DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DELAWARE HEALTH CARE COMMISSION
Delaware Health Care Commission

5001 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**" means 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 (DHCC) 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.

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

"**Regulations**" means 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 CFR §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 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.

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4.0 Information Reporting

4.1 The State entered into an intergovernmental agreement with the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS), to calculate reinsurance payments to issuers participating in the State of Delaware's reinsurance program under Delaware's State Innovation Waiver under section 1332 of the Patient Protection and Affordable Care Act. CMS will identify paid claims eligible for reimbursement under the reinsurance program from data submitted to "EDGE Servers."

4.2 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.

4.3 A reinsurance eligible issuer must submit 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 or February 29th, 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 EDGE Server, and not this report, shall be used to calculate the paid claims eligible for reimbursement under the reinsurance program. The report shall be issued using a secure method of transmission approved by the Executive Director. The Executive Director may, in his or her discretion, waive the interim report.

4.4 The interim report must contain the following data elements for the individual ACA plan:

4.4.1 De-identified Member ID;

4.4.2 Benefit Year Member Months;

4.4.3 Benefit Year Incurred Claims (paid through February 28th or February 29th of the current calendar year); and

4.4.4 Estimate of prior Benefit Year claim payments outstanding, e.g., to be paid after February 28th or February 29th of the current calendar year.

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.

4.6 If the State's participation in the CMS EDGE Server were to be discontinued, as a condition of receiving reinsurance payments from the program, a reinsurance eligible issuer would provide the following information to the program in the form and manner prescribed by the Executive Director:

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

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

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

4.6.4 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;

4.6.5 A summary data file containing de-identified information for each reinsurance eligible individual with claims for which reinsurance payments are being requested:

4.6.5.1 The start and end dates of coverage for the reinsurance eligible individual;

4.6.5.2 The DHCC plan identification number for the reinsurance eligible health benefit plan in which the reinsurance eligible individual was enrolled;

4.6.5.3 The total amount of reinsurance eligible claims for the reinsurance eligible individual for the benefit year; and

4.6.5.4 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.

4.6.6 If requested by the Executive Director 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;

4.6.7 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

4.6.8 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.

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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 Under the intergovernmental agreement with CMS, the Executive Director receives from CMS reports detailing the reinsurance payments on a cumulative basis, to date, 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 do not exceed the total available funding for the benefit year, as determined by the Executive Director in his or her sole discretion.

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 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.

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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 received 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 DHCC 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 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.

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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 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.

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