DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DELAWARE HEALTH CARE COMMISSION

Statutory Authority: 16 Delaware Code, Section 9903 (16 **Del.C.** §9903)

FINAL

ORDER

Delaware Health Insurance Individual Market Stabilization Reinsurance Program and Fund

NATURE OF THE PROCEEDINGS:

Delaware Health and Social Services ("DHSS") initiated proceedings to adopt the State of Delaware Regulations Governing Reinsurance. The DHSS proceedings to adopt regulations were initiated pursuant to 29 Delaware Code Chapter 101 and authority as prescribed by 16 Delaware Code, subsection 9903.

On September 1, 2019 (Volume 23, Issue 3), DHSS published in the Delaware *Register of Regulations* its notice of proposed regulations, pursuant to 29 **Del.C.** §10115. It requested that written materials and suggestions from the public concerning the proposed regulations be delivered to DHSS by October 1, 2019, after which time DHSS would review information, factual evidence and public comment to the said proposed regulations.

Written comments were received during the public comment period and evaluated. The results of that evaluation are summarized in the accompanying "Summary of Evidence."

SUMMARY OF EVIDENCE

In accordance with Delaware Law, public notices regarding proposed Department of Health and Social Services (DHSS) Regulations Governing Reinsurance were published in the Delaware *Register of Regulations*. Written comments were received on the proposed regulations during the public comment period (September 1, 2019 through October 1, 2019).

Entities offering written comments include:

- State Council for Persons with Disabilities (SCPD), Kyle Hodges, Policy Director
- Governor's Advisory Council for Exceptional Citizens (GACEC), Ann Fisher, Chairperson; Wendy Strauss, Executive Director
- Highmark Blue Cross Blue Shield Delaware, Kellie M. Garson, Esq., Counsel

Comments from the State Council for Persons with Disabilities (SCPD)

The act and regulations are a laudable attempt to both offer more choices to health consumers while proving an incentive and safety net to carriers who offer benefit plans covered by the act if the claims they pay become overwhelming financially. It is also meant to "shore up" the ACA marketplace for Delawareans. Delaware has joined a growing number of states that have instituted a reinsurance program, which includes Alaska, Maine, Maryland, and New Jersey. The threshold amount and the percentage of reimbursement differ from state to state. For example, Maryland's reinsurance program pays 80% of the individual market claims that are between $20,000 and $250,000. If possible, the Executive Director should consider lowering the threshold amount from that stated in the proposal, which should help keep premiums from increasing and may well result in a decrease. Before the reinsurance program, insurers in Maryland had proposed significant rate increases; after implementation of the reinsurance program, Maryland saw the average premium decrease markedly.

- Response: The Health Care Commission appreciates this suggestion. Commission staff worked extensively with nationally renowned actuaries to develop a proposal that would be the most appropriate for Delaware's individual health insurance market in calendar year 2020. However, we will have the opportunity to review and set thresholds each year of the program, and will consider your comments during future updates to the program for calendar year 2021 and beyond.

Comments from the Governor's Advisory Council for Exceptional Citizens (GACEC)

The Act and regulations are an admirable attempt to both offer more choices to health consumers while proving an incentive and safety net to carriers who offer benefit plans covered by the act if the claims they pay become overwhelming financially. It is also meant to support the ACA marketplace for Delawareans. Delaware has joined a growing number of states that have instituted a reinsurance program, which includes Alaska, Maine, Maryland, and New Jersey. The threshold amount and the percentage of reimbursement differ from state to state. For example, Maryland's reinsurance program pays 80% of the individual market claims that are between $20,000 and $250,000. If possible, the DHCC should consider lowering the threshold amount from that stated in the proposal, which should help keep premiums from increasing and may well result in a decrease. Before the reinsurance program, insurers in Maryland had proposed significant rate increases; after implementation of the reinsurance program, Maryland saw the average premium decrease markedly.

- Response: The Health Care Commission appreciates this suggestion. Commission staff worked extensively with nationally renowned actuaries to develop a proposal that would be the most appropriate for Delaware's individual health insurance market in calendar year 2020. However, we will have the opportunity to review and set thresholds each year of the program, and will consider your comments during future updates to the program for calendar year 2021 and beyond.

Comments from Highmark Blue Cross Blue Shield Delaware

We suggest more specificity as to when the reinsurance parameters will be set each year. Ideally, this should be communicated to issuers in 1Q of the year prior to the effective date so that issuers may incorporate these parameters into their rate calculations in advance of the DOI's mandatory rate filing submission deadline in 2Q of the year prior to the effective date.

- Response: The Health Care Commission appreciates this suggestion. We want to keep the language pertaining to parameters general at this time, as anything more specific could affect the CMS timetable. We will re-evaluate the parameters, including coinsurance changes, after the first year.

Section 4.1 and its subsections set forth requirements of issuers. Section 4.2 states that "*In lieu of* subsections 4.1.1. through 4.1.8, the State" may contract with CMS to use the EDGE server for its Reinsurance Program.

Are the requirements of Section 4.1 still required of issuers if the State is using the EDGE server?

- Response: The Health Care Commission appreciates this comment. The requirements of Section 4.1 would not be required if the State used the EDGE server. At this time, the State is working on a contract to implement the EDGE server in Delaware's reinsurance program.

FINDINGS OF FACT:

Some changes were made to the regulations since publication as proposed. The Department finds that the proposed regulations, as set forth in the attached copy, should be adopted in the best interest of the general public of the State of Delaware.

THEREFORE, IT IS ORDERED, that the proposed State of Delaware Regulations Governing Reinsurance is adopted and shall become effective December 11, 2019 (ten days), after publication of the final regulation in the Delaware *Register of Regulations*.

10/16/19
Date

DR. KARA ODOM WALKER
SECRETARY

Delaware Health Insurance Individual Market Stabilization Reinsurance Program and Fund

1.0 Purpose

1.1 The purpose of these Regulations is to establish procedures for the Delaware Health Insurance Individual Market Stabilization Reinsurance Program and Fund established pursuant to House Bill No. 193, 150th General Assembly for the purpose of stabilizing insurance rates and premiums in the individual market and providing greater financial certainty to consumers of health insurance in the State.

1.2 Policies and procedures for implementation of these regulations may be established in manuals and other documents by the Executive Director of the Delaware Health Care Commission or the Cabinet Secretary of Delaware Health and Social Services.

1.3 Nothing in these regulations shall preempt or otherwise conflict with any applicable state and federal laws and rules.

2.0 Authority

This regulation is promulgated pursuant to the authority granted in Chapter 99, Title 16, of the Delaware Code.

3.0 Definitions

The following definitions shall apply to this regulation:

"**Attachment point**" means the threshold dollar amount, adopted by the Executive Director, after which point the claims costs of an insured individual's covered benefits under a reinsurance-eligible health benefit plan in a benefit year are eligible for reinsurance payments.

"**Benefit year**" means a calendar year beginning on or after January 1, 2020 for which reinsurance eligible health benefit plan provides health insurance coverage.

"**Cabinet Secretary**" means the Cabinet Secretary of Delaware Health and Social Services.

"**Coinsurance rate**" means the rate at which the Executive Director may reimburse a reinsurance eligible health benefit plan for claims costs incurred after the attachment point and before the reinsurance cap for an insured individual's covered benefits in a benefit year.

"**Commission**" or "**DHCC**" mean the Delaware Health Care Commission created pursuant to 16 **Del.C.** §9902.

"**DHSS**" means Department of Health and Social Services.

"**DOI**" means Department of Insurance.

"**Executive Director**" means the Executive Director of the Delaware Health Care Commission or designee.

"**Health insurance carrier**" or "**carrier**" means any entity that provides health insurance in this State. For the purposes of this regulation, carrier includes an insurance company, health service corporation, health maintenance organization, managed care organization, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation. The entities providing insurance under the following types of plans do not meet the definition of carrier, per this regulation: plans of health insurance or health benefits designed for issuance to persons eligible for coverage under Titles XVIII, XIX, and XXI of the Social Security Act (42 U.S.C. §§1395 et seq., 1396 et seq., and 1397aa et seq.), known as Medicare, Medicaid; Chapter 52 of Title 29 of the Delaware Code; or any other similar coverage under state or federal governmental plans. Additionally, this regulation shall not apply to stand-alone dental insurance, stand-alone vision insurance, long-term care insurance, disability income insurance and all accident-only insurance.

"**Health insurance coverage**" means legal entitlement to payment or reimbursement for health care costs, generally under a contract with a health insurance company**[, or]** a group health plan offered in connection with employment**[, ~~or a government program like Medicare, Medicaid, or the Children's Health Insurance Program (CHIP)~~]**.

"**Program**" means the Delaware Health Insurance Individual Market Stabilization Reinsurance Program created by 16 **Del.C.** §9903(g).

"**Regulations**" mean all parts of the Rules and Regulations pertaining to the Delaware Health Insurance Individual Market Stabilization Reinsurance Program.

"**Reinsurance cap**" means the threshold dollar amount, adopted by the Executive Director, for claims costs incurred by a reinsurance eligible health benefit plan for an insured individual's covered benefits in a benefit year, after which threshold the claims costs for the benefits are no longer eligible for reinsurance payments.

"**Reinsurance eligible claim**" means a claim for services covered under a reinsurance eligible health benefit plan that is incurred by a reinsurance eligible issuer during the applicable benefit year and within the period of eligibility for the member that is paid by the reinsurance eligible issuer before June 1 of the following year. A reinsurance eligible claim shall not be adjusted for risk nor for pharmacy rebates. A reinsurance eligible claim does include a claim for certain abortion services, as defined in 45 C.F.R. §156.280(d)(1).

"**Reinsurance eligible health benefit plan**" means health insurance coverage offered on the individual market that:

1. Constitutes minimum essential coverage, as set forth in 26 U.S.C. §5000A(f);
2. Is approved by the State's **[~~health insurance commissioner~~ Insurance Commissioner]**;
3. Is delivered or issued for delivery by a carrier in the State; and
4. Is not a grandfathered plan as defined in §1251 of the Patient Protection and Affordable Care Act, 29 CFR §2590.715-1251.

"**Reinsurance eligible individual**" means an individual who is insured in a reinsurance eligible health benefit plan on or after January 1, 2020.

"**Reinsurance eligible issuer**" means a health insurance carrier that offers a reinsurance eligible health benefit plan to reinsurance eligible individuals.

"**Reinsurance payment**" means payments issued to a reinsurance eligible issuer in accordance with Section 6.0.

"**State**" means the State of Delaware.

4.0 Information Reporting

4.1 As a condition of receiving reinsurance payments from the program, a reinsurance eligible issuer must provide the following information to the program in the form and manner prescribed by the Executive Director:

4.1.1 The name and company code assigned to the reinsurance eligible issuer by the National Association of Insurance Commissioners;

4.1.2 The identification number assigned to the reinsurance eligible issuer by the DHCC;

4.1.3 The total amount of the reinsurance eligible issuer's reinsurance eligible claims for the benefit year;

4.1.4 The portion of the reinsurance eligible issuer's total reinsurance eligible claims for the benefit year that fall between the attachment point and reinsurance cap;

4.1.5 A summary data file containing **[~~the following~~ de-identified]** information for each reinsurance eligible individual with claims for which reinsurance payments are being requested:

4.1.5.1 **[~~The member identification number assigned by the reinsurance eligible issuer to the reinsurance eligible individual;~~**

~~4.1.5.2~~] The start and end dates of coverage for the reinsurance eligible individual;

[~~4.1.5.3~~4.1.5.2] The DHCC plan identification number for the reinsurance eligible health benefit plan in which the reinsurance eligible individual was enrolled;

[~~4.1.5.4~~4.1.5.3] The total amount of reinsurance eligible claims for the reinsurance eligible individual for the benefit year; and

[~~4.1.5.5~~4.1.5.4] The total amount of reinsurance eligible claims for the reinsurance eligible individual for the benefit year that fall between the attachment point and reinsurance cap.

4.1.6 If requested by the Executive Director**[~~, in conjunction with the final year-end report or an audit~~]**, a **[~~detailed~~ de-identified]** claims file extracted from the reinsurance eligible issuer's claims processing system that includes the issuer's complete record of all reinsurance eligible claims for the benefit year**[, in accordance with applicable state and federal confidentiality laws]**;

4.1.7 An attestation signed by an executive officer of the reinsurance eligible issuer stating that the information is accurate as of the date of submission; and

4.1.8 Any other information requested by the Executive Director that he or she deems necessary to administer the program**[, in accordance with applicable state and federal confidentiality laws]**.

4.2 In lieu of subsections 4.1.1 through **[~~4.1.5~~4.1.8]**, the State may enter a legal agreement with the Centers for Medicare and Medicaid Services (CMS), whereby the State shall use the CMS EDGE server for the purposes of the program.

4.3 Carriers must sign an attestation that they meet the submission and data requirements of the State Reinsurance Program through their participation in CMS EDGE Server.

4.4 As a condition of receiving reinsurance payments from the program, a reinsurance eligible issuer must submit **[~~the information required under subsection 4.1 to the DHCC:~~ one interim report due on March 31st after the benefit year, containing de-identified data from the prior benefit year with claims paid by February 28th, and an estimate of claims payments still outstanding. This report will be used to aid the Executive Director in setting parameters for future program years. The report shall be issued using a secure method of transmission approved by the Executive Director.**

~~4.4.1 Using a secure method of transmission approved by the Executive Director; and~~

~~4.4.2 On the following timeframes:~~

~~4.4.2.1 Upon request, one interim report during the benefit year for the purposes of estimating reinsurance payments;~~

~~4.4.2.2 One interim report due on February 15th after the benefit year, containing data from the prior benefit year with claims paid by January 31st, and an estimate of claims payments still outstanding. This report will be used to aid the Executive Director in setting parameters for future program years; and~~

~~4.4.2.3 One final report due June 30th after the benefit year, containing all reinsurance eligible claims incurred during the prior benefit year and paid by June 1st for the purposes of calculating final reinsurance payments to carriers.~~]

4.5 DHCC shall annually receive from the Department of Insurance the actual Second Lowest Cost Silver Plan premium under the Affordable Care Act 1332 waiver, 45 U.S.C. §18052, and an estimate of the premium as it would have been without the waiver.

5.0 Reinsurance Parameters

Annually, the Executive Director shall set an attachment point, cap, and coinsurance rate for the reinsurance program for the upcoming year based on anticipated revenue and recently reported premium, enrollment, and claims data.

6.0 Reinsurance Payments

6.1 A reinsurance eligible issuer becomes eligible for a reinsurance payment when the claims costs for at least one reinsurance eligible individual's covered benefits in a calendar year exceed the attachment point.

6.2 The Executive Director shall calculate the total reinsurance payment owed to each reinsurance eligible issuer.

6.2.1 Subject to subsections 6.2.2 and 6.2.3, the reinsurance payment made to each reinsurance eligible issuer for a benefit year will be the product of the coinsurance rate and the portion of the reinsurance eligible issuer's total reinsurance eligible claims for the benefit year that fall between the attachment point and the reinsurance cap.

6.2.2 The Executive Director shall uniformly reduce or increase the coinsurance rate to the extent necessary, but at no time shall the increase exceed 100%, to ensure that reinsurance payments **[~~equal~~ do not exceed]** the total available funding for the benefit year, as determined by the Executive Director in his or her sole discretion.

6.2.3 In making the calculation under subsection 6.2.1, the Executive Director in his or her sole discretion may disregard any or all reinsurance eligible claims reported by a reinsurance eligible issuer under Section 4.0 that cannot be verified as part of the audit described under subsection 7.1.

6.3 The program shall issue reinsurance payments to all reinsurance eligible issuers on an annual basis in the year following each benefit year. **[The Executive Director shall issue a payment schedule to all issuers.]**

6.4 Payments shall be made directly to reinsurance eligible issuers by a method designated by the Executive Director.

6.5 **[~~The program shall not issue reinsurance payments if~~ If]** the Executive Director determines that a reinsurance eligible issuer has substantively failed to comply with this regulation**[, he or she shall give notice thereof to the issuer stating the Executive Director's findings and stating how the nonconformance can be remedied. The Executive Director shall specify a time period for remedying the nonconformance. The program shall not issue reinsurance payments until the nonconformance is remedied]**.

7.0 Duties of the Administrator

7.1 The program shall be administered by the Executive Director. As administrator of the program, the Executive Director may:

7.1.1 Conduct an audit of the information submitted under Section 4.0.

7.1.2 Notify reinsurance eligible issuers of the results of the calculation described in Section 6.0, including any modifications of the coinsurance rate **[once HCC receives the results from CMS]**.

7.1.3 Issue reinsurance payments to each reinsurance eligible issuer in accordance with Section 6.0.

7.1.4 Assign the functions vested in him or her by the Delaware Health Insurance Individual Market Stabilization Reinsurance Program and these regulations to subordinate officers and employees as he or she deems necessary. The designee shall have the same power and authority that would be afforded to the Executive Director.

7.1.5 Contract with other state agencies and third parties as he or she deems necessary **[to administer the program]**.

7.1.6 Use, access, store, and disclose the information submitted to the program under Section 4.0, including disclosing the information to the **[~~Commissioner of the Department of Insurance~~ Insurance Commissioner, in accordance with applicable state and federal confidentiality laws,]** for the purposes of ensuring the efficient administration of the program and to reduce the reporting burden on issuers.

7.1.7 Submit an annual report to the Governor and General Assembly, in consultation with the DHSS and DOI **[and in accordance with applicable state and federal confidentiality laws]**.

7.1.8 Perform other functions he or she deems reasonably necessary to administer the program.

8.0 Document Retention and Audits

8.1 A reinsurance eligible issuer must maintain documents and records, whether paper, electronic, or in other media, sufficient to substantiate its requests for reinsurance payments made pursuant to this regulation for a minimum period of 10 years and must make those documents and records available to the program upon request by the Executive Director for purposes of verification, investigation, or audit**[, in accordance with applicable state and federal confidentiality laws]**.

8.2 The Executive Director may audit a reinsurance eligible issuer to assess its compliance with the requirements of this **[~~Section~~ regulation]**. The reinsurance eligible issuer must ensure that its relevant contractors, subcontractors, or agents cooperate with any audit under this Section. If an audit results in a finding of material weakness or significant deficiency with respect to compliance with any requirement of this Section, the reinsurance eligible issuer must complete all of the following:

8.2.1 Within 30 calendar days of the issuance of the final audit report, provide a written corrective action plan to the program for approval;

8.2.2 Implement that plan; and

8.2.3 Provide to the program written documentation of the corrective actions once taken.

8.3 If, at the conclusion of the audit, the Executive Director determines that a reinsurance eligible issuer received excess reinsurance payments, at the request of the Executive Director, the reinsurance eligible issuer shall return the excess payments to the program in a manner to be determined by the Executive Director within 60 days of his or her request.

9.0 Severability

If any provisions of this regulation or the application thereof to any person or circumstance shall be held invalid, such invalidity shall not affect the provisions or application of these regulations which can be given effect, and to this end the provisions of these regulations are declared to be severable.