SPONSOR: Rep. B. Short & Sen. Bushweller
Reps. Barbieri, Heffernan, Keeley, Osienski, Scott; Sen. Ennis

HOUSE OF REPRESENTATIVES
147th GENERAL ASSEMBLY

HOUSE BILL NO. 162

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

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

Section 1. Amend Section 3303, Title 18 of the Delaware Code by making insertions as shown by underlining and deletions as shown by strike through as follows:

§ 3303. Scope, format of policy.

No policy of health insurance shall be delivered or issued for delivery to any person in this State unless it otherwise complies with this title and complies with the following:

(1) The entire money and other considerations therefor shall be expressed therein;

(2) The time when the insurance takes effect and terminates shall be expressed therein;

(3) It shall purport to insure only 1 person, except that a policy may insure, originally or by subsequent amendment, upon the application of an adult member of a family, who shall be deemed the policyholder, any 2 or more eligible members of that family, including husband, wife, dependent children or any children under a specified age which shall not exceed ~~19~~ 26 years and any other person dependent upon the policyholder;

(4) The style, arrangement and overall appearance of the policy shall give no undue prominence to any portion of the text, and every printed portion of the text of the policy and of any endorsements or attached papers shall be plainly printed in light-faced type of a style in general use, the size of which shall be uniform and not less than 10 point with a lower case unspaced alphabet length not less than 120 point (the “text” shall include all printed matter except the name and address of the insurer, name or title of the policy, the brief description, if any, and captions and subcaptions);

(5) The exceptions and reductions of indemnity shall be set forth in the policy and, other than those contained in §§ 3305-3326, inclusive, of this title, shall be printed, at the insurer’s option, either included with the benefit provision to which they apply, or under an appropriate caption such as “exceptions,” or “exceptions and reductions,” except that if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of such exception or reduction shall be included with the benefit provision to which it applies;

(6) Each such form, including riders and endorsements, shall be identified by a form number in the lower left-hand corner of the first page thereof; and

(7) The policy shall contain no provision purporting to make any portion of the charter, rules, constitution or bylaws of the insurer a part of the policy unless such portion is set forth in full in the policy, except in the case of the incorporation of, or reference to, a statement of rates or classifications of risks, or short-rate table filed with the Commissioner.

(8) The policy shall contain no provision or nondisclosure clause prohibiting physicians or other health care providers from giving patients information regarding diagnoses, prognoses and treatment options.

Section 2. Amend Section 3354(a)(3), Title 18, of the Delaware Code by making insertions as shown by underlining and deletions as shown by strike through as follows:

§ 3354. Supplemental coverage for children of insureds.

(a) Definitions. -- As used in this section:

(3) "Dependent" means a covered person's child by blood or by law who is less than 26 years of age.~~:~~

~~a. Is less than 26 years of age;~~

~~b. Is unmarried;~~

~~c. Is a resident of Delaware or is enrolled as a full-time student at an accredited public or private institution of higher education; and~~

~~d. If not actually provided coverage as a named subscriber, insured, enrollee or covered person under any other group or individual health benefits plan, group health plan, or church plan, or entitled to benefits under 42 U.S.C. § 1395 et seq.~~

Section 3. Amend Section 3354(d), Title 18, of the Delaware Code by making insertions as shown by underlining and deletions as shown by strike through as follows:

§3354. Supplemental coverage for children of insureds.

(d) 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 ~~twenty-fourth~~ twenty-sixth birthday, may make a written election for coverage as a dependent pursuant to this section, until the dependent's ~~twenty-fourth~~ twenty-sixth birthday. The election must be made:

(1) Within 30 days prior to the termination of coverage at the specific age provided in the contract's language;

(2) Within 30 days after meeting the requirements for dependent status as set forth in subsection (a) of this section, when coverage for the dependent under the contract's language had previously terminated; or

(3) During an open enrollment period, as provided pursuant to the contract, if the dependent meets the requirements for dependent status as set forth in subsection (a) of this section during the open enrollment period.

Coverage for a dependent who makes a written election for coverage may not be conditioned upon or discriminate on the basis of lack of evidence of insurability.

Section 4. Amend Chapter 33, Title 18, of the Delaware Code by making insertions as shown by underlining as follows:

§ 3367. No lifetime or annual limits.

(a)(1) Except as provided in paragraph (b) of this section, a health insurance issuer offering group or individual health insurance coverage may not establish any lifetime limit on the dollar amount of benefits for any individual.

(2)(i) Except as provided in paragraphs (a)(2)(ii), (b) and (d) of this section, a health insurance issuer offering group or individual health insurance coverage may not establish any annual limit on the dollar amount of benefits for any individual.

(ii) A health flexible spending arrangement (as defined in section 106(c)(2) of the Internal Revenue Code) is not subject to the requirement in paragraph (a)(2)(i) of this section.

(b)(1) The rules of this section do not prevent a health insurance issuer offering group or individual health insurance coverage from placing annual or lifetime dollar limits with respect to any individual on specific covered benefits that are not essential health benefits to the extent that such limits are otherwise permitted under applicable Federal or State law.

(2) The rules of this section do not prevent a health insurance issuer offering group or individual health insurance coverage from excluding all benefits for a condition. However, if any benefits are provided for a condition, then the requirements of this section apply. Other requirements of Federal or State law may require coverage of certain benefits.

(c) The term "essential health benefits" as used in this section means essential health benefits under Section 1302(b) of the Patient Protection and Affordable Care Act, Delaware law and applicable federal and State regulations.

(d)(1) With respect to policy years beginning prior to January 1, 2014, a health insurance issuer offering group or individual health insurance coverage may establish, for any individual, an annual limit on the dollar amount of benefits that are essential health benefits, provided the limit is no less than the following amounts:

(i) For a policy year beginning on or after September 23, 2010, but before September 23, 2011, $750,000.

(ii) For a policy year beginning on or after September 23, 2011, but before September 23, 2012, $1,250,000.

(iii) For policy years beginning on or after September 23, 2012 but before January 1, 2014, $2,000,000.

(2) In determining whether an individual has received benefits that meet or exceed the applicable amount described in paragraph (d)(1) of this section, an issuer must take into account only essential health benefits.

Section 5. Amend Section 3517, Title 18, of the Delaware Code by making insertions as shown by underlining and deletions as shown by strike through as follows:

§ 3517. Preexisting conditions; limits.

(a) A group health insurance policy shall not include a provision that excludes coverage, and a health insurer shall not deny a claim under the policy, as a result of ~~contain a provision specifying the additional exclusions or limitations, if any, applicable under the policy with respect to~~ a disease or physical condition of a person~~, not otherwise excluded from the person's coverage by name or specified description~~ effective on the date of the person's loss, which existed prior to the effective date of the person's coverage under the policy. ~~Any such exclusion or limitation may only apply to a disease or physical condition for which medical advice or treatment was received by the person during the 12 months prior to the effective date of the person's coverage. In no event shall such exclusion or limitation apply to loss incurred or disability commencing after the earlier of (1) the end of a continuous period of 12 months commencing on or after the effective date of the person's coverage during all of which the person has received no medical advice or treatment in connection with such disease or physical condition; and (2) the end of the 2-year period commencing on the effective date of the person's coverage.~~ This subsection shall not apply to accident only; credit; dental; vision; Medicare supplement; benefits for long-term care, home health care, community-based care or any combination thereof; disability income insurance; liability insurance including general liability insurance and automobile liability insurance; coverage for on-site medical clinics; coverage issued as a supplement to liability insurance, worker's compensation or similar insurance; or automobile medical payment insurance.

(b) For those policies not subject to subsection (a), a group health insurance policy shall contain a provision specifying the additional exclusion or limitations, if any, applicable under the policy with respect to a disease or physical condition of a person, not otherwise excluded from the person's coverage by name or specific description effective on the date of the person's loss, which existed prior to the effective date of the person's coverage under the policy. Any such exclusion or limitation may only apply to a disease or physical condition for which medical advice or treatment was received by the person during the 12 months prior to the effective date of the person's coverage. In no event shall such exclusion or limitation apply to loss incurred or disability commencing after the earlier of (1) the end of a continuous period of 12 months commencing on or after the effective date of the person's coverage during all of which the person has

received no medical advice or treatment in connection with such disease or physical condition; and (2) the end of the 2-year period commencing on the effective date of the person's coverage.

~~(b)~~(c) Notwithstanding subsection (a) or (b) of this section, a group health insurance policy issued by a health insurer, health service corporation or health maintenance organization shall contain a provision which extends coverage for an insured who is hospitalized on the date coverage terminates for a period of 10 consecutive days during a single period of continuous hospitalization, if coverage terminations for any reason except nonpayment of premium. Benefits shall continue at the same level as provided in the terminated policy for the 10-day period.

~~(c)~~(d) Following the termination of the 10-day period set forth in subsection ~~(b)~~ (c) of this section, the succeeding insurer, if any, shall provide benefits for an insured who is hospitalized on the effective date of coverage at the level provided in the policy then in force, notwithstanding any preexisting conditions or other similar exclusions contained in the new policy. This provision applies only to a continuing single period of hospitalization.

Section 6. Amend Section 3570(a)(3), Title 18, of the Delaware Code by making insertions as shown by underlining and deletions as shown by strike through as follows:

§ 3570. Supplemental coverage for children of insureds.

(a) Definitions. -- As used in this section:

(3) "Dependent" means a covered person's child by blood or by law who is less than 26 years of age.~~:~~

~~a. Is less than 26 years of age;~~

~~b. Is unmarried;~~

~~c. Is a resident of Delaware or is enrolled as a full-time student at an accredited public or private institution of higher education; and~~

~~d. If not actually provided coverage as a named subscriber, insured, enrollee or covered person under any other group or individual health benefits plan, group health plan, or church plan, or entitled to benefits under 42 U.S.C. § 1395 et seq.~~

Section 7. Amend Section 3570(d), Title 18, of the Delaware Code by making insertions as shown by underlining and deletions as shown by strike through as follows:

§3570. Supplemental coverage for children of insureds.

(d) 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 ~~twenty-fourth~~ twenty-sixth birthday, may make a written election for coverage as a dependent pursuant to this section, until the dependent's ~~twenty-fourth~~ twenty-sixth birthday. The election must be made:

(1) Within 30 days prior to the termination of coverage at the specific age provided in the contract's language;

(2) Within 30 days after meeting the requirements for dependent status as set forth in subsection (a) of this section, when coverage for the dependent under the contract's language had previously terminated; or

(3) During an open enrollment period, as provided pursuant to the contract, if the dependent meets the requirements for dependent status as set forth in subsection (a) of this section during the open enrollment period.

Coverage for a dependent who makes a written election for coverage may not be conditioned upon or discriminate on the basis of lack of evidence of insurability.

Section 8. Amend Chapter 35, Title 18, of the Delaware Code by making insertions as shown by underlining as follows:

§ 3571H. No lifetime or annual limits.

(a)(1) Except as provided in paragraph (b) of this section, a group health plan, or a health insurance issuer offering group or individual health insurance coverage, may not establish any lifetime limit on the dollar amount of benefits for any individual.

(2)(i) Except as provided in paragraphs (a)(2)(ii), (b) and (d) of this section, a group health plan, or a health insurance issuer offering group or individual health insurance coverage, may not establish any annual limit on the dollar amount of benefits for any individual.

(ii) A health flexible spending arrangement (as defined in section 106(c)(2) of the Internal Revenue Code) is not subject to the requirement in paragraph (a)(2)(i) of this section.

(b)(1) The rules of this section do not prevent a group health plan, or a health insurance issuer offering group or individual health insurance coverage, from placing annual or lifetime dollar limits with respect to any individual on specific covered benefits that are not essential health benefits to the extent that such limits are otherwise permitted under applicable Federal or State law.

(2) The rules of this section do not prevent a group health plan, or a health insurance issuer offering group or individual health insurance coverage, from excluding all benefits for a condition. However, if any benefits are provided for a condition, then the requirements of this section apply. Other requirements of Federal or State law may require coverage of certain benefits.

(c) The term "essential health benefits" as used in this section means essential health benefits under Section 1302(b) of the Patient Protection and Affordable Care Act, Delaware law and applicable federal and State regulations.

(d)(1) With respect to plan years beginning prior to January 1, 2014, a group health plan, or a health insurance issuer offering group or individual health insurance coverage, may establish, for any individual, an annual limit on the dollar amount of benefits that are essential health benefits, provided the limit is no less than the following amounts:

(i) For a plan year beginning on or after September 23, 2010, but before September 23, 2011, $750,000.

(ii) For a plan year beginning on or after September 23, 2011, but before September 23, 2012, $1,250,000.

(iii) For plan years beginning on or after September 23, 2012 but before January 1, 2014, $2,000,000.

(2) In determining whether an individual has received benefits that meet or exceed the applicable amount described in paragraph (d)(1) of this section, a plan or issuer must take into account only essential health benefits.

§ 3571I. Guaranteed availability of coverage.

(a) Guaranteed availability of coverage in the group market. Subject to paragraphs (b) through (d) of this section, a health insurer that offers health insurance coverage in the group market in this State must offer to any employer in this State all products that are approved for sale in the group market, and must accept any employer that applies for any of those products.

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

(1) 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 CFR § 147.106(b)(3), pursuant to 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 CFR §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 CFR § 155.725(h).

(2) Special enrollment periods. A health insurer in the group market shall establish special enrollment periods for qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended. Enrollees shall 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 CFR §155.420(b). These special enrollment periods are in addition to any other special enrollment periods that are required under federal and state law.

(c) Special rules for network plans. (1) In the case of a health insurer that offers health insurance coverage in the group market through a network plan, the health insurer may do the following:

(i) Limit the employers that may apply for the coverage to those with eligible individuals in the group market who live, work or reside in the service area for the network plan.

(ii) Within the service area of the plan, deny coverage to employers if the carrier has demonstrated to the Commissioner the following:

(A) It will not have the capacity to deliver services adequately to enrollees of any additional groups because of its obligations to existing group contract holders and enrollees.

(B) It is applying paragraph (c)(1) of this section uniformly to all employers without regard to the claims experience of those employers and their employees (and their dependents) or any health-status related factor relating to such employees and dependents.

(2) A health insurer that denies health insurance coverage to an employer in any service area, in accordance with paragraph (c)(1)(ii) of this section, may not offer coverage in the group market within the service area to any employer for a period of 180 calendar days after the date the coverage is denied. This paragraph (c)(2) does not limit the health insurer's ability to renew coverage already in force or relieve the carrier of the responsibility to renew that coverage.

(3) Coverage offered within a service area after the 180-day period specified in paragraph (c)(2) of this section is subject to the requirements of this section.

(d) Application of financial capacity limits. (1) A health insurer may deny health insurance coverage in the group market if the health insurer has demonstrated to the Commissioner the following:

(i) It does not have the financial reserves necessary to underwrite additional coverage.

(ii) It is applying this paragraph (d)(1) uniformly to all employers in the group market in this State consistent with applicable State law and without regard to the claims experience of those employers and their employees (and their dependents) or any health status-related factor relating to such employees and dependents.

(2) A health insurer that denies health insurance coverage to any employer in this State under paragraph (d)(1) of this section may not offer coverage in the group market in this State before the later of either of the following dates:

(i) The 181st day after the date the health insurer denies coverage

(ii) The date the health insurer demonstrates to the Commissioner that the carrier has sufficient reserves to underwrite additional coverage.

(3) Paragraph (d)(2) of this section does not limit the carrier's ability to renew coverage already in force or relieve the carrier of the responsibility to renew that coverage.

(4) Coverage offered after the 180-day period specified in paragraph (d)(2) of this section is subject to the requirements of this section.

(5) The Commissioner may provide for the application of this paragraph (d) on service-area-specific basis.

(e) Marketing. A health insurer and its officials, employees, agents and representatives must comply with any applicable State laws and regulations regarding marketing by health insurers and cannot employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in health insurance coverage.

(f) Grandfathered health plans. This section does not apply to grandfathered health plans. For purposes of this section, "grandfathered health plans" means plans provided by a health insurer in which an individual was enrolled on March 23, 2010, for as long as it maintains that status in accordance with federal regulations.

§ 3571J. Prohibition on Excessive Waiting Periods. A group health plan and a health insurer offering group health insurance coverage shall not apply any waiting period that exceeds 90 days. As used in this section, "waiting period" means the period that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of a group health plan can become effective.

§ 3571K. Non-discrimination in health care.

(a) Providers. A group health plan and a health insurer offering group health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law. This section shall not require that a group health plan or health insurer contract with any health care provider willing to abide by the terms and conditions for participation established by the plan or insurer. Nothing in this section shall be construed as preventing a group health plan, a health insurer or the Commissioner from establishing varying reimbursement rates based on quality or performance measures.

(b) Individuals. The provisions of section 1558 of the Patient Protection and Affordable Care Act (relating to non-discrimination) shall apply with respect to a group health plan or health insurer offering group health insurance coverage.

§ 3571L. Comprehensive health insurance coverage.

(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 Section 1302 of the Patient Protection and Affordable Care Act 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 paragraphs (1) and (2) of section 1302(c) of the Patient Protection and Affordable Care Act and State law.

(c) Child-only plans. If a health insurer offers health insurance coverage in any level of coverage specified under section 1302(d) of the Patient Protection and Affordable Care Act 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 21.

(d) Dental only. This section shall not apply to a plan described in section 1302(d)(2)(B)(ii)(I) of the Patient Protection and Affordable Care Act.

§ 3571M. Prohibiting discrimination against individual participants and beneficiaries based on health status.

(a) In General. A group health plan and a health insurer offering group health insurance coverage may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan or coverage based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

(1) Health status.

(2) Medical condition (including both physical and mental illnesses).

(3) Claims experience.

(4) Receipt of health care.

(5) Medical history.

(6) Genetic information.

(7) Evidence of insurability (including conditions arising out of acts of domestic violence).

(8) Disability.

(9) Any other health status-related factor determined appropriate by the Commissioner.

(b) Programs of health promotion or disease prevention.

(1) General Provisions.

(A) General rule. For purposes of subsection (b)(2)(B), a program of health promotion or disease prevention (referred to in this subsection as a "wellness program") shall be a program offered by an employer that is designed to promote health or prevent disease that meets the applicable requirements of this subsection.

(B) No conditions based on health status factor. If none of the conditions for obtaining a premium discount or rebate or other reward for participation in a wellness program is based on an individual satisfying a

standard that is related to a health status factor, such wellness program shall not violate this section if participation in the program is made available to all similarly situated individuals and the requirements of paragraph (2) are complied with.

(C) Conditions based on health status factor. If any of the conditions for obtaining a premium discount or rebate or other reward for participation in a wellness program is based on an individual satisfying a standard that is related to a health status factor, such wellness program shall not violate this section if the requirements of paragraph (3) are complied with.

(2) Wellness programs not subject to requirements. If none of the conditions for obtaining a premium discount or rebate or other reward under a wellness program as described in paragraph (1)(B) are based on an individual satisfying a standard that is related to a health status factor (or if such a wellness program does not provide such a reward), the wellness program shall not violate this section if participation in the program is made available to all similarly situated individuals. The following programs shall not have to comply with the requirements of paragraph (3) if participation in the program is made available to all similarly situated individuals:

(A) A program that reimburses all or part of the cost for membership in a fitness center.

(B) A diagnostic testing program that provides a reward for participation and does not base any part of the reward on outcomes.

(C) A program that encourages preventive care related to a health condition through the waiver of the copayment or deductible requirement under a group health plan for the costs of certain items or services related to a health condition (such as prenatal care or well-baby visits).

(D) A program that reimburses individuals for the costs of smoking cessation programs without regard to whether the individual quits smoking.

(E) A program that provides a reward to individuals for attending a periodic health education seminar.

(3) Wellness programs subject to requirements. If any of the conditions for obtaining a premium discount, rebate or reward under a wellness program as described in paragraph (1)(C) is based on an individual satisfying a standard that is related to a heath status factor, the wellness program shall not violate this section if the following requirements are complied with:

(A) The reward for the wellness program, together with the reward for other wellness programs with respect to the plan that requires satisfaction of a standard related to a health status factor, shall not exceed 30 percent of the cost of employee-only coverage under the plan. If, in addition to employees or individuals, any class of dependents (such as spouses or spouses and dependent children) may participate fully in the wellness program, such reward shall not

exceed 30 percent of the cost of the coverage in which an employee or individual and any dependents are enrolled. For purposes of this paragraph, the cost of coverage shall be determined based on the total amount of employer and employee contributions for the benefit package under which the employee is (or the employee and dependents are) receiving coverage. A reward may be in the form of a discount or rebate of a premium or contribution, a waiver of all or part of a cost-sharing mechanism (such as deductibles, copayments, or coinsurance), the absence of a surcharge, or the value of a benefit that would otherwise not be provided under the plan. The Commissioner may increase the reward available under this subparagraph to up to 50 percent of the cost of coverage if the Commissioner determines that such an increase is appropriate.

(B) The wellness program shall be reasonably designed to promote health or prevent disease. A program complies with the preceding sentence if the program has a reasonable chance of improving the health of, or preventing disease in, participating individuals and it is not overly burdensome, is not a subterfuge for discriminating based on a health status factor, and is not highly suspect in the method chosen to promote health or prevent disease.

(C) The plan shall give individuals eligible for the program the opportunity to qualify for the reward under the program at least once each year.

(D) The full reward under the wellness program shall be made available to all similarly situated individuals. For such purpose, among other things:

(i) The reward is not available to all similarly situated individuals for a period unless the wellness program allows –

(I) for a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard; and

(II) for a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is medically inadvisable to attempt to satisfy the otherwise applicable standard.

(ii) If reasonable under the circumstances, the plan or health insurer may seek verification, such as a statement from an individual's physician, that a health status factor makes it unreasonably difficult or medically inadvisable for the individual to satisfy or attempt to satisfy the otherwise applicable standard.

(E) The plan or health insurer involved shall disclose in all plan materials describing the terms of the wellness program the availability of a reasonable alternative standard (or the possibility of waiver of the otherwise

applicable standard) required under subparagraph (D). If plan materials disclose that such a program is available, without describing its terms, the disclosure under this subparagraph shall not be required.

(4) Nothing in this section shall prohibit a program of health promotion or disease prevention that was established prior to the date of enactment of this section and applied with all applicable regulations, and that is operating on such date, from continuing to be carried out for as long as such regulations remain in effect.

§ 3571N. Insurance offered through the State health insurance exchange,

(a) A health insurer that offers health insurance coverage in the small group market through the State health insurance exchange program established pursuant to the Patient Protection and Affordable Care Act shall first satisfy all certification standards required by Federal and State law, and the health insurer shall offer only those plans that are "qualified health plans" as required by Federal and State law.

(b) The Commissioner shall adopt regulations, in accordance with the Administrative Procedures Act, that set forth the certification and compliance standards and requirements for health insurers operating within the State health exchange.

§ 3571O. Rating Factors. In establishing rates for health insurance coverage offered in the group market, health insurers shall comply with the rating requirements established under the Patient Protection and Affordable Care Act and 45 CFR §147.102. The Commissioner shall adopt regulations, in accordance with the Administrative Procedures Act, 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 Section 3573, Title 18, of the Delaware Code, by making insertions as shown by underlining and deletions as shown by strike through as follows:

§ 3573. Limitations on preexisting condition limitations.

A health benefit plan that covers a large group in this State:

(1) Shall not deny, exclude or limit benefits for a covered individual because of a preexisting condition ~~for losses incurred more than 12 months following the date of enrollment of the individual in such plan or, if earlier, the first day of the waiting period for such enrollment~~;

(2) ~~May impose a preexisting exclusion only if such exclusion relates to a condition (whether physical or mental), regardless of the cause of the condition for which medical advice, diagnosis, care or treatment was recommended or received within 6 months immediately preceding the effective date of coverage;~~

~~(3) Shall not impose any preexisting condition exclusion relating to pregnancy or in the case of a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning~~

~~on the date of the adoption or placement for adoption, is covered under creditable coverage. This paragraph shall not apply to coverage before the date of such adoption or placement for adoption;~~

~~(4)~~ May impose an affiliation period~~, if it does not utilize preexisting condition limitations~~. An affiliation period shall run concurrently with any waiting period. A health maintenance organization may, in lieu of an affiliation period, use an alternative method to address adverse selection with the prior approval of the Commissioner;

~~(5)~~ (3) Shall waive an affiliation period ~~or time period applicable to a preexisting condition exclusion or limitation~~ for the period of time an individual was previously covered by creditable coverage if such creditable coverage was continuous to a date not more than 63 days prior to the effective date of the new coverage. For purposes of calculating continuous coverage, a waiting period shall not be considered a gap in coverage. This paragraph shall not preclude application of any waiting period applicable to all new enrollees under the plan. The method of crediting and certifying coverage shall be determined by the Commissioner by regulation; and

~~(6)~~ (4) May not exclude coverage for late enrollees for a preexisting condition. ~~late enrollees for no more than an 18-month preexisting condition exclusion; except that, if both a waiting period and a preexisting condition exclusion are applicable to a late enrollee, the combined period shall not exceed 18 months from the date the individual enrolls for coverage under the health benefit plan. Health maintenance organizations that do not use preexisting condition exclusion periods in any of their plans may impose up to a 3-month affiliation period in lieu of the 18-month preexisting condition period.~~

Section 10. Amend Section 3602(6), Title 18, of the Delaware Code by making insertions as shown by underlining and deletions as shown by strike through as follows:

§3602. Definitions.

(6) "Dependent" means a spouse, an enrollee's child by blood or law who is less than 26 years of age ~~an unmarried child under the age of 18 years, an unmarried child who is a full-time student under the age of 25 years and who is financially dependent upon the enrollee~~ and an unmarried child of any age who is medically certified as totally disabled and dependent upon the enrollee.

Section 11. Amend Section 3606, Title 18, of the Delaware Code by making insertions as shown by underlining and deletions as shown by strike through as follows:

(a) Notwithstanding § 3306 of this title, 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 ~~insurer's~~ insured's health history or medical treatment history, the policy must cover any loss ~~occurring after 12 months~~ from any preexisting condition ~~not specifically excluded from coverage by terms of the policy~~,

and~~, except as so provided,~~ the policy or contract shall not include wording that would permit a defense based upon preexisting conditions.

(b) Notwithstanding subsection (a) of this section and § 3306 of this title, an insurer or a health service corporation which issues a specified disease policy, regardless of whether such policy is issued on the basis of a detailed application form, a simplified application for or an enrollment form, may not deny a claim for any covered loss that begins after the policy has been in force ~~for at least 6 months, unless such loss results from a preexisting condition which first manifests itself within 6 months prior to the effective date of the policy or contract or was diagnosed by a physician at any time prior to such date~~. Except for rescission for misrepresentation, no other defenses based upon preexisting conditions are permitted.

Section 12. Amend Chapter 36, Title 18, of the Delaware Code by making insertions as shown by underlining and deletions as shown by strikethrough as follows:

~~§ 3607. Limited guaranteed issue.~~

~~(a) Every carrier offering individual health plans in Delaware shall offer and accept for enrollment, pursuant to subsection (b) of this section, every federally eligible individual who applies for coverage within 63 days after termination of such individual's prior coverage, except that this requirement shall not apply to carriers offering coverage only through bona fide associations or to carriers offering individual coverage only through conversion policies.~~

~~(b) A carrier shall meet the requirements of subsection (a) of this section if:~~

~~(1) The carrier offers at least 2 different health benefit policy forms, both of which are designed for, are made generally available and actively marketed to and enroll both federally eligible and other individuals; and~~

~~(2) The offering of policy forms includes, at a minimum:~~

~~a. The policy forms for health benefit plan coverage with the largest and next to largest premium volume of all such policy forms offered by the carrier in Delaware; or~~

~~b. A lower-level coverage policy form and higher-level policy form which include benefits substantially similar to other individual health insurance coverage offered by the carrier in Delaware and are covered under a risk adjustment, risk spreading or financial subsidization method. As used in this subparagraph:~~

~~1. "Higher-level coverage" means a policy form for which the actuarial value of the benefits under the coverage is at least 15 percent greater than the actuarial value of lower-level coverage offered by the carrier in Delaware and the actuarial value of the benefits under the coverage is at least 100 percent but not greater than 120 percent of the policy form weighted average.~~

~~2. "Lower-level coverage" means a policy form for which the actuarial value of the benefits under the coverage is at least 85 percent but not greater than 100 percent of the policy form weighted average.~~

~~3. "Policy form weighted average" means the average actuarial value of the benefits provided by all the health insurance coverage issued (as elected by the carrier) either by that carrier or, if such data are available, by all carriers in Delaware in the individual health benefit plan market during the previous year (not including coverage issued under this section) weighted by enrollment for the different coverage.~~

~~c. Preexisting condition limitations shall not be applied to federally eligible individuals for coverage provided pursuant to this section.~~

~~(c) With respect to the provisions of subsection (b) of this section, a carrier that offers coverage in the individual market through a network plan may limit the individuals who may be enrolled to those that live, reside or work within the service area of the plan. Such a carrier may deny coverage to eligible individuals if it demonstrates to the Commissioner that it will not have the capacity to deliver services adequately to additional enrollees and it is applying this subsection uniformly to individuals without regard to any health status-related factor of such individuals and without regard to whether the individuals are eligible individuals.~~

~~(d) A carrier may apply to the Commissioner to suspend, for a period of time, its duty to issue coverage pursuant to subsection (b) of this section where continued compliance would adversely affect the financial condition of the company. Where such a suspension is granted, the carrier may not offer coverage in the individual market for a period of at least 180 days after the suspension is granted.~~

~~(e) For the purposes of this section, the term "health benefit plan" as defined in §3602(10) of this title does not include nonrenewable short-term individual health benefit plans with a duration of 6 months or less.~~

§ 3607. Guaranteed availability of coverage.

(a) Guaranteed availability of coverage in the individual market. Subject to paragraphs (b) through (d) of this section, a carrier that offers health insurance coverage in the individual market in this State must offer to any individual in this State all products that are approved for sale in the individual market, and must accept any individual that applies for any of those products.

(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 CFR

§155.410(b) and (e), with such coverage becoming effective consistent with the dates described in 45 CFR §155.410(c) and (f).

(2) Special enrollment periods. A carrier in the individual market shall establish special enrollment periods for qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended. Enrollees shall 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 CFR §155.420(b). These special enrollment periods are in addition to any other special enrollment periods that are required under federal and state law.

(c) Special rules for network plans. (1) In the case of a carrier that offers health insurance coverage in the individual market through a network plan, the carrier may do the following:

(i) Limit the individuals who may apply for the coverage in the individual market to those who live or reside in the service area for the network plan.

(ii) Within the service area of the plan, deny coverage to individuals if the carrier has demonstrated to the Commissioner the following:

(A) It will not have the capacity to deliver services adequately to enrollees of any additional individuals because of its obligations to existing contract holders and enrollees.

(B) It is applying paragraph (c)(1) of this section uniformly to all individuals without regard to the claims experience of those individuals (and their dependents) or any health-status related factor relating to such individuals and dependents.

(2) A carrier that denies health insurance coverage to an individual in any service area, in accordance with paragraph (c)(1)(ii) of this section, may not offer coverage in the individual market within the service area to any individual for a period of 180 calendar days after the date the coverage is denied. This paragraph (c)(2) does not limit the carrier's ability to renew coverage already in force or relieve the carrier of the responsibility to renew that coverage.

(3) Coverage offered within a service area after the 180-day period specified in paragraph (c)(2) of this section is subject to the requirements of this section.

(d) Application of financial capacity limits. (1) A carrier may deny health insurance coverage in the individual market if the carrier has demonstrated to the Commissioner the following:

(i) It does not have the financial reserves necessary to underwrite additional coverage.

(ii) It is applying this paragraph (d)(1) uniformly to all individuals in the individual market in this State consistent with applicable State law and without regard to the claims experience of those individuals (and their dependents) or any health status-related factor relating to such individuals and dependents.

(2) A carrier that denies health insurance coverage to any individual in this State under paragraph (d)(1) of this section may not offer coverage in the individual market in this State before the later of either of the following dates:

(i) The 181st day after the date the carrier denies coverage

(ii) The date the carrier demonstrates to the Commissioner that the carrier has sufficient reserves to underwrite additional coverage.

(3) Paragraph (d)(2) of this section does not limit the carrier's ability to renew coverage already in force or relieve the carrier of the responsibility to renew that coverage.

(4) Coverage offered after the 180-day period specified in paragraph (d)(2) of this section is subject to the requirements of this section.

(5) The Commissioner may provide for the application of this paragraph (d) on service-area-specific basis.

(e) Marketing. A carrier and its officials, employees, agents and representatives must comply with any applicable State laws and regulations regarding marketing by carriers and cannot employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in health insurance coverage.

(f) Grandfathered health plans. This section does not apply to grandfathered health plans. For purposes of this section, "grandfathered health plans" means plans provided by a health insurer in which an individual was enrolled on March 23, 2010, for as long as it maintains that status in accordance with federal regulations.

Section 13. Amend Chapter 36, Title 18, of the Delaware Code by making insertions as shown by underlining as follows:

§ 3609. Non-discrimination in health care.

(a) Providers. A health insurer offering individual health insurance coverage shall not discriminate with respect to participation under the coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law. This section shall not require that a health insurer contract with any health care provider willing to abide by the terms and conditions for participation established by the insurer. Nothing in this section shall be construed as preventing a health insurer or the Commissioner from establishing varying reimbursement rates based on quality or performance measures.

(b) Individuals. The provisions of section 1558 of the Patient Protection and Affordable Care Act (relating to non-discrimination) shall apply with respect to a health insurer offering individual health insurance coverage.

§ 3610. Comprehensive health insurance coverage.

(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 Section

1302 of the Patient Protection and Affordable Care Act 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 paragraph (1) of section 1302(c) of the Patient Protection and Affordable Care Act and State law.

(c) Child-only plans. If a health insurer offers health insurance coverage in any level of coverage specified under section 1302(d) of the Patient Protection and Affordable Care Act 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 21.

(d) Dental only. This section shall not apply to a plan described in section 1302(d)(2)(B)(ii)(I) of the Patient Protection and Affordable Care Act.

§ 3611. Prohibiting discrimination against individual participants and beneficiaries based on health status.

(a) In General. A health insurer offering individual health insurance coverage may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the coverage based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

(1) Health status.

(2) Medical condition (including both physical and mental illnesses).

(3) Claims experience.

(4) Receipt of health care.

(5) Medical history.

(6) Genetic information.

(7) Evidence of insurability (including conditions arising out of acts of domestic violence).

(8) Disability.

(9) Any other health status-related factor determined appropriate by the Commissioner.

§ 3612. Insurance offered through the State health insurance exchange,

(a) A health insurer that offers health insurance coverage in the individual market through the State health insurance exchange program established pursuant to the Patient Protection and Affordable Care Act shall first satisfy all certification standards required by Federal and State law, and the health insurer shall offer only those policies that are "qualified health plans" as required by Federal and State law.

(b) The Commissioner shall adopt regulations, in accordance with the Administrative Procedures Act, that set forth the certification and compliance standards and requirements for health insurers operating within the State health exchange.

§ 3613. Rating Factors. 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 and 45 CFR §147.102. The Commissioner shall adopt regulations, in accordance with the Administrative Procedures Act, 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 14. Amend subparagraphs (15), (16) and (34) of Section 7202, Title 18, of the Delaware Code by making insertions as shown by underlining and deletions as shown by strike through as follows:

§7202. Definitions.

(15) "Dependent" means a spouse, ~~an unmarried child under the age of 18 years, an unmarried child who is a full-time student under the age of 25 years and who is financially dependent upon the parent~~ a child under the age of 26 years, and an unmarried child of any age who is medically certified as totally disabled and dependent upon the parent.

(16) "Eligible employee" means an employee who works on a full-time basis and has a normal work week of 30 or more hours. The term includes ~~a sole proprietor,~~ a partner of a partnership and an independent contractor, if the ~~sole proprietor,~~ partner or independent contractor is included as an employee under a health benefit plan of a small employer, but does not include a sole proprietor, a family member of a sole proprietor, or an employee who works on a part-time, temporary or substitute basis.

(34) "Small employer" means any person, firm, corporation, partnership or association that is actively engaged in business that, on at least 50 percent of its working days during the preceding calendar quarter, employed no more than 50 eligible employees, the majority of whom were employed within this State. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of state taxation, shall be considered 1 employer. For the avoidance of doubt, a sole proprietorship that employs only the sole proprietor and/or such sole proprietor's family members shall not be considered a small employer for purposes of this Chapter.

Section 15. Amend Section 7207(c), Title 18, of the Delaware Code by making insertions as shown by underlining and deletions as shown by strike through as follows:

§ 7207. Availability of coverage; preexisting conditions; minimum participation

(c) Health benefit plans covering small employers shall comply with the following provisions:

(1) A health benefit plan shall not deny, exclude or limit benefits for a covered individual for losses due to a preexisting condition. ~~where such were incurred more than 12 months following the date of enrollment in such plan or, if earlier, the first day of the waiting period for such enrollment. A health benefit plan shall not define a preexisting condition more restrictively than a condition (whether physical or mental), regardless of the cause of the condition for which medical advice, diagnosis, care, or treatment was recommended or received within 6 months immediately preceding the effective date of coverage.~~

(2)~~a. A health benefit plan shall not impose any preexisting condition exclusion relating to pregnancy or in the case of a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. This subparagraph shall not apply to coverage before the date of such adoption or placement for adoption.~~

~~b. If a~~ A health maintenance organization ~~does not utilize preexisting condition limitations in any health benefit plan, it~~ may impose an affiliation period. An affiliation period shall run concurrently with any waiting period imposed. Such a health maintenance organization may, in lieu of an affiliation period, use an alternative method to address adverse selection with the prior approval of the Insurance Commissioner.

(3) A health benefit plan shall waive any affiliation period ~~time period applicable to a preexisting condition exclusion or limitation period~~ with respect to particular services for the period of time an individual was previously covered by qualifying previous coverage that provided benefits with respect to such services provided, that the qualifying previous coverage was continuous to a date not more than 63 days prior to the effective date of the new coverage, excluding any waiting period applicable to the new plan. This paragraph does not preclude application of any waiting period applicable to all new enrollees under the health benefit plan.

(4) A health benefit plan may not ~~either~~ exclude coverage for late enrollees for a preexisting condition. ~~18 months or contain an 18-month preexisting condition exclusion; provided, that if both a period of exclusion from coverage and a preexisting condition exclusion are applicable to a late enrollee, the combined period shall not exceed 18 months from the date the individual became eligible to enroll for coverage under the health benefit plan, except as provided in paragraph (1) of this subsection.~~

(5)a. Except as provided in subsection (d) of this section, requirements used by a small employer carrier in determining whether to provide coverage to a small employer, including requirements for minimum participation of

eligible employees, shall be applied uniformly among all small employers with the same number of eligible employees applying for coverage or receiving coverage from the small employer carrier.

b. A small employer carrier may vary the application of minimum participation requirements and minimum employer contribution requirements only by the size of the small employer group.

c. An employee who does not participate in the health benefit plan and who presents satisfactory evidence that the employee has coverage through a spouse or other qualifying existing coverage shall not be counted by a small employer carrier with respect to number or percent participation requirements.

d. A small employer carrier shall not increase any requirement for minimum employee participation or any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has contracted for coverage.

(6)a. If a small employer carrier offers coverage to a small employer, the small employer carrier shall offer coverage to all of the eligible employees of a small employer and their dependents. A small employer carrier shall not offer coverage to only certain individuals in a small employer group or to only part of the group, except in the case of late enrollees as provided in paragraph (4) of this subsection.

b. A small employer carrier shall not modify a basic or standard health benefit plan with respect to a small employer or any eligible employee or dependent through riders, endorsements or otherwise, to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan.

Section 16. Amend Section 2 of Chapter 246, Volume 78, of the Delaware Laws by making deletions as shown by strike through as follows:

"Section 2. This Act shall take effect within 30 days of its enactment ~~and shall expire on January 1, 2014~~."

Section 19. Effective Date. This law shall apply to all individual and group health insurance contracts, as applicable, issued or renewed on or after January 1, 2014. For the avoidance of doubt, this Act shall not apply to accident-only, dental only, vision care only, specified diseases, long term care, hospital, indemnity, disability income or other fixed indemnity policies.

SYNOPSIS

This bill is designed to bring the health insurance provisions of the Delaware Insurance Code in compliance with the Patient Protection and Affordable Care Act ("PPACA").

Sections 1, 2, 3, 6, 7, 10, and 14 (in part) of this bill amend the Delaware Insurance Code to reflect the requirement that dependents be covered up until the age of 26.

Sections 5, 9, 11, and 15 of this bill amend the Delaware Insurance Code to reflect the requirement that coverage not be denied due to preexisting conditions.

Section 4 of this bill adds a new provision to the Delaware Insurance Code for individual health insurance policies that (i) prohibits insurance companies from imposing lifetime and annual limits on essential health benefits for policies that have policy years beginning on or after January 1, 2014, and (ii) for policies that have policy years beginning prior to January 1, 2014, sets the minimum limits insurance companies may impose for essential health benefits.

Section 8 of this bill adds several new provisions to Chapter 35 of the Delaware Insurance Code (relating to group and blanket health insurance policies), specifically including provisions that: (i)(A) prohibit insurance companies from imposing lifetime and annual limits on essential health benefits for policies that have policy years beginning on or after January 1, 2014, and (B) for policies that have policy years beginning prior to January 1, 2014, set the minimum limits insurance companies may impose for essential health benefits; (ii) require guaranteed availability of coverage and set forth the enrollment period and network plan requirements; (iii) prohibit excessive waiting periods; (iv) prohibit discrimination against health care providers; (v) require health insurance companies to ensure that (A) plans offered cover all essential health benefits, (B) annual cost-sharing provisions do not exceed the limitations imposed by PPACA and (C) the health insurance companies offer child-only plans; (vi) prohibit discrimination against participants and beneficiaries based on health status and provide the requirements for health promotion and disease prevention programs; and (vii) discuss the certification requirements for participation in the State health exchange program.

Section 12 of this bill deletes the current provision in the Delaware Insurance Code regarding limited guarantee issue of insurance policies and adds a new provision relating to individual health insurance policies that requires guaranteed availability of coverage and sets forth the enrollment period and network plan requirements.

Section 13 of this bill adds several new provisions to Chapter 36 of the Delaware Insurance Code (relating to individual health insurance policies), specifically including provisions that: (i) prohibit excessive waiting periods; (ii) prohibit discrimination against health care providers; (iii) require health insurance companies to ensure that (A) coverage offered covers all essential health benefits, (B) annual cost-sharing provisions do not exceed the limitations imposed by PPACA and (C) the health insurance companies offer child-only plans; (iv) prohibit discrimination against participants and beneficiaries based on health status; and (v) discuss the certification requirements for participation in the State health exchange program.

The remaining amendments set forth in Section 14 of this bill (relating to Section 7202(16) and (34)) amend the definitions of “eligible employee” and “small employer” to conform to the federal definition, which dictates that sole proprietors and their family members are not “eligible employees” for purposes of acquiring a small group insurance policy.

Section 16 of this bill relates to the Mini-COBRA small employer group health policies provision, 28 Del. Laws, c. 246 (the “Mini-COBRA Bill”). The Mini-COBRA Bill was originally passed as a short-term bill that was needed until the provisions of the Patient Protection and Affordable Care Act (“PPACA”) became applicable to states, which was to occur on January 1, 2014. However, because PPACA’s legislation relating to small employer group health policies now permits insurance companies to impose a ninety (90) day waiting period prior to the effective date of coverage, which was not anticipated when the Mini-COBRA Bill was passed, it is desirable to remove the sunset provision of the Mini-COBRA Bill so that the Mini-COBRA Bill remains in the Delaware Code, at least until a point in time when PPACA or other law may no longer permit an insurance company to impose waiting periods.