

State of Delaware
Department of Health and Social Services

Regulatory and Policy Report

August 12, 2011

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Version History

Version	Date	Comments
Version 1.0 – J. Paterson	July 20, 2011,	Initial draft
Version 1.1 – J. Paterson	August 12, 2011	Responses incorporated from Delaware comment and review

1 Executive Summary

This report will provide an overview of the federal law and proposed federal regulations regarding planning and establishing a state-administered health insurance exchange (Exchange). This report will also provide a review of the State of Delaware statutes and regulations that may impact or be impacted by the Exchange. The State review focuses specifically on the insurance and Medicaid legal framework and includes analyses of the areas in State law that has gaps or conflicts with federal law. After the statement of the overview of the law and the identification of potential gaps and conflicts in Delaware law, this report provides initial findings and recommendations for resolution.

The methodology for this review and analysis included an examination of the federal law and proposed federal regulations relating to the establishment of an Exchange. This analysis included creation of a matrix providing information about federal law and relevant State law, if available and applicable, and defines whether there is a gap in the current State of Delaware legal framework, as well as an initial recommendation to fill any gaps or provide any necessary statutory authorization.

Section 6 of this report details the findings and recommendations in accordance with the ACA guiding principles and priorities defined in federal guidance. The initial finding is that the State of Delaware has to, either by State statute or executive order, incorporate by reference or expressly state that it will provide all of the federally-required Exchange functions and oversight responsibilities. A key finding is the importance of the coordination of the Medicaid enrollment and eligibility changes as part of the regulatory updates required. Another important finding is the State should review the current insurance mandates and evaluate whether any of the State's mandates may fall outside of the federal definition of "essential health benefits" and become a financial liability for the State.

Although this report identifies gaps and potential conflicts within the State legal structure, Section 5.2 identifies the limits of this report. There are certain additional questions that are not addressed or identified as part of this report. Specifically, open questions remain regarding program integration and the governance and operation of the Exchange, including privacy and security. At the time that decisions are made regarding the operation of the Exchange, this report can be updated to reflect those decisions and the ongoing evolution of the federal regulatory scheme.

2 Introduction

The Patient Protection and Affordable Care Act (PPACA), along with the Health Care and Education Reconciliation Act of 2010, make up the new health care reform law (i.e., the ACA). Included in this legislation is the requirement that states establish Health Insurance Exchanges. The ACA provides alternatives to a state-administered Exchange, including deferring administration of the Exchange to the federal government or joining with other states to administer a regional Exchange. In addition to the federal legislation, Centers for Medicare and Medicaid Services (CMS) published a Notice of Proposed Rulemaking (NPRM) in the Federal Register Volume 76, No. 136 on Friday, July 15, 2011. The proposed rules provide the following regulations:

- Federal requirements that States must meet if they elect to establish and operate an Exchange;
- Minimum requirements that health insurance issuers must meet to participate in an Exchange and offer qualified health plans(QHPs); and
- Basic standards that employers must meet to participate in the Small Business Health Options Program (SHOP).

Based on the legal framework available, Public Consulting Group (PCG) has completed an initial assessment of the legal and policy implications of establishing a state-administered Exchange in the State of Delaware. This document presents the results of this assessment.

2.1 Statement of the Issues

The ACA and the proposed federal regulations provide the authority for the planning and establishment of an Exchange and, specifically, provide the initial authority for establishment of a state-based Exchange. Although the ACA provides for the establishment of an Exchange, there are State requirements and decisions around the Exchange that will impact the State of Delaware's legal and regulatory framework. This report provides a review and analysis of the State regulatory framework and identifies areas that will require resolution in order to provide for the successful implementation of the Exchange.

2.2 Objectives of the Review

1. Identify and summarize the Exchange requirements of the ACA.
2. Identify and summarize the current State statutes and regulations potentially impacted by the ACA for the establishment of the Exchange.
3. Identify gaps in the State regulatory framework that may impact the establishment of the Exchange.
4. Provide recommendations for Delaware regulatory and policy planning for the Exchange.

2.3 Scope of the Review

The scope of the review includes: 1) ACA Exchange requirements; 2) CMS proposed Exchange regulations, as defined in the NPRM; 3) Delaware State insurance statutes and regulations; and 4) Delaware Medicaid and Children's Health Insurance Program (CHIP) statutes and regulations.

2.4 Review Methodology

1. Review the federal requirements for the State of Delaware Exchange.
2. Review the State statutes and regulations that may impact the Delaware Exchange.
3. Create a matrix that identifies the ACA Exchange functions with the current State legal and regulatory framework, as applicable.
4. Identify gaps in the State legal and regulatory framework.
5. Present key findings and recommendations.

3 Federal Legal and Regulatory Framework

This section includes the overview of the federal law and proposed federal regulations relevant to establishing the Exchange in the State of Delaware. The Exchange will be implemented in compliance with the ACA and, thus, must include all of the functions required by the ACA. According to the ACA, the Exchange must do the following:

- Implement procedures to certify, recertify, and decertify QHPs;
- Provide for the operation of a toll-free hotline;
- Maintain a Website through which individuals can view standardized comparative information on plans;
- Assign a rating to each Exchange plan based on criteria developed by the Secretary of the United States Department of Health and Human Services (HHS);
- Use a standardized format for presenting Exchange plan options;
- Inform individuals of eligibility requirements for Medicaid, Delaware Healthy Children Program, or any other State or local medical assistance program. If, through the screening process, individuals are determined by the Exchange to be eligible for one of those programs, enroll them;
- Provide for a calculator to determine the actual cost of coverage to individuals after taking into account any premium credits and cost-sharing subsidies;
- Certify whether individuals are exempt from the individual mandate excise tax and transfer the list of such individuals to the Secretary of the United States Treasury Department;
- Provide to employers the name of the employees who dropped the employer's coverage and received premium tax credits because the employer's plan was unaffordable or did not provide the required minimum actuarial value; and
- Establish the Navigator program.

Additional Exchange functions include:

- Presentation of enrollee satisfaction survey results;
- Provision for open enrollment periods;
- Consultation with stakeholders, including Native American tribes; and
- Publication of data on the Exchange's administrative costs.

The Exchange is also required to follow the federal regulatory standards established for insurers so that they may be certified as a QHP by the Exchange, including:

- Marketing;
- Network adequacy;
- Accreditation for performance measures;

- Quality improvement and reporting; and
- Uniform enrollment procedures.

Additional areas where the Exchange must ensure plan compliance with regulatory standards established by HHS include:

- Information on the availability of in-network and out-of-network providers, including provider directories and availability of essential community providers;
- Consideration of plan patterns and practices with respect to past premium increases and a submission of the plan justifications for current premium increases;
- Public disclosure of plan data identified, including claims handling policies, financial disclosures, enrollment and disenrollment data, claims denials, rating practices, cost sharing for out of network coverage, and other information identified by HHS;
- Timely information for consumers requesting their amount of cost sharing for specific services from specified providers;
- Information for participants in group health plans; and
- Information on plan quality improvement activities.

4 Delaware Legal and Regulatory Framework

This section reviews and describes the current State regulatory framework that may be impacted by the establishment of the Exchange. This section also includes a brief discussion of the State of Delaware's planned legislative and executive activities.

4.1 Delaware Insurance Law

The insurance industry is primarily regulated through each state's Department of Insurance. The State of Delaware's insurance statute is found in Title 18 of the Delaware Code at:

<http://delcode.delaware.gov/title18/index.shtml#TopOfPage>

Title 18 is comprehensive and provides the framework for regulation of the industry through the Delaware Insurance Department. The following sections of the Delaware insurance code were examined to identify gaps and conflicts with the ACA related to establishment of the Exchange:

Title 18 – Insurance Code:

- Chapter 1 – General Definitions and Provisions
 - Section 103 – “Transacting insurance” defined.
- Chapter 3 – The Insurance Commissioner:
 - Section 318 – Examination of insurers.
 - Section 319 – Examination of agents, promoters and others.
 - Section 323 – Administrative procedures; hearings in general.
 - Section 328 – Appeal from the Commissioner.
 - Section 332 – Arbitration of disputes involving health insurance coverage.
 - Section 333 – Arbitration of disputes between insurance carriers and health care providers.
- Chapter 5 – Authorization of Insurers and General Requirements:
 - Section 505 – Certificate of authority required.
 - Section 511 – Capital funds required.
 - Section 515 – Application for certificate of authority.
- Chapter 7 – Fees and Taxes:
 - Section 702 – General premium tax; underwriting profits tax.
 - Section 713 – Reporting gross premiums received by life and health insurers; special fund for payments to all nonprofit organizations that provide ambulance or rescue services.
- Chapter 9 – Kinds of Insurance; Limits of Risk; Reinsurance:

- Subchapter I – Kinds of Insurance:
 - Section 903 – “Health insurance” defined.
- Chapter 11 – Assets and Liabilities:
 - Subchapter II – Liabilities and Reserves:
 - Section 1108 – Health insurance policy reserves.
- Chapter 17 – Licensing of Professional Insurance Personnel
- Chapter 24 – Insurance Fraud
- Chapter 25 – Rates and Rating Organizations
- Chapter 27 – The Insurance Contract:
 - Subchapter I – Insurance Contracts Generally
 - Section 2708 – Consent of insured; life, health insurance.
 - Section 2712 – Filing, approval of forms.
 - Section 2713 – Grounds for disapproval.
- Chapter 33 – Individual Health Insurance Contracts
- Chapter 35 – Group and Blanket Health Insurance
- Chapter 36 – Individual Health Insurance Minimum Standards:
 - Section 3603 –Standards for policy provisions.
 - Section 3604 – Minimum standards for benefits.
 - Section 3606 – Preexisting conditions.
 - Section 3607 – Limited guaranteed issue.
 - Section 3608 – Renewability of coverage.
- Chapter 38 – Dental Plan Organization Act
- Chapter 40 – Health Insurance for Children and Persons on Medicaid
- Chapter 44 – Delaware Life and Health Insurance Guaranty Association Act
- Chapter 61 – Prohibition of Rescissions Based Upon Post-Claims Underwriting
- Chapter 63 – Health Service Corporations
- Chapter 64 – Regulation of Managed Care Organization
- Chapter 72 – Small Employer Health Insurance
- Chapter 73 – Pharmacy Access Act
- Chapter 74 – The HIV Testing for Insurance Act
- Chapter 76 – Discount Medical Plans

4.2 Delaware Medicaid Regulatory Framework

In addition to impacts to the insurance regulatory framework, establishment of the Exchange may impact the Medicaid statute and regulations and the CHIP statute and regulations. The Delaware Department of Health and Social Services, Division of Social Services and the Division of Medicaid and Medical Assistance (DMMA) administer the Medicaid and the Delaware Healthy Children Programs. The federal statutes for the Medicaid program and CHIP program are found in the Social Security Act Title XIX at 42 U.S.C. 1302 et. seq.(Medicaid) and Title XXI (CHIP). The federal rules for these programs are found at 42 Code of Regulations (CFR) Parts 430-499. The Delaware authority is found in 31 Del.C. §502(5), §503 (b), and §505 (3) and administrative regulations found in the Delaware Administrative Code – Title 16 Health and Human Services 5100 Delaware Social Services Manual (Sections 14000-20000, Sections 14000, 15000, 16000, 17000, and 20000).

Title 31 – Welfare Code

<http://delcode.delaware.gov/title31/index.shtml#TopOfPage>

Title 31 Chapter 5 – State Public Assistance Code

<http://delcode.delaware.gov/title31/c005/index.shtml>

Delaware Administrative Code – Title 16 Health and Human Services 5100 Delaware Social Services Manual Sections 14000-20000

<http://regulations.delaware.gov/AdminCode/title16/5000/5100/index.shtml#TopOfPage>

In 2014, in compliance with the ACA, Delaware Medicaid will cover the expansion population: 1) employing the new uniform income rules; 2) using the no asset or resource test; 3) applying the new federal matching rates; 4) continuing the existing cost sharing and immigrant status rules; and 5) extending Medicaid coverage to persons under 26 who were in foster care at age 18. The State of Delaware's current Medicaid regulations will need to be amended to incorporate the requirements for the new eligible population. One of the most important changes will be the income test based on modified adjusted gross income (MAGI). Transition to MAGI will require change in the way Medicaid eligibility is determined and processed by the State.

4.3 Other Delaware Law

The Exchange may also impact other State statutes. The following State of Delaware titles were reviewed:

16 Del.C. § 30B - Through this code Delaware provides prescription assistance for individuals 65 years old or older with income up to 200 percent of the Federal Poverty Level (FPL), who are ineligible for or do not have prescription drug benefits or coverage through federal (excluding Medicare Part D coverage),

State, or private sources. This statute has implementing regulations found in the Delaware Administrative Code at Title 16 Sections 30000 et. seq.

<http://regulations.delaware.gov/AdminCode/title16/5000/5100/30000/30000%20Delaware%20Prescription%20Assistance%20Program.shtml>

Delaware also provides a State-funded Community Health Access Program (CHAP) for lower income residents of Delaware who: 1) are uninsured; 2) are ineligible for State medical assistance programs; meet financial eligibility guidelines, including the Delaware Cancer Treatment Program for uninsured Delaware residents diagnosed with cancer after July 1, 2004; and have household incomes up to 650 percent of the FPL.

Title 5 – Banking:

- Chapter 7 – Corporation Law for State Banks and Trust Companies:
 - Subchapter II – Formation of Bank or Trusts Company

Title 6 – Commerce and Trade:

- Chapter 12A – Uniform Electronic Transactions Act
- Chapter 21 – Antitrust:
 - Section 2103 – Restraint of trade unlawful.
 - Section 2104 – Exemptions.

Title 16 – Health and Safety:

- Chapter 8A – Universal Newborn and Infant Hearing Screening
- Chapter 12 – Informed Consent and Confidentiality:
 - Subchapter II – Genetic Information
- Chapter 26 – Childhood Lead Poisoning Prevention Act
- Chapter 99 – Delaware Health Care Commission:
 - Subchapter III – Delaware Health Program:
 - Section 9909 – Delaware Healthy Children Program.
- Chapter 103 – Delaware Health Information Network

4.4 Delaware Administrative Regulations

Delaware has robust administrative regulations that can be found at:

<http://regulations.delaware.gov/AdminCode/title18/index.shtml#TopOfPage>

The specific relevant administrative code sections reviewed are found in the following:

Title 18: 901-907 – Consumer Rights

<http://regulations.delaware.gov/AdminCode/title18/900/index.shtml#TopOfPage>

Title 18 - 1301-1313 – Health Insurance General

<http://regulations.delaware.gov/AdminCode/title18/1300/index.shtml#TopOfPage>

Title 18 – 1400 Health Insurance Specific Provisions

<http://regulations.delaware.gov/AdminCode/title18/1400/index.shtml#TopOfPage>

4.5 Delaware Current Mandatory Health Insurance Requirements

PPACA §1311(d)(3) states that if Delaware mandates QHPs to cover certain health benefits and services, beyond what is federally required in 2014, then Exchange plans must be reimbursed by the State of Delaware for the additional costs associated with those benefits. ACA provisions state that federal assistance will not be available for costs attributable to state-mandated benefits. Delaware is currently conducting a review and evaluation of the current Delaware insurance mandates listed below compared to the preliminary broad list of federal essential health benefits.

Newborn Children – Required for both individual and group health policies – 18 Del. C. §3335 and §3550 – Coverage from birth.

Newborns and Mothers Health Protection – Required for both individual and large employer policies – 18 Del. C. § 3341 and §3576 – Plans must comply with the provisions of federal law.

Newborn and Infant Hearing Screening – Required for individual and group health insurance policies – 18 Del. C. § 3352 and §3568 – Requires coverage for hearing loss screening tests of newborns and infants provided by a hospital before discharge.

Child Immunizations – Group health insurance – 18 Del. C. § 3558 – Requires coverage for immunizations from birth to 18 years of age, including: diphtheria, hepatitis B, measles, mumps, pertussis, polio, rubella, tetanus, varicella, haemophilus influenzae b, and hepatitis A.

Lead Poisoning Screening – Required for individual and group health policies – 18 Del. C. § 3337 and §3554 – Benefits are provided for outpatient services. The policy is required to provide a benefit for a baseline screening test at or around 12 months of age and must provide benefits for screening and diagnostic evaluations for children under the age of six who are at high risk.

Obstetrical and Gynecological Coverage – Required for both individual and group policies – 18 Del. C. § 3342 and §3556 – Permits a female insured to designate her obstetrician-gynecologist as the primary care physician. Permits a female insured to have direct access to her in-network obstetrician-gynecologist without a referral in instances where a primary care physician other than the ob-gyn was chosen.

Midwife Services Reimbursement – Required for individual and group health policies – 18 Del. C. § 3336 and §3553 – Requires payment of benefits for services of a duly licensed midwife practicing within the scope of licensure. Also requires payment for facilities used by the midwife.

Reconstructive Surgery Following Mastectomies – Required for individual and group health policies – 18 Del. C. § 3347 and §3563 – Requires coverage for reconstruction if benefits for a mastectomy are paid.

Cancer Monitoring Test – Required for individual and group health insurance policies – 18 Del. C. §3338 and §3552 – Requires coverage of CA-125 monitoring of ovarian cancer following treatment.

Cancer Screening Tests:

- Pap Smear – 18 Del. C. §3345 – Individual health insurance policies are required to provide benefits for an annual pap smear for all females age 18 and over if the policy provides benefits for outpatient services.
- Pap Smear – 18 Del. C. § 3552(a) – Group health insurance policies that provide benefits for outpatient services must provide benefit for pap smears. 18 Del. C. §3561 – Group health insurance requires coverage for an annual pap smear for all females aged 18 and over.

Mammography – 18 Del. C. §3552(c) – Group health insurance policies must cover periodic mammographic exams beginning at age 35.

PSA – 18 Del. C. § 3552(b) – Group health insurance policies that provide benefits for outpatient services must provide benefit for persons age 50 and above.

Colorectal Screening – Individual and group health insurance – 18 Del. C. § 3346 and §3562 – Require coverage for persons 50 years and older and for those deemed at moderate risk.

Diabetes – Individual and group insurance – 18 Del. C. §3344 and §3560 – Require coverage of insulin pumps, blood glucose meters and strips, urine testing strips, insulin, syringes, and pharmacological agents for controlling blood sugar. The benefits are to be provided to the same extent as for any other sickness under the contract.

Reversible Contraceptives – Group health insurance – 18 Del. C. § 3559 – Requires coverage of FDA-approved prescription contraceptive drugs and devices and for outpatient services related to the used of contraceptive methods to prevent unplanned pregnancy.

Mental Health – Large employer insurance – 18 Del. C. § 3576 – Requires compliance with federal law regarding mental health parity.

Serious Mental Illness and Drug and Alcohol Dependency – Individual and large employer insurance – 18 Del. C. § 3343 and §3578 (Large Groups) – Require coverage for biologically-based serious mental illness on the same basis as any other illness. The code permits benefit management. The section does not apply to out-of-network services.

Clinical Trials – Individual and group health policies – 18 Del. C. §3351 and §3567 – Require coverage for routine patient care cost defined in the code for covered person engaging in clinical trials for treatment of life threatening diseases.

Prescription Medication – Individual and group health insurance – 18 Del. C. §3350 and §3566 – Requires coverage for any outpatient drug prescribed to treat a covered chronic, disabling, or life-threatening illness if the drug has been FDA approved and is recognized for treatment of the indication of the drug. Coverage will include medically necessary services associated with the administration of the drug. This applies to policies that provide coverage for outpatient prescriptions.

Emergency Care – Individual health and group health insurance – 18 Del. C. § 3349 and §3565 – Require coverage for treatment by a non-network provider. Provisions of the code do not apply to volunteer fire departments.

Referrals – Individual health and group health policies – 18 Del. C. § 3348 and §3564 – Require that carriers permit a network provider to refer a patient to an out-of-network provider under certain circumstances and protect the patient from balance billing by the non-network provider.

Child Abuse or Neglect – Individual and group health policies – 18 Del. C. §3340 and §3557 – Prohibit carriers from limiting coverage for any child referred by the Division of Family Services or a law enforcement agency for suspected child abuse or neglect. The carrier may not require a referral by the primary physician.

Supplemental Coverage for Children of Insureds – 18 Del. C. §3570 - Required for individual and group coverages. If a carrier's contract with a subscriber provides coverage for a covered person's dependent under which coverage of the dependent terminates at a specific age before the dependent's 24th birthday, the contract must nevertheless provide coverage to the dependent after that specific age until the dependent's 24th birthday. A dependent covered by a covered person's contract, where coverage under the contract's language would terminate at a specific age before the dependent's 24th birthday, may make a written election for coverage as a dependent pursuant to this section, until the dependent's 24th birthday. The election must be made:

(g) A covered person's contract may require payment of a premium by the covered person or dependent, subject to any approvals required by Delaware law, for any period of coverage relating to a dependent's written election for coverage pursuant to subsection (d) of this section. The payment may not exceed 102 percent of the applicable portion of the premium previously paid for that dependent's coverage under the contract prior to the termination of coverage at the specific age provided in the contract.

Phenylketonuria and Other Inherited Metabolic Diseases – 18 Del. C. §3355 and §3571 - Individual and group plans – A diseases health insurance contract shall, under the family member coverage, include coverage for medical formulas and foods and low protein modified formulas and modified food products for the treatment of inherited metabolic diseases, if such medical formulas and foods or low protein modified formulas and food products are:

(1) Prescribed as medically necessary for the therapeutic treatment of inherited metabolic, and (2) Administered under the direction of a physician. (Chapters 3354 and 3570.)

Scalp Hair Prosthesis – 18 Del. C. §3356 and §3571B – All group and blanket health insurance policies, contracts or certificates that are delivered or issued for delivery in the State by any health insurer, health service corporation, or managed care organization (MCO) that provides for medical or hospital expenses and also provides coverage for other prostheses, shall provide coverage for expenses for a scalp hair prosthesis worn for hair loss suffered as a result of alopecia areata, resulting from an autoimmune disease. Such coverage shall be subject to the same limitations and guidelines as other prostheses, provided that such coverage for alopecia areata shall not exceed \$500 per year.

Hearing Aid Coverage – Individual and group – 18 Del. C. §3357 and §3571A – Every group and blanket health insurance contract, including each policy or contract issued by a health service corporation, that is delivered, issued for delivery, or renewed in the State on or after January 1, 2009, shall provide coverage of up to \$1000 per individual hearing aid, per ear, every three years, for children less than 24 years of age, covered as a dependent by the policy holder.

Dental Services for Children with a Severe Disability – Individual and group – 18 Del. C. §3357 and §3571C – Every contract or policy described in subsection (b) of this section shall authorize payment to a licensed practitioner for dental services to a child with a severe disability irrespective of lack of contractual or network status. Unless otherwise negotiated with the practitioner in advance, such payment shall be in an amount at least equal to the insurer's reasonable and customary compensation for the same or similar services in the same geographical area. A non-network practitioner accepting payment under this section may not balance bill the insured.

Screening of Infants and Toddlers – Individual and group – 18 Del. C. §3360 and §3571D – Every health insurance policy covered by this section shall entitle children covered by the policy to receive developmental screenings at ages 9 months, 18 months, and 30 months.

4.6 Delaware Health Care Commission

The Delaware Health Care Commission (the Commission) was created by legislation (16 Del.C. c. 99) to assess the barriers to health care and to develop a pathway to basic, affordable health care for all Delawareans. Four government officials – the Secretary of Finance, Secretary of Health & Social Services, Secretary of Children, Youth & Their Families, and the Insurance Commissioner – are joined by six private citizens appointed either by the Governor, the Speaker of the House, or the President Pro Tempore of the Senate.

The Commission is a policy-setting body and is authorized to conduct pilot projects to test methods for catalyzing private-sector activities that will help the State meet its health care needs.

4.7 Proposed State Legislation/Executive Order

The State of Delaware considered the initial question of whether to establish a State-based Exchange, participate in a regional Exchange, or defer to the federal government. As it considered this question, the State considered the governance and administrative requirements for the Exchange. All of the options for governance were reviewed and considered. Specifically, the State of Delaware considered the following options:

- State agency (existing or newly created);
- Quasi-public authority; or
- Non-profit entity.

The State of Delaware also analyzed the prime considerations for establishment of a State-based Exchange including:

- Control/authority over a portion of the commercial health insurance market;
- Funding and feasibility of establishing and operating the Exchange;
- Uncertainty over how the federal government will operate the Exchange;
- Ability to collaborate with other states in a timely fashion; and
- Coordination of benefits across State programs.

The State will continue to review and analyze the Exchange requirements for a State-administered, federal, and regional exchange and may execute an Executive Order and/or introduce legislation for the 2012 or 2013 sessions as required to meet the ACA requirements.

5 Regulatory Gap Analysis

This section of the report provides the gap analysis of the Exchange legislative and regulatory framework. Specifically, this section will provide information regarding whether the current State of Delaware statutes and regulations provide the necessary authority to establish the Exchange in accordance with the ACA. In the event the State statutes and regulations are missing specific provisions required, or the statutes and regulations are incomplete or in conflict with the federal legislation or regulations, this section lists and evaluates the impact of the missing, incomplete, and/or conflicting regulatory framework. Sections 5.1 through 5.9 provide a summary of the Exchange functions and Section 5.10 provides a matrix of the Exchange functions with the relevant Delaware citation and identification of the gap with a high level resolution.

PCG focused on the business operations areas of the Exchange as described in Sections 5.1-5.9 below and compared the State of Delaware's regulations with the ACA requirements. The matrix in Table 1 provides the business operations areas, ACA citation, and Delaware code or administrative regulation citation. The table also provides additional information regarding whether there is a gap in the current State regulatory framework, or if current State law is in conflict with ACA provisions.

5.1 Establishment of an Exchange

The ACA requires that by January 1, 2014, each state must have an exchange to facilitate access to insurers' QHPs. To accomplish the establishment of an Exchange, planning and establishment grants are available from HHS. Additional funding through "cooperative agreements" is available to states making progress in establishing an Exchange, implementing ACA's private health insurance market reforms, and meeting other benchmarks. However, no funding will be available after January 1, 2015. Exchanges will have to be self-sustaining by then, using assessments on insurers or other funding options to generate revenues to support Exchange operations. The State of Delaware is currently assessing the most appropriate legal mechanism, governance, and operational model for the State's Exchange.

5.2 Establishment of a Basic Health Program for Low Income Individuals Not Eligible For Medicaid

The ACA creates an optional program for coverage of lower-income individuals not eligible for Medicaid called the Basic Health Program (BHP). The BHP option allows states to establish a separate health coverage program for individuals and families who are not eligible for Medicaid, have not reached the age of 65, and whose household income exceeds 133 percent, but does not exceed 200 percent of the FPL. Eligible individuals would be those under 200 percent of the FPL who would otherwise be eligible for advance premium tax credits through the Exchange. However, an individual eligible for a state's BHP would not be eligible for Exchange coverage.

Federal funding for the BHP will be based on 95% of the funding that would have been provided to individuals had they purchased coverage through the Exchange. The BHP must provide "platinum" level benefits for individuals and families with income up to 150% FPL and "gold" level benefits for individuals and families with income between 150% and 200% FPL. The

premiums charged can be no greater than what the member would have paid for “silver” level coverage through the Exchange.

The State of Delaware is currently assessing whether to establish a BHP and would likely need statutory authority to implement this optional program.

5.3 Eligibility

Individual Eligibility: The Exchange is open to any legal resident not incarcerated. Individuals who are eligible to participate in the Exchange may be eligible for an advance premium tax credit and/or cost sharing reduction. Effective January 1, 2014, individuals and families with income up to 400 percent FPL who do not qualify for Medicaid coverage and who meet other Exchange eligibility requirements will be provided advance premium tax credits and reduced cost-sharing for commercial health insurance offered through the Exchange.

Employers: The Exchange will be available to the small group market, which the ACA defines as 1-100 workers, with the option for states to define the market as 1-50 until January 1, 2016, at which time employers with up to 100 employees must be allowed to purchase coverage through the Exchange, and the State’s small group market will be expanded to include groups with 51 to 100 employees.

- Starting in 2017, states may allow employers with more than 100 employees to participate in the Exchange. (ACA §1312(f).)
- Members of Congress and congressional staff may only be offered health plans created by the ACA or offered through an Exchange. (ACA §1312(d).)

18 Del. C. §7202 currently identifies a small employer as an employer that employs no more than 50 employees. As stated above, ACA provides the option for Delaware to leave its current definition of the small employer until 2016 or change its statute to define the small employer as an employer with up to 100 employees. Delaware is currently assessing whether to change the current Delaware definition.

Medicaid: Current Medicaid eligibility in the State of Delaware includes 30 different types of covered groups with different eligibility criteria. The ACA requires all state Medicaid programs to expand eligibility to include all non-elderly, non-pregnant individuals with income at or below 133 percent FPL who were previously ineligible for Medicaid. With an additional 5 percent income disregard, the FPL eligibility threshold will be effectively expanded to include individuals and families with modified adjusted gross income at or below 138 percent FPL. Until additional federal regulations and guidance are issued regarding these newly eligible populations, the full impact of the expansion cannot be determined, other than to conclude that there will likely be additional Medicaid-related regulations required, and probable amendments to the Delaware State Medicaid Plan.

Delaware Health Children Program: This program is the State of Delaware CHIP program established under Title XXI of the Social Security Act.

Modified Adjusted Gross Income: Mandatory use of MAGI for eligibility determination; required five percent income disregard (effectively increasing upper limit to 138 percent FPL); and, prohibited use of resource or asset test for most Medicaid beneficiaries.

Advance Premium Tax Credits: This requirement ties premium tax credits to coverage purchased exclusively through the Exchange. Qualifying individuals and families will receive advance premium tax credits toward the purchase of an Exchange plan (although the advance payment will actually go directly to the insurer). Premium tax credits are available to those with household incomes up to 400% FPL for the family size. Premium tax credits are the lesser of the following amounts:

- Total monthly premium for QHP; ***or***
- The excess of the adjusted monthly premium for the second-lowest-cost silver plan, over a defined percentage of household income as defined by the FPL.
 - Up to 133% FPL = 2.0% of income
 - 133-150% FPL = 3.0% -4.0% of income
 - 150-200% FPL = 6.3%-8.05% of income
 - 200-300% FPL = 6.3%-9.5% of income
 - 300-400% FPL – Capped to 9.5% of income

Individuals above 400 percent FPL will not be eligible for premium tax credits but will be eligible to purchase unsubsidized coverage through the Exchange.

Cost Sharing: Those who qualify for premium tax credits and are enrolled in an Exchange plan at the silver tier will also be eligible for assistance in paying any point-of-service cost-sharing. Exchange plans will be required to limit out-of-pocket costs based on high deductible health plans (HDHPs) limits. For 2011, the out-of-pocket maximum for HSA-qualified HDHPs is \$5,950 for single coverage and \$11,900 for family coverage. The cost-sharing subsidies will further reduce those out-of-pocket maximums by two-thirds for qualifying individuals and families between 100 percent and 200 percent FPL, by one-half for qualifying individuals and families between 201 percent and 300 percent FPL, and by one-third for qualifying individuals and families between 301 percent and 400 percent FPL. The Secretary of HHS will make periodic payments to insurers (potentially using capitated, risk-adjusted payments) for the cost-sharing subsidies of their qualified enrollees. There are no cost-sharing for American Indians under 300% FPL enrolled in individual market coverage through the Exchange.

Enforcement of the Individual Mandate: The ACA includes an individual mandate as of 2014 to maintain health insurance with tax penalties for noncompliance. In other words, individuals who do not maintain acceptable health insurance coverage for themselves and their children will be required to pay an additional tax (with some exceptions). Legal aliens are covered by the requirement to maintain health insurance. Illegal aliens are expressly exempted from this mandate. The Exchange will need to establish a mechanism by which an individual may apply for an exemption from the individual mandate, based on affordability (i.e., premium is greater than eight percent of MAGI), religious beliefs or hardship. The Exchange must provide the Secretary of the United States Treasury with the names and the taxpayer identification number of each of the individuals who are granted an exemption from the individual mandate.

HHS Verification: Section 1411 of the ACA requires that the Secretary of HHS establish a program to determine whether an individual who is to be covered in the individual market by a QHP offered through an Exchange or who is claiming a premium tax credit or reduced cost-sharing is a citizen or national of the United States or an alien lawfully present in the United States. The verification system will use three pieces of personal data to verify citizenship and immigration status. The Social Security Administration (SSA) will verify the name, social security number, and date of birth of the individual. For individuals who do not claim to be United States citizens but attest to being lawfully present in the United States, the attestation will be considered substantiated if it is consistent with Department of Homeland Security (DHS) data. The ACA requires such verification of all individuals seeking Exchange coverage, regardless of whether they would be federally subsidized or would pay premiums entirely on their own.

Small Business Qualification for Tax Credit: Beginning in tax year 2011, ACA will provides a two-year tax credit to eligible small businesses that provide employer-sponsored insurance to their employees. The amount of the tax credit is set on a sliding scale and decreases depending upon the number of employees and the wages they earn. Beginning in 2014, small business tax credits will only be available for coverage purchased through the Exchange.

5.4 Enrollment/Disenrollment

Administrative Simplification: HHS has developed and published interim final federal rules in the Federal Register on July 8, 2011 for the electronic exchange of health information, transaction standards for electronic fund transfers, and requirements for financial and administrative transactions. (ACA §1104.). The rules can be found at 45 CFR Parts 160 and 162.

Applying for Coverage: Medicaid and CHIP Enrollment Simplification – The State of Delaware Department of Health and Social Services (DHSS) will develop a single form that will allow individuals to apply for enrollment in Medicaid, CHIP, or Exchange subsidies and receive a determination of eligibility. Exchanges are required to inform individuals of eligibility requirements for Medicaid and CHIP. If an Exchange determines that such individuals are eligible for any such program, Exchanges are required to enroll such individuals in such program. (ACA §§1311, 1413 and proposed 45 CFR §155.405.)

Plan Comparison: Consumers must be given choices through the Exchange and be able to effectively compare the plan offerings.

Plan Management: QHPs are managed by the Exchange and:

- Are certified;
- Provide the essential health benefits package;
- Are offered by an issuer that is licensed and in good standing in Delaware;
- Agree to offer at least one silver plan and one gold plan;
- Agree to charge the same premium whether the plan is sold through the Exchange or outside the Exchange; and
- Comply with all other requirements.

Continuity of Coverage: The Exchange must develop standards for a summary of benefits and coverage explanation to be provided to all potential policyholders and enrollees. This summary will include:

- Uniform definitions;
- A description of coverage and cost sharing for each category of essential benefits;
- Exceptions, reductions, and limits in coverages;
- Renewability of the continuation of coverage provisions;
- A “coverage facts label;” that illustrates coverage under common benefits scenarios;
- A statement of minimum essential coverage with an actuarial value of at least 60 percent that meets the requirements of the individual mandate;
- A statement that the outline is a summary and to consult actual policy language; and
- A contact number for consumers.

Open Enrollment Management: Exchanges must provide for an initial open enrollment period, annual open enrollment periods after the initial period, special enrollment periods under circumstances similar to those for Medicare prescription drug plans (PDPs), and a special enrollment period for Native Americans. The NPRM for Exchanges provides additional details regarding enrollment management. The proposed rule identifies an initial open enrollment period that would run from October 1, 2013 through February 28, 2014, with shorter annual enrollment periods (October 15 through December 7) in subsequent years.

5.5 Administration

Exchanges will be required to handle some administrative functions currently handled by insurers, which may reduce insurers’ administrative burden and expenses for the individual and small group markets. For example, Exchanges will be responsible for operating a toll-free telephone hotline to respond to requests for assistance, maintaining a Website through which enrollees and prospective enrollees shop for plans, enrolling applicants in the plan of their choice, and coordinating with other federal and State agencies regarding potential subsidies that would go to health insurers on behalf of eligible individuals.

Appeals: The ACA requires non-grandfathered plans to make two changes to their appeal process, imposing a new requirement for an external review and making changes to the internal appeal provisions that plans already have in place. Under the ACA, these protections are being extended to include the individual market and group health plans not previously subject to the federal requirements. The ACA also requires external independent review be made available either under applicable state law or, for coverage not subject to the state independent review laws, under a new federal process. Proposed rule 45 CFR §155.200 (d) also requires the Exchange to have an appeal process for eligibility determinations.

Certification/Decertification/Recertification of QHPs: The ACA requires the Secretary of HHS to promulgate regulations establishing criteria for the certification of health plans as QHPs. The Exchange, in turn, must implement procedures for the certification, recertification, and decertification of health plans as QHPs, consistent with guidelines developed by the Secretary of HHS. The proposed regulations at 45 CFR §155.1010 provide the initial certification requirements. Under section 1311(e)(1) of the ACA, an Exchange may certify a health plan as a QHP if: (A) the health plan meets the standards for certification

as set forth in regulations promulgated by the Secretary of HHS; and (B), the Exchange determines “that making available such health plan through such Exchange is in the interests of qualified individuals and qualified employers in the State or States in which such Exchange operates....” An exception to subsection (B) prevents an Exchange from excluding a health plan: (i) on the basis that a plan is a fee-for-service plan; (ii) by imposing premium price controls; or (iii) on the basis that the plan provides treatments necessary to prevent patients’ deaths in circumstances the Exchange determines are inappropriate or too costly. QHPs will be required to meet the federal regulations for certification found at 45 CFR § 156.285. The Exchange has the authority to decertify plans that no longer meet the certification requirements. The proposed decertification regulation is found at 45 CFR §155.1080.

Fraud Detection: The ACA makes important changes in the federal fraud and abuse laws. Payments made by, through, or in connection with an Exchange that include any federal funds are subject to the federal False Claims Act (the “FCA”). In addition, compliance with the requirements of the ACA concerning eligibility for a health insurance issuer to participate in the Exchange shall be a material condition of an issuer’s entitlement to receive payments, including payments of premium tax credits and cost-sharing reductions, through the Exchange. Exchanges will be subject to annual audits and the State agency with enforcement can investigate and implement other financial integrity provisions. (Sections 1311(b), 1312(d), and 1313).

5.6 Financial Management

The Exchange will be required to account for its expenditures (ACA Section 1311(d), 1313).

Premium Payment Subsidy: Section 1401(36B) of the ACA explains that the subsidy will be provided as an advanceable, refundable tax credit and gives a formula for its calculation.

The Exchange will also be required to complete financial accounting and management for the following:

- Delinquency management;
- Premium aggregation;
- Funding management; and
- Treasury Communication.

5.7 Exchange Website

Health Care Reform Insurance Web Portal Requirements - Section 1103(a), as amended by Section 10102(b) of the ACA, requires the establishment of an internet website through which individuals and small businesses can obtain information about the insurance coverage options that may be available to them in their state. HHS has issued an interim final rule in at 45 CFR § 159 in order to implement this mandate. This interim final rule adopts the categories of information that will be collected and displayed as Web portal content, and the data required from issuers and request from states, associations, and high risk pools in order to create this content.

Navigators: Exchanges will award grants to “Navigators,” such as trade and professional associations, consumer organizations, unions, chambers of commerce, insurance agents and brokers, and resource partners of the Small Business Administration. The Navigators will:

1. Conduct public education activities;
2. Distribute fair and impartial information about QHPs and the availability of premium tax credits and cost-sharing reductions for eligible individuals;
3. Facilitate enrollment; and
4. Provide referrals to health insurance consumer assistance, health insurance ombudsman, or any other appropriate state agency for enrollees with grievances, complaints, or questions about their health plan, coverage, or a claim determination.

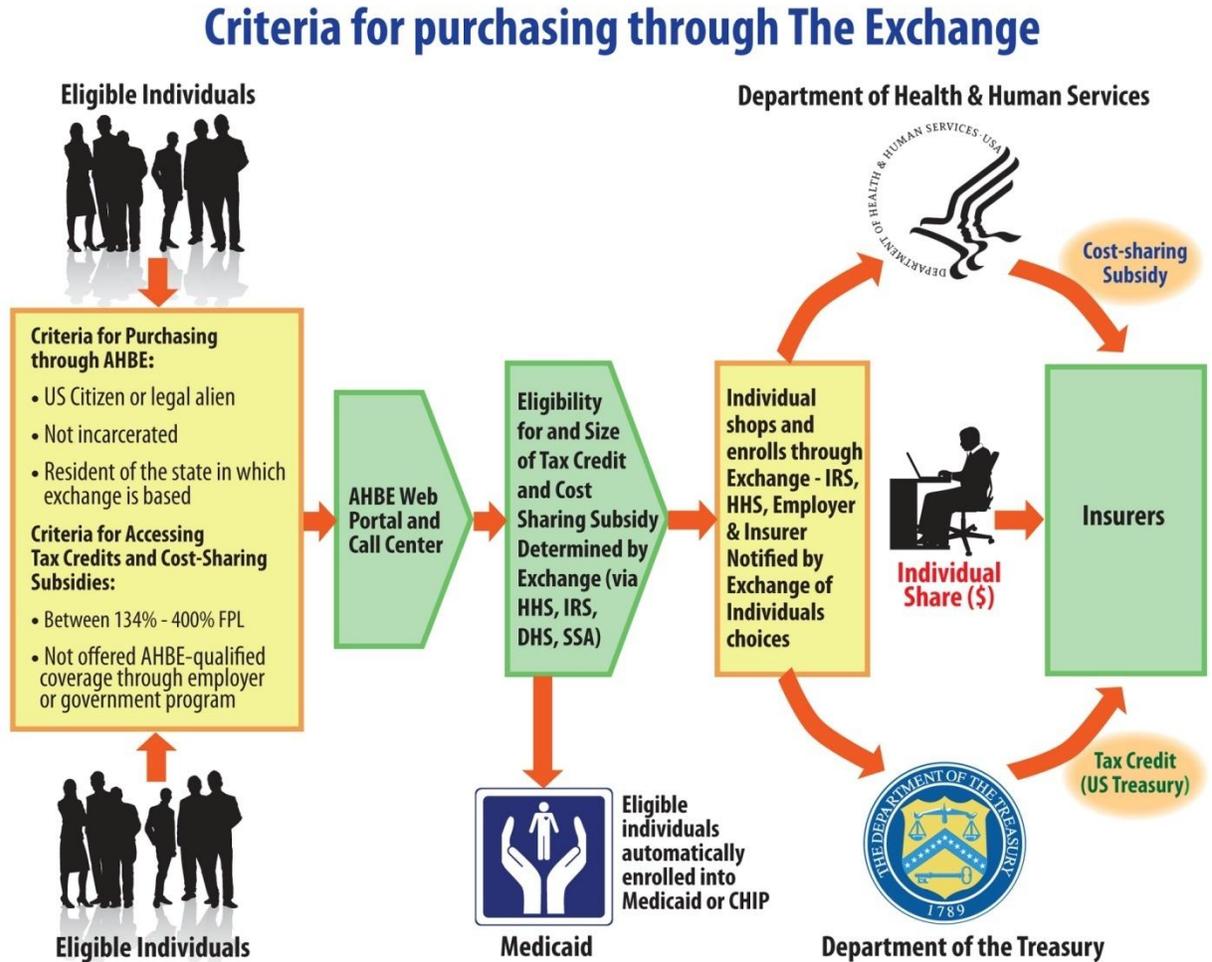
It is clear that Navigators will need to meet standards and may not be health insurance issuers. There are several important unanswered questions regarding state regulation of Navigators. At this time, the State of Delaware is continuing to assess whether to require a license or certification for Navigators, how the Navigators may be identified, and, ultimately, whether and to what degree Navigators will require regulation. (ACA §§1311(i), 10104(h).)

Special Rules: The State may prohibit QHPs offered through the Exchange from covering abortions. (ACA Section 1303). The proposed federal rules at 45 CFR Part 156.280 codify the ACA provision and include information regarding .the non-discrimination clause for providers and facilities, a voluntary choice clause for issuers with respect to abortion services, the standards for the segregation of funds for QHP issuers that elect to cover abortion services for which public funding is prohibited, and the associated communication requirements related to such services.

5.8 Privacy and Security

The below diagram provides a high level flow of information into and through the Exchange. At the time the governance and operations are determined, specific information will be developed for the State of Delaware, and the diagram below illustrates the type of information that will be included. This information is most likely covered by the Health Insurance Portability and Accountability Act (HIPAA) privacy and security standards, as well as any applicable Delaware privacy statutes and regulations.

Figure 1: Criteria for Purchasing Through the Exchange



Data governance is an important consideration for the Exchange and will be considered at the time that the final governance and operational structure is determined. Prior to having these decisions, PCG knows that HIPAA applies including the new proposed rule at 45 CFR §155.260 et. seq. and, most likely, any State of Delaware privacy statute and regulations. Therefore, until there is clearer definition of the data partners and data elements for the Exchange, it is not feasible to complete an assessment of the impact of the Exchange and the current State privacy statutes and regulations. The information included in this report is a summary of the federal HIPAA regulations that are applicable to the Exchange.

5.8.1 Federal HIPAA Regulations

1. Health Information Technology for Economic and Clinical Health Act—Title XIII, Sections 13001-13424, February 17, 2009.
<http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveridentities/hitechact.pdf>
2. HIPAA Privacy Rule—45 C.F.R. Parts 160 and 164, Standards for Privacy of Individually Identifiable Information; Final Rule, December 28, 2000.

<http://www.hhs.gov/ocr/privacy/hipaa/administrative/privacyrule/prdecember2000all8parts.pdf>

3. Modifications to the HIPAA Privacy Rule—45 C.F.R. Parts 160 and 164, *Standards for Privacy of Individually Identifiable Information; Final Rule*, August 14, 2002.

<http://www.hhs.gov/ocr/privacy/hipaa/administrative/privacyrule/privrulepd.pdf>

4. HIPAA Security Rule—45 C.F.R. Parts 160, 162, and 164, *Health Insurance Reform: Security Standards; Final Rule*, February 20, 2003.

<http://www.hhs.gov/ocr/privacy/hipaa/administrative/securityrule/securityrulepdf.pdf>

5. HIPAA Enforcement Rule—45 C.F.R. Parts 160 and 164, *HIPAA Administrative Simplification: Enforcement; Final Rule*, February 16, 2006.

<http://www.hhs.gov/ocr/privacy/hipaa/administrative/privacyrule/finalenforcementrule06.pdf>

6. Modifications to HIPAA Enforcement Rule—45 C.F.R. Parts 160 and 164, *HIPAA Administrative Simplification: Enforcement; Interim Final Rule*, October 30, 2009.

<http://www.hhs.gov/ocr/privacy/hipaa/administrative/enforcementrule/enfifr.pdf>

7. Breach Notification Rule—45 C.F.R. Parts 160 and 164, *Breach Notification for Unsecured Protected Health Information; Interim Final Rule*, August 24, 2009.

<http://edocket.access.gpo.gov/2009/pdf/E9-20169.pdf>

8. Modifications to HIPAA Privacy, Security and Enforcement Rules—45 C.F.R. Parts 160 and 164, Modifications to the HIPAA Privacy, Security, and Enforcement Rules Under the Health Information Technology for Economic and Clinical Health Act; Proposed Rule, July 14, 2010.

<http://frwebgate3.access.gpo.gov/cgi-bin/PDFgate.cgi?WAISdocID=XObLxD/7/2/0&WAISaction=retrieve>

9. HIPAA Electronic Transaction and Code Sets—45 C.F.R. Parts 160 and 162, *Health Insurance Reform: Standards for Electronic Transactions; Announcement of Designated Standard Maintenance Organizations; Final Rule and Notice*, August 17, 2000.

<http://www.cms.gov/TransactionCodeSetsStands/Downloads/txfinal.pdf>

10. HIPAA Electronic Transaction and Code Sets—45 C.F.R. Parts 160 and 162, *Health Insurance Reform: Modifications to Electronic Transaction Standards and Code Sets*, undated.

<http://www.cms.gov/TransactionCodeSetsStands/Downloads/ModificationstoElectronicDataTransactionStandardsandCodeSets.pdf>

11. HIPAA – NPRM The Department of Health and Human Services (HHS) Office for Civil Rights (OCR) has published in the May 31, 2011, Federal Register the Notice of Proposed Rule Making (NPRM) entitled HIPAA Privacy Rule Accounting of Disclosures

Under the Health Information Technology for Economic and Clinical Health Act (76(104), pp. 31426-31449). This NPRM is available online in [pdf](#).

12. Guidance found at the Office of Civil Rights:

<http://www.hhs.gov/ocr/>

13. Exchanges subject to HIPAA and are subject to civil monetary penalties for noncompliance – NPRM Federal Register July 15, 2011, proposed 45 CFR §155.270.

14. Guidance found at the Office of the National Coordinator:

http://healthit.hhs.gov/portal/server.pt?open=512&objID=1147&parentname=CommunityPage&parentid=10&mode=2&in_hi_userid=11113&cached=true

5.9 Specific Delaware Choices Regarding Establishing the Exchange

5.9.1 Establish the Exchange

A state that elects to operate an Exchange must adopt the federal standards for the requirements of the Exchange articulated in Section 2 above or a state law/executive order implementing them by January 1, 2014. If the State of Delaware elects not to establish an Exchange and/or the Secretary of HHS determines by January 1, 2013 that the State is not electing to operate an Exchange, that it will not have the Exchange operational by January 1, 2014, or that it has not taken the necessary actions to implement the market reforms, then the Secretary of HHS will establish and operate an Exchange for the State, either directly or through agreement with a non-profit agency. At this time, the State of Delaware is considering a plan to initially establish a state-administered Exchange as a quasi state agency with authority granted either through a gubernatorial executive order or a state statute. The State plans to implement the Exchange in accordance with the federal statute and proposed regulations found in ACA and 45 CFR §155 and 156 and will be updating its State regulatory framework.

5.9.2 Small Business Health Option Program (SHOP Exchange)

Each state shall establish an Exchange that facilitates the purchase of QHPs and provides for the establishment of a Small Business Health Options Program (SHOP Exchange) to assist qualified employers in the enrollment of employees in small group qualified health benefits plans. The State of Delaware may choose to establish a single Exchange that performs both the individual and SHOP functions. At this time, the State has not formally decided to operate a single Exchange to administer the individual and SHOP Exchange, but it is likely that it will authorize one entity to administer both Exchanges. The State of Delaware is also evaluating whether to continue to have separate risk pools for the individual and small group markets, or merging these markets.

5.9.3 Basic Health Program

The Secretary of HHS shall establish a BHP under which a state may contract with health plans providing at least the essential health benefits to individuals between 133 percent and 200 percent FPL and legal immigrants who are not eligible for Medicaid. The federal government will provide states creating BHPs

the subsidy funds that eligible individuals would have otherwise received had they purchased coverage through the Exchange. Individuals eligible to participate in the BHP would not be eligible to purchase coverage through the Exchange and premiums may not exceed what the individual would have paid in the Exchange. Cost sharing may not exceed that of a platinum plan in the Exchange for individuals below 150 percent FPL or that of a gold plan those with income between 150 and 200 percent FPL. Delaware is currently evaluating whether to establish a BHP.

5.9.4 State Waiver

Delaware may apply for a waiver of the following requirements beginning for plan year January 2017:

- Requirements for QHPs;
- Requirements for Health Insurance Exchanges;
- Requirements for reduced cost sharing in QHPs;
- Requirements for premium subsidies;
- Requirement for employer mandate; and/or
- Requirements for the employee mandate.

In order to qualify for a waiver, the State: 1) would have to provide coverage that is at least as comprehensive as coverage offered through Exchange; 2) must cover at least as many State residents as would be expected under the ACA; and 3) may not increase the federal deficit. Although a waiver may be sought, the timing of the waiver does not allow Delaware to defer the initial establishment of the Exchange.

5.9.5 Delaware Mandated Health Benefits

If the State of Delaware requires certain health benefits be included in the health plans offered through the Exchange (i.e., State mandates) that exceed the essential benefits package established by HHS, the State will be responsible for defraying the cost of additional benefits for all individuals purchasing coverage through the Exchange. HHS has not published the regulations regarding what will be included in the essential health benefits package; an initial notice of proposed rulemaking regarding the essential health benefits package is expected later in 2011. The State of Delaware currently has a number of mandated benefits that must be covered by commercial health plans (see Section 4.5 for a description). However, for coverage sold through the Exchange, the federal law requires that the cost of any benefits that exceed the federally-defined essential health benefits must be paid for by the State. The State is currently evaluating the existing mandates and plans to identify those that may exceed essential health benefits. At the time that federal regulations and guidance are provided, the State of Delaware will review and document those required benefits that exceeds the federal requirements and develop a cost estimate for covering mandates beyond the essential health benefits.

5.10 Identification of Gaps

The table below identifies the Exchange functional area as defined in the prior sections, and also provides the State of Delaware code and administrative regulation, if applicable. The table also indicates whether there is a gap in the current State law.

Please note that this report presumes that if the gap can be addressed through either a policy or regulatory change without the necessity of amending or creating new statutory law, the recommendation is to update the administrative code or policy.

Table 1: Exchange Regulatory Matrix

<i>Exchange Functional Area</i>	<i>Specific Function</i>	<i>Federal Legislation ACA Citation</i>	<i>Delaware Statutory Code</i>	<i>Delaware Regulatory Administrative Code</i>	<i>State Agency Responsible</i>	<i>Gap in Current Legal Framework</i>	<i>Recommendation</i>
Establishment of an Exchange	Operation of the Exchange	PPACA §1311	Initial establishment may be made through an executive order with legislation possibly filed during the 2012 or 2013 sessions, as may be required for federal approval and funding.	N/A	Chief Executive	Yes	Execute an Executive Order prior to December 2011. Include in the order that the Exchange shall have the authority to function in accordance with all federal requirements.
Establishment of an Exchange - Individual and SHOP Exchange Status	Operation of the Exchange		TBD	TBD	Chief Executive	TBD	Determine whether Delaware will create one or two Exchanges.
Establish Delaware Basic Health Program for low income individuals not eligible for Medicaid	Operation of a Basic Health Program for low income individuals not eligible for Medicaid	PPACA §1331	TBD	N/A	TBD	TBD	Determine whether Delaware will establish a BHP.
Eligibility	Individual eligibility	PPACA 2001(a)(1)/42 USC§1396(a)(10)(A)(1)(VII)	TBD	TBD through amendments to Title 16 5100 Delaware Social Services Manual	DMMA	Yes -Regulatory	Amendments to Delaware Social Services Manual. May require a Delaware Medicaid State Plan Amendment

Exchange Functional Area	Specific Function	Federal Legislation ACA Citation	Delaware Statutory Code	Delaware Regulatory Administrative Code	State Agency Responsible	Gap in Current Legal Framework	Recommendation
Eligibility	Employer eligibility – small group market	PPACA 1312	72 Del C. §7202	Title 18 §1308	DOI	Yes – statutory and regulatory if Delaware decides to expand the small group market up to 100 employees prior to 2016. Required in 2016, per PPACA.	Amendments to statute and regulation.
Eligibility	Mandatory Use of MAGI for Eligibility Determination; Required 5% income disregard (effectively increasing upper limits to 138% FPL); and, prohibit use of resource or asset test for most Medicaid categories of services.	PPACA Definition Sections 1004(a)-(b)/ 2002(a)	16 Del. C. (Health) and 31 Del. C. (Welfare) § 503(b).	Title 16 Administrative Code 5100 Delaware Social Services Manual Sections 13000 et. seq.	DHSS / DMMA / DSS	Yes – regulatory changes needed for Medicaid eligibility.	Amendments to regulation and may require a Delaware Medicaid State Plan Amendment.

Exchange Functional Area	Specific Function	Federal Legislation ACA Citation	Delaware Statutory Code	Delaware Regulatory Administrative Code	State Agency Responsible	Gap in Current Legal Framework	Recommendation
Eligibility	Mandated Expansion to 133% (138%) FPL with Enhanced FMAP	2001(a)(1)	16 Del. C. (Health) and 31Del. C. (Welfare) §503(b).	Title 16 Administrative Code 5100 Delaware Social Services Manual Sections 13000 et. seq.	DMMA	Yes – Regulatory	Amendments to regulation and may require a Delaware Medicaid State Plan Amendment.
Eligibility	Mandatory Coverage of Foster Care Children Up to Age 26	PPACA §2004	16 Del. C. (Health) and 31Del. C. (Welfare) §503(b).	Title 16 Administrative Code 5100 Delaware Social Services Manual Sections 13000 et. seq.	DMMA	Yes – Regulatory	Amendments to regulation and may require a Delaware Medicaid State Plan Amendment.
Eligibility	Premium Tax Credit	PPACA §1401; IRC §36B.	No current Delaware insurance code provision.	No current Delaware Admin Code provision .		Yes – but can be addressed in Initial Exchange executive order. The order can expressly state that the Exchange has the authority to generate tax credits in accordance with ACA.	Execute an Executive Order prior to December 2011. Include in the order that the Exchange shall have the authority to function in accordance with all federal requirements.

Exchange Functional Area	Specific Function	Federal Legislation ACA Citation	Delaware Statutory Code	Delaware Regulatory Administrative Code	State Agency Responsible	Gap in Current Legal Framework	Recommendation
Eligibility	Cost Sharing	PPACA §1402	No current Delaware insurance code provision.	No current Delaware Admin Code provision .		Yes, but can be addressed in Initial Exchange executive order; can expressly state that the Exchange has the authority to determine cost sharing in accordance with ACA.	Execute an Executive Order prior to December 2011. Include in the order that the Exchange shall have the authority to function in accordance with all federal requirements Include the express authority as part of enabling executive order.
Eligibility	HHS Verification	PPACA §1312(f)(3). §1311(d)(4)(F) and §1413(a).	No current Delaware insurance code provision.	No current Delaware Admin Code provision.		No –The federal government is mandating verification of individual eligibility using 3 pieces of personal data. The Exchange has to have the functional capacity, but there is no additional legal/regulatory authority required to conduct the verification.	N/A

Exchange Functional Area	Specific Function	Federal Legislation ACA Citation	Delaware Statutory Code	Delaware Regulatory Administrative Code	State Agency Responsible	Gap in Current Legal Framework	Recommendation
Eligibility	Exemption for Individuals	PPACA §1411.	No current Delaware insurance code provision.	No current Delaware Admin Code provision.		No - federal government establishes exemption status. The Exchange will adjudicate federally mandated exemptions based on criteria established by HHS.	N/A
Enrollment / Disenrollment	Applying for Coverage Medicaid and CHIP Enrollment Simplification	PPACA §2201	No current Delaware insurance code provision.	No current Delaware Admin Code provision.		No – May require policy changes. ACA mandates simplification. Exchange function to manage enrollment, but Delaware to provide information and direction through the policy manual to stakeholders and individuals.	

<i>Exchange Functional Area</i>	<i>Specific Function</i>	<i>Federal Legislation ACA Citation</i>	<i>Delaware Statutory Code</i>	<i>Delaware Regulatory Administrative Code</i>	<i>State Agency Responsible</i>	<i>Gap in Current Legal Framework</i>	<i>Recommendation</i>
Enrollment / Disenrollment	Plan Comparison	2201 / 1301	No current Delaware insurance code provision.	No current Delaware Admin Code provision.		Yes, but can be addressed in Initial Exchange executive order. The order can expressly state that the Exchange has the authority to conduct plan comparisons in accordance with ACA.	Execute an Executive Order prior to December 2011. Include in the order that the Exchange shall have the authority to function in accordance with all federal requirements Include the express authority as part of enabling executive order.
Enrollment / Disenrollment	Plan Management	PPACA §1311	No current Delaware insurance code provision.	No current Delaware Admin Code provision.		Yes, but can be addressed in Initial Exchange executive order. The order can expressly state that the Exchange has the authority to manage plans in accordance with ACA.	Execute an Executive Order prior to December 2011. Include in the order that the Exchange shall have the authority to function in accordance with all federal requirements Include the express authority as part of enabling executive order.

Exchange Functional Area	Specific Function	Federal Legislation ACA Citation	Delaware Statutory Code	Delaware Regulatory Administrative Code	State Agency Responsible	Gap in Current Legal Framework	Recommendation
Enrollment / Disenrollment	Continuity of Coverage	PPACA §1311	No current Delaware insurance code provision.	No current Delaware Admin Code provision.		Yes, but can be addressed in Initial Exchange executive order. The order can expressly state that the Exchange has the authority to manage plans in accordance with ACA.	Execute an Executive Order prior to December 2011. Include in the order that the Exchange shall have the authority to function in accordance with all federal requirements Include the express authority as part of enabling executive order.
Enrollment / Disenrollment	Open Enrollment Management	PPACA §1311(c)(6)	No current Delaware insurance code provision.	No current Delaware Admin Code provision		Yes – Regulatory	Amend insurance regulations regarding open enrollment periods for Exchange plans. And include the authority for enrollment management in the initial Exchange enabling statute/executive order.

<i>Exchange Functional Area</i>	<i>Specific Function</i>	<i>Federal Legislation ACA Citation</i>	<i>Delaware Statutory Code</i>	<i>Delaware Regulatory Administrative Code</i>	<i>State Agency Responsible</i>	<i>Gap in Current Legal Framework</i>	<i>Recommendation</i>
Administration	Appeals	PPACA §1311 The IFR will be codified in 26 C.F.R. Parts 54 and 602, 29 C.F.R. Part 2590, and 45 C.F.R. Part 147. Technical Amendment issued June 22, 2011 regarding external review.	18Del. C. §323 et.seq. Administrative procedures Arbitration of Disputes (18 Del. C. §332) Arbitration of Disputes (18 Del.C. §333) Arbitration of disputes between carriers and health care providers.	Delaware Administrative Code Title 18 §1301 et. seq.	DOI	Yes – Regulatory	Amend current regulations to conform to ACA appeals requirements.
Administration	Quality of Performance	PPACA §1311 (Exchange_ PPACA §2717 Health Plans and insurers PPACA §2701 Medicaid and Medicare PPACA §3002 and 3002 hospitals and physicians.	None at this time.	None at this time.		Yes – statutory or executive order.	Ensure that the reporting requirements are expressly stated in the enabling legislation/executive order.

Exchange Functional Area	Specific Function	Federal Legislation ACA Citation	Delaware Statutory Code	Delaware Regulatory Administrative Code	State Agency Responsible	Gap in Current Legal Framework	Recommendation
Administration	Certification/Decertification	PPACA §1311	None on point, but analogous is the Delaware authority to conduct business in Delaware 18 Del. C. §505.	None on point but analogous is Delaware Administrative Code Title 18 200 – Licensing.	DOI	Yes, but can be addressed in Initial Exchange executive order. The order can expressly state that the Exchange has the authority to manage plans in accordance with ACA.	Execute an Executive Order prior to December 2011. Include in the order that the Exchange shall have the authority to function in accordance with all federal requirements.
Administration	Fraud Detection	1311(b), 1312(d)(3), 1313)	Authority to investigate insurance companies in Delaware is with the Dept of Insurance. 18 Del. C. §318 This authority may be extended to the DOI to investigate the Exchange.	Administrative Code Title 18 §900 et. seq. consumer protection.		Yes – Regulatory	Promulgate new regulations defining new elements for fraud, as well as health care fraud definition to include in Delaware civil and criminal codes.

<i>Exchange Functional Area</i>	<i>Specific Function</i>	<i>Federal Legislation ACA Citation</i>	<i>Delaware Statutory Code</i>	<i>Delaware Regulatory Administrative Code</i>	<i>State Agency Responsible</i>	<i>Gap in Current Legal Framework</i>	<i>Recommendation</i>
Financial Management	Premium Payment – Subsidy Calculation	PPACA §1401; §1402;§1415	None at this time	None at this time.		Yes, but can be addressed in initial Exchange executive order/statute. The order/statute can expressly state that the Exchange has the authority to complete premium payment subsidy calculations in accordance with ACA.	Execute an Executive Order prior to December 2011. Include in the order that the Exchange shall have the authority to function in accordance with all federal requirements.
	Treasury Communication	PPACA §1411; §1412	None	None		Yes, but can be addressed in Initial Exchange executive order. The order can expressly state that the Exchange has the authority to complete treasury communications in accordance with ACA.	Execute an Executive Order prior to December 2011. Include in the order that the Exchange shall have the authority to function in accordance with all federal requirements.

<i>Exchange Functional Area</i>	<i>Specific Function</i>	<i>Federal Legislation ACA Citation</i>	<i>Delaware Statutory Code</i>	<i>Delaware Regulatory Administrative Code</i>	<i>State Agency Responsible</i>	<i>Gap in Current Legal Framework</i>	<i>Recommendation</i>
Exchange Website	Navigators	1311 1103 (and IFR at 45 C.F.R. Part 159)	TBD	TBD		TBD	
	Privacy and Security?	See this report Section XX with HIPAA citations	TBD	TBD		TBD	

5.11 Limits to the Gap Analysis

This gap analysis focused on the establishment and initial business operations of the Exchange. There are sure to be additional questions remaining that are not addressed or identified as part of this gap analysis. Specifically, open questions remain regarding governance and operations that will need to be considered as details about the operation of the Exchange become clear and as additional federal guidance and regulations are issued. For example, open questions about program integration and, specifically, the governance of the Exchange that includes the following yet to be established responsibilities:

- The role of the Medicaid agency;
- The role of the Department of Insurance;
- The operations of the Exchange;
- The Exchange board and conflict of interest and disclosure requirements;
- The current functions of the Medicaid agency to move to or contract with the Exchange;
and
- The current functions of the Department of Insurance to move to or contract with the Exchange.

Additionally, this analysis does not address initiatives that the State of Delaware may consider regarding improved transparency around health insurance rates. These initiatives include whether to develop new premium filing requirements, improve the ability to review rates, post premium filings on its website, or employ a new rate comparison feature or include public forums and hearings on proposed rate increases.

6 Key Findings and Regulatory Recommendations

This section provides high level recommendations to resolve or eliminate regulatory barriers for Exchange establishment and initial implementation. In defining the State of Delaware Exchange, the State must comply with the ACA and federal regulations as well as provide additional authority and duties relevant to the State of Delaware health insurance market. Therefore, in formulating the key findings and regulatory recommendations, the ACA principles and priorities as defined in federal guidance were considered:

- Establishing a state-administered Exchange;
- Promoting efficiency;
- Avoiding adverse selection;
- Streamlined access and continuity of care;
- Public outreach and stakeholder involvement;
- Public accountability and transparency; and
- Financial accountability.

Additional considerations for the key findings and regulatory recommendations are those areas of law and regulations beyond the federal law and expressly delegated to the State by ACA. Data and information sharing recommendations are not included because the Exchange governance and operations have yet to be finalized.

The key findings are noted in the table below:

Table 2: Key Findings and Recommendations

ACA Principles	Key Finding and Recommendation
Establish a State-Administered Exchange	Delaware has to incorporate by reference or explicitly state in a State statute or executive order that it will provide all of the federally-required Exchange functions and oversight responsibilities.
Streamlined Access and Continuity of Care	Prioritize the coordination with DMMA to assure that eligibility and enrollment requirements are met and State Medicaid regulations and policy are updated to reflect the new ACA requirements.
Financial Accountability	Prioritize the promulgation and amendments to State regulations to incorporate financial oversight and authority for regulation of the Exchange, particularly relating to fraud investigations and financial management review.
Establish a State-Administered Exchange	Evaluate the current State insurance mandates as part of the Benefits Assessment.

ACA Principles	Key Finding and Recommendation
Establish a State-Administered Exchange	Consider the privacy and security framework at the time the Exchange governance and operations are complete.
Public Accountability and Transparency	Incorporate, as part of the statute or executive order establishing the Exchange, the reporting requirements for price, quality, benefits, consumer choice, and other factors the State deems necessary for measuring and evaluating insurer performance.
Promoting Efficiency	Assure that the State has the necessary authority to enforce and or promote the enforcement of the federal standards for: <ul style="list-style-type: none"> • Marketing • Network Adequacy • Accreditation for performance measures • Quality Improvement and reporting • Uniform enrollment procedures

The recommendations are provided in accordance with the elements presented in the matrix in Table 1. These recommendations are a high level assessment of each exchange function impact to the State of Delaware’s statutes and administrative code. Additional evaluation of the specific sections of the statutes and administrative code and whether the change reflects the need for new regulatory authority or amending current existing authority is suggested.

7 Conclusions

1. The State of Delaware's current statutory and regulatory authority is well defined and organized.
2. The establishment of the Exchange will require some statutory, regulatory, and policy changes, particularly to the insurance code and the Medicaid regulatory and policy framework.
3. The priority for regulatory action by the State of Delaware relates specifically to establishing oversight and monitoring of the Exchange. These initial actions may include amending insurance or other state regulations to address any regulatory responsibilities of the Exchange, including the Exchange's financial management and accounting functions.
4. There are gaps in the current Medicaid regulatory framework that will require amendment and or promulgation of new regulations to comply with the federal eligibility and enrollment requirements.
5. With the completion of the executive order, or statute with express authority provided, the State of Delaware will have the initial authority needed to establish and operate the Exchange.

8 Reference Sources

Peterson, Chris L., Gabe, Thomas (April 28, 2010) *Congressional Research Service, Health Insurance Premium Credits in the Patient Protection and Affordable Care Act (PPACA)*.

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Appendix A: Acronyms

Acronym	Stands For:
ACA	Affordable Care Act
BHP	basic health program
CHAP	State of Delaware Community Health Access Program
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare and Medicaid Services
CFR	Code of Federal Regulations
DHS	United States Department of Homeland Security
DHSS	State of Delaware Department of Health and Social Services
DMMA	Delaware Division of Medicaid and Medical Assistance
FCA	False Claims Act
FFP	federal financial participation
FPL	Federal Poverty Level
HDHP	high deductible health plans
HHS	United States Department of Health and Human Services
HIPAA	Health Information Portability and Accountability Act
HSA	health savings accounts
MAGI	modified adjusted gross income
MCO	managed care organization
NPRM	Notice of Proposed Rulemaking
PCG	Public Consulting Group
PDP	prescription drug plan
PPACA	Patient Protection and Affordable Care Act
QHP	qualified health plans
SHOP	Small Business Health Options Program
SSA	Social Security Administration