Results

- State provides to HHS QHP Certification evaluation findings and use SERFF to submit data for recommended plans to HIOS
  - FFE will review and ratify State findings.

- FFE will compile QHP Certification findings.
  - Concurrently:
    - HHS will view all evaluation findings per QHP at one time to begin the final certification process
    - Plans will be loaded onto the plan preview portal.

Plan Preview

- Issuer will view their QHP as it will be presented to consumers on the Exchange Web Portal
  - Benefits – view detailed benefit information for all your QHPs.
  - Rates – view eligible QHP and premiums for a given consumer.
- Issuers will review for:
  - Accuracy of data
  - Benefit data displayed as expected
  - Correct plans and rates are displayed

Plan Preview (cont.)

- If inaccuracies are found, inform HHS/State: only changes that do not cause a re-review of data will be permitted.
  - Resubmit into SERFF data corrections approved by the State and HHS.
  - *QHP display on Plan Preview does not guarantee certification*.
- HHS makes Certification decisions and notifies the State and Issuers.
- Issuers are required to sign a QHP Agreement with HHS.

3. Review of State-specific Standards

Essential Health Benefits

- The Affordable Care Act requires that any health insurance plan offered to an individual or small business must meet certain standards.
- These standards, known as essential health benefits, must cover the ten broad categories of services listed below.
  - This list applies to health insurance plans offered inside and outside of the Exchange and represents the **minimum services that must be covered**. Health insurance plans may cover additional services at their own discretion.
- Essential Health Benefit (EHB) Service Categories
  1. Ambulatory patient services
  2. Emergency services
  3. Hospitalization
  4. Maternity and newborn care
  5. Mental health and substance use disorder services, including behavioral health treatment
  6. Prescription drugs
  7. Rehabilitative and habilitative services and devices
  8. Laboratory services
  9. Preventive and wellness services and chronic disease management
  10. Pediatric services, including oral and vision care

DE's EHB Selection Process

- HSS allowed states to select best option from existing health plans with the three largest enrollments among Small Group, State and Federal Employee plans
  - State mandates enacted after December 2011 and not included in eligible plans, such as coverage for Autism-related services, **must be paid for by the state**
- HBE Project conducted thorough analysis of benefits across all eligible plans
  - Findings of the analysis were presented to the HCC, followed by a 45-day open comment period and two Public forums to gather stakeholder input
  - Health Reform Committee developed a recommendation in August based on the analysis and stakeholder input
- Overwhelming support for the selection of Blue Cross/Blue Shield EPO Small Group Plan
- EHB Benchmark approved by the HCC at September 6th meeting and submitted to HSS on September 29th

Delaware EHB Benchmark

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 benchmark.

- http://cciio.cms.gov/resources/EHBBenchmark/delaware-ehb-benchmark-plan.pdf

Delaware EHB Benchmark

Service Category	Small Group BCBS EPO
Preventive Services: All USPSTF Schedule A and B benefits are covered regardless of their inclusion in the below description	
Examinations	well baby care; routine physical exam; routine GYN exam and pap smear
Tests and Screenings	Examples: blood antigen test for prostate cancer; blood occult; blood sugar test; cholesterol test; colonoscopy; electrocardiogram; flexible sigmoidoscopy; hemoglobin test; lead screening; mammogram; osteoporosis screening; alcohol misuse, and tobacco use/caused disease counseling; depression screening; tuberculin testing
Routine Immunizations	Examples: Dtap and combinations; Hepatitis A, B; Hib; Influenza; IPV; Meningitis; MMR; pneumococcal; Td; Varicella vaccine
Routine Vision Exams	Visual acuity tests are covered for adults and children as part of routine physical exams. Specialist visits are covered for adults 18 and older (every 24 mo, in network). Vision exams covered only by network optometrist or ophthalmologist
Routine Hearing Exams	Covered as part of routine physical exam

Delaware EHB Benchmark

Service Category	Small Group BCBS EPO
Inpatient Hospital Care	
Room and Board	Room and board, special diets and general nursing care.
Other Hospital Care	When medically necessary: use of operating and recovery room; drugs listed in US Pharmacopoeia/National Formulary; various therapy including chemo, occupational, physical, radiation, inhalation, speech, cognitive, cardiac. Surgical dressings; admin of blood/blood plasma; machine tests; imaging exams; durable medical equipment; lab tests; dialysis
Maternity Care	hospital and birthing center care for pregnancy, childbirth, miscarriage
Newborn Care	covered provided newborn is enrolled
Outpatient Surgical Facility	Minor surgeries at hospitals or approved ambulatory surgical centers; dental only covered when done at dentist or oral surgeon office. Dental surgery done in hospital outpatient or ambulatory surgical center must be approved
Emergency Room	Emergency care in emergency facilities
Skilled Nursing Facility	Confinement in skilled nursing facility; must be approved; covers skilled nursing and related care as impatient; rehabilitation if needed (Limited to 120 days, benefits renew after 180 days without care.)

Delaware EHB Benchmark

Service Category	Small Group BCBS EPO
Surgical and Medical	
Surgical	Cutting and operative procedures; treatment of fractures/dislocations; delivery of newborns. Services done in hospital; approved ambulatory surg. Centers, home, doctor office. Includes pre and post operative care.
Dental Surgery	Extracting bony impacted teeth; correcting accidental injuries (jaws, cheeks, lips, tongue, roof/floor of mouth)
Multiple Surgical Procedures	Provide full contract benefits for procedure with highest allowable charge, determine coverage for other procedures using special rules
Women's Cancer Related Surgery	Health and Cancer Rights Act of 1998; coverage of mastectomy-related services
Anesthesia	When medically necessary
Organ Transplants	Level of coverage depends upon facility where transplant is performed
Artificial Insemination and Intrauterine Insemination	not covered
In Vitro Fertilization and related	not covered
Inpatient Medical Services	One doctor visit per day; one consultation per specialty per admission
Emergency Care	Emergency care in emergency facilities
Obstetric Care	By doctors and midwives; coverage is same as for other surgical and medical care; one routine ultrasound/pregnancy covered
Newborn Care	Medical care of newborn child by physician if child enrolled

Delaware EHB Benchmark

Service Category	Small Group BCBS EPO
Emergency and Urgent Care	
Emergency Care	Emergency facility, ancillary services and physician care when condition is serious enough, delay in care may cause permanent damage, or care within 48 hours from onset; coverage for life threatening only; MH and SA emergencies; may have co-pay
Emergency Ambulance and Paramedic	Covered if sudden/serious condition; taken to nearest hospital
Urgent Care and Urgent Care Facilities/Medical Aid Units	injury or sudden illness need care within a day or two to avoid threat to life, health, function or cannot adequately manage pain

Delaware EHB Benchmark

Service Category	Small Group BCBS EPO
Diagnostic and Therapeutic Services	
Inpatient Diagnostic and Therapeutic Care	Covered
Outpatient Diagnostic and Therapeutic care	Covered
Diagnostic Services	Includes imaging services; lab tests; machine tests
Preadmission Testing	Completed before scheduled admission for surgery as an outpatient, within 7 days before admission
Therapy Services	Chemo by doctor; occupational (30 days per CY); physical (30 days per CY); radiation for cancer and neoplastic diseases; inhalation; speech (30 days per CY); dialysis; cognitive (30 consecutive days); cardiac (3 sessions per week, 3 months of treatment); vision

Delaware EHB Benchmark

Service Category	Small Group BCBS EPO
Other	
Hospice	Care by hospice doctor; nursing home; home health aide; social service guidance; nutritional counseling; physical, speech, occupational therapy; spiritual counseling; medical supplies; prescription drugs; bereavement counseling for family (240 days)
Home Health Care	Skilled nursing; therapy; medical and surgical supplies; social service guidance; home health aide when supervised by RN (3X per week for aide, 100 visits per CY)
Home and Outpatient Infusion	Nursing care; medications; solutions; needed infusion pumps, poles, supplies
Inpatient Private Duty Nursing	inpatient in acute hospital (240 hours in 12 month period)
Doctors Visits	In office or in home
Specialist/Referral Care	covered
Diabetic Education	instruction on care and treatment; individual or group setting
Nutritional Counseling	covered for assessments and guidance of members at risk for diabetes, malnutrition, eating disorders, cardiovascular disease.
Allergy Testing and Treatment	covered
Chiropractic Care	Treatment of spinal conditions: office visit for initial eval; manual manipulation; ultrasound, traction therapy, electrotherapy. (30 visits per CY)

Delaware EHB Benchmark

Service Category	Small Group BCBS EPO
Durable Medical Equipment & Prosthetics	
Durable Medical Equipment	prescribed by doctor; medically necessary and appropriate. Exs include ortho. Braces, wheel chairs, orthotics, hospital beds
Prosthetics	intended to replace all/part of organ or body part; prescribed by provider. Exs. Hair prostheses, limb, ear, eye, electro-larynx medical foods and formula for metabolic disorders; hearing aids (limits apply)
Care for Morbid Obesity	office visits; lab tests; surgery: gastric bypass, stapling, biliopancreatic bypass, gastric banding, sleeve gastrectomy. Requirements apply
Care for Weight Loss	not covered
Prescription Drug Benefits	Dispensing limits: 90 day supply, limit of 3 month supply for oral contraceptives, renewals past one year from orig. prescription not accepted

Delaware EHB Benchmark

Service Category	Small Group BCBS EPO
Mental Health and Substance Abuse: Mental Health Parity and Addiction Equity Act (MHPAEA) Standard will apply in 2014	
	All mental health and substance abuse diagnoses identified in the MHPAEA, as modified in 2008, are covered at parity with medical and surgical benefits offered through this plan. Limitations regarding other diagnoses not identified through MHPAEA are listed below.
Inpatient care	Includes doctor and facility costs, and electroconvulsive therapy (for other diagnoses, covered for 31 days per CY)
Partial hospital care program	Partial hospital care is defined as care provided for 8 or fewer hours/day (For other diagnoses, covered for 62 days per CY)
Intensive Outpatient Care	Other diagnoses are not covered for intensive outpatient care
Outpatient care	Includes brief crisis intervention psychotherapy, psychiatric consults, supporting psychotherapeutic therapy, psychological tests (8 hours/yr for testing, other diagnoses limited to 20 visits per CY)
Substance Abuse Benefits	Includes treatment of alcoholism and drug addiction through inpatient, intensive outpatient, or office visit treatment

Federal QHP Standards

- As prescribed in the PPACA, all Issuers and plans participating in the Exchange must meet federal certification standards for Qualified Health Plans. The Final Rule regarding federal standards for QHPs may be found on the Federal Register at the following URL:

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

Delaware QHP Standards

- In establishing its state QHP standards, Delaware sought to balance the need to expand value for consumers and encourage Issuer participation in the Exchange. Highlights include:
  - Requirements for a state-wide Service Area that expands provider coverage throughout the entire state
  - Network Adequacy standards that align with Medicaid and Department of Public Health standards
  - Issuer-required Transition Plans that support continuity of care for consumers as they move from QHPs to Medicaid and vice-versa
  - Quality Improvement Strategies, including a requirement that all Issuers participate, at the prevailing rate, in the Delaware Health Information Network (DHIN)

Delaware QHP Standards

The State followed a number of guidelines in developing its QHP Standards, including:

- All QHP Certification Standards will apply to both Individual and Small Group (SHOP) plans sold inside the Exchange.
  - All plans, *both inside and outside of the Exchange*, must comply with EHB benchmarks established by the state, with certain exceptions for stand-alone pediatric dental plans.

- All QHPs must comply with existing federal standards and regulations, including those within the ACA as well as other federal requirements, such as Mental Health Parity.

State Standards—Continuity of Care

- A QHP issuer must have a transition plan for continuity of care for those individuals who become eligible or lose eligibility for public health programs. The Continuity of Care Transition Plan must include a transition period for prescriptions, including how the plan specifically addresses mental health pharmacy.

- For treatment of a medical condition or diagnosis that is in progress, or for which a preauthorization for treatment has been issued, the QHP issuer/plan must cover the service for the lesser of: a period of 90 days or until the treating provider releases the patient from care.

State Standards—Continuity of Care

- For medications prescribed by a provider, a continuity/transition period of at least 60 days must be provided. 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 medications prescribed for the treatment of a specific mental health diagnosis, a continuity/transition period of at least 90 days must be provided by the QHP. The prescribed medication must be covered at a tier comparable to the plan from which the individual transitioned.

State Standards—Essential Providers

- 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 and3556

- The QHP issuer must make appropriate provider directories available to individuals with limited English proficiency and/or disabilities.

State Standards—Withdrawal for Exchange

- The QHP Issuer must comply with the following State regulations in the event that it withdraws either itself or a plan(s) from the Exchange:
  - Issuers withdrawing plans for Individuals must comply with 18 Del.C.§§3608(a)(3)a, and 3608(a)(4).
  - Issuers withdrawing Small Group plans must comply with 18 Del.C. §§7206 (a)(5),7206(a)(6) and 7206(b), Renewability of coverage.
- Issuers must submit a withdrawal and transition plan to the Department of Insurance for review/approval.

State Standards—Accreditation

- QHP issuers participating in a Federal Exchange will be required to be accredited and comply with quality reporting requirements that HHS will specify in future rulemaking. The National Committee for Quality Assurance (NCQA) and URAC – will be recognized as accrediting entities on an interim basis subject to conditions.
  - In subsequent phases, HHS plans to adopt an application and review process for the recognition of additional accrediting entities.

- The state will follow the proposed federal standards for accreditation, including requiring that QHP Issuers without existing accreditation must schedule the accreditation within the first year of participation in the Exchange, and 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.

State Standards—Network Adequacy

- QHP network arrangement must make available to every member a Primary Care Provider (PCP) whose office is located within 20 miles or no more than 30 minutes driving time from the member's place of residence.

- Each QHP issuer that has a network arrangement must meet and require its providers to meet State standards for timely access to care and services as outlined in the table, titled **Appointment Standards,** found on page 27 of 84 in the Delaware Medicaid and Managed Care Quality Strategy 2010 document relating to General, Specialty, Maternity and Behavioral Health Services.

- Issuers must establish mechanisms to ensure compliance by providers, monitor providers regularly to determine compliance, and take corrective action if there is a failure to comply with Network Standards.

State Standards—Network Adequacy

- 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.

State Standards—Rating Area

- As it applies to QHPs, the ACA defines a "Rating Area" as a geographic area established by a state that provides boundaries by which Issuers can adjust premiums (156.255)

- The State of Delaware will require Issuers to <u>use a single rating area—that of the entire state</u>, in developing its rates for QHP in the Exchange

State Standards—Service Area

- As it applies to the ACA, a Service Area is the geographic area in which an individual must reside or be employed in order to enroll in a QHP in accordance with §155.30 and§155.70. 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.

State Standards—Quality Rating

- "…the Affordable Care Act directs the Secretary (of HHS) to develop and administer a rating system and an enrollee satisfaction survey system, the results of which will be available to consumers. HHS intends to issue future rulemaking on quality reporting and disclosure requirements."

- HHS intends to propose a phased approach to new quality reporting and display requirements for all Exchanges

- The State will adopt the Quality Rating standards as provided in federal guidance.

State Standards
Quality Improvement Strategies

- Issuers will be required to participate in state quality improvement workgroups intended to standardize QHP quality improvement strategies, activities, metrics and operations, including payment structures to improve health outcomes, medical home models and technology and data analytics to support coordination and improved quality and outcomes.

- Issuers 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.
  - Information can be found at www.dhin.org

State Standards—Marketing and Benefit Design

- As required by the ACA, a QHP may not employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs.

- Issuers and QHPs must comply with state laws and regulations regarding marketing by health insurance issuers, including Delaware Insurance Code Title 18§23 Unfair Methods of Competition and Unfair or Deceptive Acts and the requirements defined in 18 Del Admin Code§ 1302 Accident and Sickness Insurance Advertisements.

Compliance with federal standards regarding incarcerated individuals

PPACA §1312(f)(1)(B) states:

- "(B) INCARCERATED INDIVIDUALS EXCLUDED.—An individual shall not be treated as a qualified individual if, at the time of enrollment, the individual is incarcerated, other than incarceration pending the disposition of charges."

- Issuers are expected to describe, within their QHP Application, how the plan will provide access to in-network or out-of-network providers for those enrollees who may be incarcerated but whose case is not yet fully adjudicated. (i.e., sentenced)

Contact for Delaware Department of Corrections:

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CO-OP Plans

CO-OP Plan Review

- CO-OP Plans are required to meet the same state and federal standards as regular QHPs
- Review process will be conducted on the same basis and in the same manner as insurance carriers, using the certification processes already described above.
- The DOI will review all plans and provide recommendations to CMS only those CO-OP plans that meet Delaware-specific QHP standards as well as federal laws and standards in accordance with 42 CFR 156.520 (e).

Delaware SHOP

- Reviews of SHOP plans will be conducted through the same process, timelines and criteria as for Individual plans.
- SHOP QHPs will be required to comply with SHOP-specific criteria as outlined in §156.285 of the final federal rule

- The state has requested federal guidance as to whether Partnership states have authority to define select SHOP policies on a state-wide basis.
  - ✓ Employer-defined contribution approach as described in section §155.725
  - ✓ Individual Rating vs. Average Age Rating for the Employee Choice model

- The state continues to consider SHOP-specific requirements during Exchange planning and implementation efforts

4. NAIC Training

NAIC SERFF Training

- SERFF will conduct State and industry training sessions separately
- The delivery format will be Webinar only
- Sessions will be approximately 90 minutes
- Training content will cover SERFF Workflow only- no training on templates
- Participants will be required to register ahead of time
- Training is at no cost
- SERFF will provide additional details regarding the schedule, registration and training agendas over the next few weeks.

- Recommend that states and industry staff monitor the SERFF HIX website for new information.
  - http://www.serff.org/hix.htm

5. Key Contacts for the Delaware Exchange

Delaware Exchange Contacts

For Issuer and QHP/Plan Management--

- Linda Nemes, Asst. Director of Market Regulation
  - Email: linda.nemes@state.de.us

For general inquiries regarding the Delaware Exchange Project—

- Crystal English, Sr. Administrator – Health Benefit Exchange
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