CHAPTER 186
FORMERLY
SENATE BILL NO. 35

AN ACT TO AMEND TITLE 18 OF THE DELAWARE CODE RELATED TO HEALTH INSURANCE CONTRACTS.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF DELAWARE:

Section 1. Amend § 3361, Title 18 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 3361. Limitations on preexisting condition limitations for minor children.

~~(a) No individual health insurance policy, contract or certificate that is delivered or issued for delivery in this State by any health insurer, health service corporation or managed care organization which provides for hospital or medical expenses shall deny coverage to a child under the age of 19 because of a preexisting condition.~~

~~(b) Each policy shall be either guaranteed issue, without exclusion for preexisting conditions, or offered during an open enrollment period the first month of every calendar year.~~ [Repealed.]

Section 2. Amend § 3368, Title 18 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 3368. No lifetime or annual limits [For application of this section, see 79 Del. Laws, c. 99, § 19]

(c) The term "essential health benefits" as used in this section means essential health benefits under § 1302(b) of the Patient Protection and Affordable Care Act [42 U.S.C. § 18022(b)], as the law and its implementing regulations were in effect on January 1, 2018; Delaware ~~law~~ law; and applicable ~~federal and~~ state regulations.

Section 3. Amend § 3530, Title 18 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 3530. Limitations on preexisting condition limitations for minor children.

~~(a) No group or blanket health insurance policy, contract or certificate that is delivered or issued for delivery in this State by any health insurer, health service corporation or managed care organization which provides for hospital or medical expenses shall deny coverage to a child under the age of 19 because of a preexisting condition.~~

~~(b) Each policy shall be either guaranteed issue, without exclusion for preexisting conditions, or offered during an open enrollment period the first month of every calendar year.~~ [Repealed.]

Section 4. Amend § 3571I, Title 18 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 3571I. No lifetime or annual limits [For application of this section, see 79 Del. Laws, c. 9, § 19]

(c) The term "essential health benefits" as used in this section means essential health benefits under § 1302(b) of the Patient Protection and Affordable Care Act [42 U.S.C. § 18022(b)], as the law and its implementing regulations were in effect on January1, 2018; Delaware ~~law~~ law; and applicable ~~federal and~~ state regulations.

Section 5. Amend Section 3571J, Title 18 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 3571J. Guaranteed availability of coverage [For application of this section, see 79 Del. Laws, c. 99, § 19]

(b) *Enrollment periods.* — A health insurer may restrict enrollment in health insurance coverage to open or special enrollment periods.

(1)a. *Open enrollment periods in the group market.* — A health insurer in the group market must permit an employer to purchase health insurance coverage for a group health plan at any point during the year. In the case of health insurance coverage offered in the small group market, a health insurer may decline to offer coverage to a plan sponsor that is unable to comply with a material plan provision relating to employer contribution or group participation ~~rules, as defined in 45 C.F.R. § 147.106(b)(3), pursuant to~~ rules under applicable state law and, in the case of a qualified health plan offered in the Small Business Health Options Program (SHOP), as permitted by 45 C.F.R. § 156.285(c). ~~With respect to coverage in the small group market, and in the large group market if such coverage is offered in a SHOP in this State, coverage shall become effective consistent with the dates described in 45 C.F.R. § 155.725(h).~~ For purposes of this paragraph (b)(1) of this section:

1. "Employer contribution rule" means a requirement relating to the minimum level or amount of employer contribution toward the premium for enrollment of participants and beneficiaries.

2. "Group participation rule" means a requirement relating to the minimum number of participants or beneficiaries that must be enrolled in relation to a specific percentage or number of eligible individuals or employees of an employer.

b. With respect to coverage in the small group market, and in the large group market if such coverage is offered in a SHOP in the State, coverage for a group enrollment received from a qualified employer at the time of an initial group enrollment or renewal becomes effective as follows:

1. Between the first and fifteenth day of any month, the health insurer or SHOP must ensure a coverage effective date of the first day of the following month unless the employer opts for a later effective date within a quarter for which small group market rates are available.

2. Between the sixteenth and last day of any month, the health insurer or SHOP must ensure a coverage effective date of the first day of the second following month unless the employer opts for a later effective date within a quarter for which small group market rates are available.

(2) *Special enrollment periods.* — A health insurer in the group market shall establish special enrollment periods for qualifying events as defined under § 603 of the Employee Retirement Income Security Act of 1974 [29 U.S.C. § 1163], as amended. Enrollees ~~shall~~ must be provided 30 calendar days after the date of the qualifying event to elect coverage, with such coverage becoming effective consistent with the dates described in ~~45 C.F.R. § 155.420(b).~~ 45 C.F.R. § 155.420(b), as in effect on January 1, 2018. These special enrollment periods are in addition to any other special enrollment periods that are required under federal and state law.

Section 6. Amend § 3571L, Title 18 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 3571L. Nondiscrimination in health care [For application of this section, see 79 Del. Laws, c. 99, § 19]

(b) *Individuals.* — The provisions of § 1557 of the Patient Protection and Affordable Care Act (relating to nondiscrimination) ~~[42 U.S.C. § 18116] shall~~ [42 U.S.C. § 18116], as the law and its implementing regulations were in effect on January 1, 2018, apply with respect to a group health plan or health insurer offering group health insurance coverage.

Section 7. Amend § 3571M, Title 18 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 3571M. Comprehensive health insurance coverage [For application of this section, see 79 Del. Laws, c. 99, § 19]

(a) *Coverage for essential health benefits package.* — A health insurer that offers health insurance coverage in the small group market shall ensure that such coverage includes the essential health benefits package in conformity with § 1302 of the Patient Protection and Affordable Care Act ~~[42 U.S.C. § 18022]~~ [42 U.S.C. § 18022], as the law and its implementing regulations were in effect on January 1, 2018, and state law. The Commissioner shall issue a regulation setting forth what constitutes "essential health benefits" for purposes of this section.

(b) *Cost-sharing under group health plans.* — A group health plan shall ensure that any annual cost-sharing imposed under the plan does not exceed the limitations provided for under § 1302(c)(1) and (2) of the Patient Protection and Affordable Care Act ~~[42 U.S.C. § 18022(c)(1) and (2)]~~ [42 U.S.C. § 18022(c)(1) and (2)], as the law and its implementing regulations were in effect on January 1, 2018, and state law.

(c) *Child-only plans.* — If a health insurer offers health insurance coverage in any level of coverage specified under § 1302(d) of the Patient Protection and Affordable Care Act ~~[42 U.S.C. § 18022(d)]~~ [42 U.S.C. § 18022(d)], as the law and its implementing regulations were in effect on January 1, 2018, or state law, the health insurer shall also offer such coverage in that level as a plan in which the only enrollees are individuals who, as of the beginning of the plan year, ~~have not attained the age of~~ are under the age of 21.

(d) *Dental only.* — This section shall not apply to a plan described in § 1311(d)(2)(B)(ii) of the Patient Protection and Affordable Care Act ~~[42 U.S.C. § 18031(d)(2)(B)(ii)].~~ [42 U.S.C. § 18031(d)(2)(B)(ii)], as the law and its implementing regulations were in effect on January 1, 2018.

Section 8. Amend § 3571P, Title 18 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 3571P. Rating factors [For application of this section, see 79 Del. Laws, c. 99, § 19]

(a) In establishing rates for health insurance coverage offered in the small group market, ~~health insurers shall comply with the rating requirements established under the Patient Protection and Affordable Care Act [P.L. 111-148] and 45 C.F.R. § 147.102. The Commissioner shall adopt regulations, in accordance with the Administrative Procedures Act [Chapter 101 of Title 29], that are consistent with Chapter 25 of this title and set forth more specifically the rating standards and requirements for health insurers operating within this State.~~ the rate may vary with respect to the particular plan or coverage involved only by determining the following:

(1) Whether the plan or coverage covers an individual or family.

(2) Rating area, as established in accordance with subsection (d) of this section.

(3) Age, except that the rate may not vary by more than 3 to 1 for like individuals of different age who are age 21 and older and that the variation in rate must be actuarially justified for individuals under age 21, consistent with the uniform age rating curve under subsection (e) of this section. For purposes of identifying the appropriate age adjustment under this paragraph (a)(3) of this section and the age band under subsection (e) of this section applicable to a specific enrollee, the enrollee's age as of the date of policy issuance or renewal must be used.

(4) Subject to § 3571N of this title, tobacco use, except that such rate may not vary by more than 1.5 to 1 and may only be applied with respect to individuals who may legally use tobacco under federal and state law. For purposes of this paragraph (a)(4) of this section, tobacco use means use of tobacco on average 4 or more times per week within no longer than the past 6 months. This includes all tobacco products, except that tobacco use does not include religious or ceremonial use of tobacco. Further, tobacco use must be defined in terms of when a tobacco product was last used.

(b) The rate established under this section must not vary with respect to the particular plan or coverage involved by any other factor not described in subsection (a) of this section.

(c) A health insurer must consider the claims experience of all enrollees in all health plans, other than grandfathered health plans, offered by such insurer in the small group market in this State, including those enrollees who do not enroll in such plans through the state health exchange, to be members of a single risk pool. A health insurer must charge the same premium rate without regard to whether the plan is offered through the state health exchange or whether the plan is offered directly from the health insurer or through an agent.

(d) In establishing rates, all health insurers offering health plans in the small group market shall use a single rating area that applies to the entire State.

(e) The following uniform age bands apply for rating purposes under paragraph (a)(3) of this section:

(1) Child age bands.

a. A single age band for individuals age 0 through 14.

b. One-year age bands for individuals age 15 through 20.

(2) Adult age bands. One-year age bands for individuals age 21 through 63.

(3) Older adult age bands. A single age band for individuals age 64 and older.

(f) Application of variations based on age or tobacco use. With respect to family coverage under health insurance coverage, the rating variations permitted under paragraphs (a)(3) and (a)(4) of this section must be applied based on the portion of the premium attributable to each family member covered under the coverage.

(1) The total premium for family coverage must be determined by summing the premiums for each individual family member. With respect to family members under age 21, the premiums for no more than the 3 oldest covered children must be taken into account in determining the total family premium.

(2) If the State does not permit any rating variation for the factors described in paragraphs (a)(3) and (a)(4) of this section, as determined by the Insurance Commissioner by regulation, the State may require that premiums for family coverage be determined by using uniform family tiers and the corresponding multipliers

established by the State. If the State does not establish uniform family tiers and the corresponding multipliers, the per-member-rating methodology under paragraph (f)(1) of this section applies in this State.

(3)a. In the case of the small group market, the total premium charged to a group health plan is determined by summing the premiums of covered participants and beneficiaries in accordance with paragraph (f)(1) or (f)(2) of this section, as applicable.

b. Subject to paragraph (f)(3)c. of this section, nothing in this section prevents the State from requiring health insurers to offer to a group health plan, or a health insurer from voluntarily offering to a group health plan, premiums that are based on average enrollee premium amounts, if the total group premium established at the time of applicable enrollment at the beginning of the plan year is the same total amount derived under paragraph (f)(1) or (f)(2) of this section, as applicable.

c. A health insurer that, in connection with a group health plan in the small group market, offers premiums that are based on average enrollee premium amounts under paragraph (f)(3)b. of this section must:

1. Ensure an average enrollee premium amount calculated based on applicable enrollment of participants and beneficiaries at the beginning of the plan year that does not vary during the plan year.

2. Unless the State establishes and, if applicable, CMS approves an alternate rating methodology, calculate an average enrollee premium amount for covered individuals age 21 and older, and calculate an average enrollee premium amount for covered individuals under age 21. The premium for a given family composition is determined by summing the average enrollee premium amount applicable to each family member covered under the plan, taking into account no more than 3 covered children under age 21.

3. Under applicable State law, ensure that the average enrollee premium amount calculated for any individual covered under the plan does not include any rating variation for tobacco use permitted under paragraph (a)(4) of this section. The rating variation for tobacco use permitted under paragraph (a)(4) of this section is determined based on the premium rate that would be applied on a per-member basis with respect to an individual who uses tobacco and then included in the premium charged for that individual.

4. To the extent permitted by applicable state law and, in the case of coverage offered through a federally-facilitated SHOP, as permitted by 45 C.F.R. § 156.285(a)(4), apply this paragraph (f)(3)c. of this section uniformly among group health plans enrolling in that product, giving those group health plans the option to pay premiums based on average enrollee premium amounts.

(g) The Commissioner may adopt regulations, in accordance with the Administrative Procedures Act [Chapter 101 of Title 29], that are consistent with Chapter 25 of this title and set forth more specifically the rating standards and requirements for health insurers operating within this State.

Section 9. Amend § 3606, Title 18 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 3606. Preexisting conditions [For application of this section, see 79 Del. Laws, c. 99, § 19]

(a) Notwithstanding § 3306 of this title, a policy or contract must not deny, exclude, or limit benefits for a covered individual for losses due to a preexisting condition, ~~if an insurer or health service corporation elects to use a simplified application form, with or without a question as to the applicant's health at the time of the application, but without any questions concerning the insured's health history or medical treatment history, the policy must cover any loss from any preexisting condition,~~ and the policy or contract ~~shall~~ must not include wording that would permit a defense based upon preexisting conditions.

Section 10. Amend § 3607, Title 18 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 3607. Guaranteed availability of coverage [For application of this section, see 79 Del. Laws, c. 99, § 19]

(b) *Enrollment periods.* — A carrier may restrict enrollment in health insurance coverage to open or special enrollment periods.

(1) *Open enrollment periods in the individual market.* — A carrier in the individual market must permit an individual to purchase health insurance coverage during ~~the initial and annual open enrollment periods described in 45 C.F.R. § 155.410(b) and (e), with such coverage becoming effective consistent with the dates described in 45 C.F.R. § 155.410(c) and (f).~~ an annual open enrollment period. For benefit years beginning on or after January 1, 2018, the annual open enrollment period begins on November 1 and extends through December 15 of the calendar year preceding the benefit year. A carrier must ensure that coverage is effective January 1 for enrollments received by the carrier on or before December 15 of the calendar year preceding the benefit year.

(2) *Special enrollment periods.* — A carrier in the individual market shall establish special enrollment periods for qualifying events as defined under § 603 of the Employee Retirement Income Security Act of 1974, as amended [29 USC § 1163]. Enrollees ~~shall~~ must be provided 30 calendar days after the date of the qualifying event to elect coverage, with such coverage becoming effective consistent with the dates described in ~~45 C.F.R. § 155.420(b).~~ 45 C.F.R. § 155.420(b), as in effect on January 1, 2018. These special enrollment periods are in addition to any other special enrollment periods that are required under federal and state law.

Section 11. Amend § 3609, Title 18 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 3609. Nondiscrimination in health care [For application of this section, see 79 Del. Laws, c. 99, § 19]

(b) *Individuals.* — The provisions of § 1557 of the Patient Protection and Affordable Care Act (relating to nondiscrimination) ~~[42 U.S.C. § 18116] shall~~ [42 U.S.C. § 18116], as the law and its implementing regulations were in effect on January 1, 2018, apply with respect to a health insurer offering individual health insurance coverage.

Section 12. Amend § 3610, Title 18 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 3610. Comprehensive health insurance coverage [For application of this section, see 79 Del. Laws, c. 99, § 19]

(a) *Coverage for essential health benefits package.* — A health insurer that offers health insurance coverage in the individual market shall ensure that such coverage includes the essential health benefits package in conformity

with § 1302 of the Patient Protection and Affordable Care Act ~~[42 U.S.C. § 18022]~~ [42 U.S.C. § 18022], as the law and its implementing regulations were in effect on January 1, 2018, and state law. The Commissioner shall issue a regulation setting forth what constitutes "essential health benefits" for purposes of this section.

(b) *Cost-sharing under individual health insurance policies.* — An individual health insurance policy shall ensure that any annual cost-sharing imposed under the plan does not exceed the limitations provided for under § 1302(c)(1) of the Patient Protection and Affordable Care Act ~~[42 U.S.C. § 18022(c)(1)]~~ [42 U.S.C. § 18022(c)(1)], as the law and its implementing regulations were in effect on January 1, 2018, and state law.

(c) *Child-only plans.* — If a health insurer offers health insurance coverage in any level of coverage specified under § 1302(d) of the Patient Protection and Affordable Care Act ~~[42 U.S.C. § 18022(d)]~~ [42 U.S.C. § 18022(d)], as the law and its implementing regulations were in effect on January 1, 2018, or state law, the health insurer shall also offer such coverage in that level as a plan in which the only enrollees are individuals who, as of the beginning of the plan year, ~~have not attained the age of~~ are under age 21.

(d) *Dental only.* — This section ~~shall~~ does not apply to a plan described in § 1311(d)(2)(B)(ii) of the Patient Protection and Affordable Care Act ~~[42 U.S.C. § 18031(d)(2)(B)(ii)].~~ [42 U.S.C. § 18031(d)(2)(B)(ii)], as the law and its implementing regulations were in effect on January 1, 2018.

Section 13. Amend Section 3613, Title 18 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 3613. Rating factors [For application of this section, see 79 Del. Laws, c. 99, § 19]

(a) In establishing rates for health insurance coverage offered in the individual market, ~~health insurers shall comply with the rating requirements established under the Patient Protection and Affordable Care Act [P.L. 111-148] and 45 C.F.R. § 147.102. The Commissioner shall adopt regulations, in accordance with the Administrative Procedures Act [Chapter 101 of Title 29], that are consistent with Chapter 25 of this title and set forth more specifically the rating standards and requirements for health insurers operating within this State.~~ the rate may vary with respect to the particular plan or coverage involved only by determining the following:

(1) Whether the plan or coverage covers an individual or family.

(2) Rating area, as established in accordance with subsection (d) of this section.

(3) Age, except that the rate may not vary by more than 3 to 1 for like individuals of different age who are age 21 and older and that the variation in rate must be actuarially justified for individuals under age 21, consistent with the uniform age rating curve under subsection (e) of this section. For purposes of identifying the appropriate age adjustment under this paragraph (a)(3) of this section and the age band under subsection (e) of this section applicable to a specific enrollee, the enrollee's age as of the date of policy issuance or renewal must be used.

(4) Subject to § 3611 of this title, tobacco use, except that such rate may not vary by more than 1.5 to 1 and may only be applied with respect to individuals who may legally use tobacco under federal and state law. For purposes of this paragraph (a)(4) of this section, tobacco use means use of tobacco on average 4 or more times per week within no longer than the past 6 months. This includes all tobacco products, except that tobacco use

does not include religious or ceremonial use of tobacco. Further, tobacco use must be defined in terms of when a tobacco product was last used.

(b) The rate established under this section must not vary with respect to the particular plan or coverage involved by any other factor not described in subsection (a) of this section.

(c) A health insurer must consider the claims experience of all enrollees in all health plans, other than grandfathered health plans, offered by such insurer in individual market in this State, including those enrollees who do not enroll in such plans through the state health exchange, to be members of a single risk pool. A health insurer must charge the same premium rate without regard to whether the plan is offered through the state health exchange or whether the plan is offered directly from the health insurer or through an agent.

(d) In establishing rates, all health insurers offering health plans in the individual market shall use a single rating area that applies to the entire State.

(e) The following uniform age bands apply for rating purposes under paragraph (a)(3) of this section:

(1) Child age bands.

a. A single age band for individuals age 0 through 14.

b. One-year age bands for individuals age 15 through 20.

(2) Adult age bands. One-year age bands for individuals age 21 through 63.

(3) Older adult age bands. A single age band for individuals age 64 and older.

(f) Application of variations based on age or tobacco use. With respect to family coverage under health insurance coverage, the rating variations permitted under paragraphs (a)(3) and (a)(4) of this section must be applied based on the portion of the premium attributable to each family member covered under the coverage.

(1) The total premium for family coverage must be determined by summing the premiums for each individual family member. With respect to family members under age 21, the premiums for no more than the 3 oldest covered children must be taken into account in determining the total family premium.

(2) If the State does not permit any rating variation for the factors described in paragraphs (a)(3) and (a)(4) of this section, as determined by the Insurance Commissioner by regulation, the State may require that premiums for family coverage be determined by using uniform family tiers and the corresponding multipliers established by the State. If the State does not establish uniform family tiers and the corresponding multipliers, the per-member-rating methodology under paragraph (f)(1) of this section applies in this State.

(g) The Commissioner may adopt regulations, in accordance with the Administrative Procedures Act [Chapter 101 of Title 29], that are consistent with Chapter 25 of this title and set forth more specifically the rating standards and requirements for health insurers operating within this State.

Approved August 6, 2019