Date: May 3, 2017

To: All Minnesota Health Plan Companies

This letter provides health plan companies guidance for health insurance filings that will be offered, sold, issued, or renewed in Minnesota on or after January 1, 2018 ("Plan Year 2018"). This letter focuses on new statutory and certification requirements applicable to individual and small group health and certified dental plan filings. It includes information related to deadlines, policy changes, and other Minnesota requirements. In addition to new requirements, the Minnesota Departments of Commerce and Health ("Departments"), along with MNsure, will continue to review health plan filings to ensure compliance with all applicable state and federal requirements, including Minnesota Statutes and the Affordable Care Act ("ACA"). Information and materials related to this letter are subject to change as corresponding Minnesota and Federal regulations are modified.

Deadlines

Filings are due on a staggered schedule as shown below. This schedule is subject to change, given the unknown timing of applicable final federal guidance and the timing of the release of risk adjustment studies. Health plan companies should provide the Departments with feedback on the feasibility of the schedule shown below:

- May 10, 2017: Minnesota deadline for filing all SERFF form filings (application, certificate of coverage, master group contract, etc.) for the individual and small group markets, on and off-exchange.

- May 17, 2017: Minnesota deadline for filing all SERFF binder content, other than Summary of Benefits and Coverages (SBCs) and rate items for both the individual and small group markets, both on and off-exchange.

- May 26, 2017: All network filings must be submitted to the MDH network portal.

- June 18, 2017: Deadline for filing SBCs. Note that the SBC format has been redesigned since the prior year, though small group plans are already using the new format as of April 1, 2017.

- July 17, 2017: All SERFF rate filings and rate-related binder items for individual and small group markets, both on and off-exchange, should be submitted.

---

1 System for Electronic Rate and Form Filing supported by the National Association of Insurance Commissioners (NAIC): [https://login.serff.com/index.html](https://login.serff.com/index.html)

2 Rate-related binder items include the URRT, actuarial memoranda, rate templates, Part II plain language narrative summarizing the rate increase justification, and the enrollment cap request template (new).
• July 31, 2017: Departments make the following proposed small group and individual market filing elements available to the public through SERFF public access: rate template, plan and benefits template, service area template, redacted actuarial memorandum, URRT, crosswalk, and Part II narrative (the plain language description of the reasons for the rate increase).

• August 16, 2017: No further changes initiated by health plan companies will be permitted. Health plan companies can make changes to respond to pending data requests and objections from the Departments.

2018 Federal and State Policy Changes

All filings must be in compliance with the final Health and Human Services Notice of Benefit and Payment Parameters (NBPP) for 2018 and other emerging Federal guidance. In addition, all filings must be in compliance with any applicable new laws passed by the Minnesota Legislature.

Recent Federal guidance that may affect Minnesota plan filings includes the following:

2018 Notice of Benefit Payment Parameters and Final Market Stabilization Rule

• The 2018 maximum annual limitation on cost sharing is $7,350 for individual coverage and $14,700 for family coverage (medical). Please clearly describe in plain language the mathematics of the application of an individual’s deductibles and out of pocket maximums within family coverage for both policy forms and SBCs, as this issue is often the cause for consumer confusion.

• Based on the 2018 NBPP and final guidance, for Plan Year 2018 the open enrollment period for individual marketplaces is November 1, 2017 through December 15, 2017.

• As proposed in the NBPP, the final rule expanded the bronze, silver, gold, and platinum variation de minimis range. The expanded variation around the bronze actuarial value target must either be compatible with a health savings account or provide coverage for at least one major non-preventive service prior to application of the deductible. See the NBPP for more detail on what qualifies as a major non-preventive service.

• For Plan Year 2018, Minnesota will not change the age curve from the unique curve which has been used in the 2014-2017 plan years. Data provided from health plan companies show that Minnesota’s age curve is more representative of cost relativities

---

3 See Senate File 1 (2017 legislative session) revisions to Minn. Stat. § 60A.08 subd. 15.
4 Lower limits for plans compatible with health savings accounts have not yet been announced by the IRS. The standalone dental limits are $350 (one child) and $700 (two or more children).
than the former or new federal standard age curve.

- There is no requirement for a health plan company to offer standardized plans. However, if a health plan company uses the standardized plan naming conventions, the Departments will review for parameter compliance.6

- Cost sharing must be counted toward the out of pocket maximum for an out-of-network provider in an in-network setting providing an essential health benefit.

- The definition of plan and product has been clarified. The objective of annual federal guidance changes on the definition of a plan and a product is to ensure that rate review authority is granted to regulators for all continuing issuers, despite the designation of plans as “new” and despite the new opportunity for health plan companies to renew plans in different issuers within the controlled group. Rate review authority has always existed in Minnesota, both for new and continuing health plan companies, under Minn. Stat. §62A.02, and is applicable regardless of whether or not a rate increase exceeded 10 percent. The Departments will review each 10-digit HIOS product ID to ensure that the plans offered within the product line retain a consistent coverage benefit set and product network type - that is, Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), EPO, Point of Service (POS), indemnity - within a service area.

- The NBPP changed the top 15 language tagline requirements, though most health plan companies met those requirements in Plan Year 2017. Health plan companies are encouraged to review the changed federal guidance to ensure that the prior year choice of languages continues to meet the revised requirements and the most recent guidance published the Secretary.7

- Health plan companies participating on the exchange must now offer at least one silver QHP and at least one gold QHP throughout each exchange-service area under revisions to 45 CFR §156.200 (c)(1). Health plan companies had already satisfied this requirement under the prior version of the federal and state law, though such requirement was in place only in cases where a bronze or catastrophic QHP was also sought. All health plan companies, including off-exchange health plan companies, must follow state law requiring both gold and silver plans to be offered throughout the service area when bronze or catastrophic plans are offered.8 The Metal Level Compliance Spreadsheet will be revised to accommodate the new change placed upon on QHPs.

---

8 See Minn. Stat. § 62K.06 subd. 2
• Current standards for the inclusion of Essential Community Providers (ECPs) will be modified to require inclusion of a minimum of 20 percent of available designated ECPs in the service area, and a minimum of 20 percent of designated Dental ECPs in the service areas for Stand Alone Dental Plans (SADPs). Consistent with guidance to issuers in the Federally Facilitated Exchange (FFE), this standard augments current requirements for the inclusion of at least one ECP in each of four ECP provider types (primary care, family planning, mental health and chemical dependency) when a designated ECP of that type is available in a given county, and the offering of contracts to all designated Indian Health ECPs within the health plan’s service area. SADPs must seek to contract with Indian Health ECPs that offer dental services in their service area. Under Minn. Stat. §62Q.19, a health plan company must offer a contract to any designated ECP in the health plan’s service area that requests a contract.

• The NBPP amended 45 CFR §147.106(h)(2) and 45 CFR §148.122(b)(2) to finalize an interpretation that the anti-duplication provision prohibits an enrollee who is either entitled to Medicare Part A or enrolled in Medicare Part B to re-enroll in individual coverage if the issuer has knowledge that the coverage would duplicate benefits under title XVIII or title XIX of the Act to which the enrollee is entitled, unless the renewal is effectuated under the same policy or contract of insurance. The crosswalk will reflect the renewal plan that qualifies for protected guarantee renewal rights for those who are entitled to or enroll in Medicare. Other renewals or new sales are likely in violation of Section 1882(d)(3) of the Social Security Act.

• The final Market Stabilization Rule allows issuers to limit guarantee availability rights based on nonpayment of premiums in the prior 12 months for individual, small group and large group markets. If the policy is adopted by an issuer, it must be done so in a uniform, nondiscriminatory manner. Further, enrollment and application forms must be revised to reflect such administrative changes, and approved, in order to take advantage of this opportunity.

• Per the NBPP, the two-year pediatric orthodontic waiting period is now disallowed; however, this change had already been made in Plan Year 2017 because of changes made to Minnesota’s dental benchmark plan.

---

CURES Act: Small Group Implications

The CURES Act\textsuperscript{10}, Section 18001, provides small employers an opportunity to offer a new type of tax-free benefit called a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) and allows an exception to the previous prohibition on employers from providing cash or compensation to employees, if the money is conditioned on the purchase of individual health insurance.\textsuperscript{11} Individual market sales would be suitable if the small employer offered a QSEHRA, but would continue to be problematic for tax exemptions and thus potentially unsuitable outside of this newly available scenario.\textsuperscript{12} Health plan companies should consider application form changes to accommodate the new QSEHRA special case.

State Law Changes

Health plan companies are reminded that the emergency services definition\textsuperscript{13} statute was expanded in the 2015 legislative session to include emergency services delivered outside of the hospital setting. Emergency Medical Treatment and Labor Act (EMTALA) and state prudence standards\textsuperscript{14} must be used to adjudicate the difference between an emergency and a non-emergency.\textsuperscript{15} Section 2719A of the ACA became effective for plan years beginning on or after September 23, 2010, and even applies to large group and self-insured employer plans, other than grandfathered plans.

2016 legislative session individual and small group filings changes:

- Provider Network Notifications (Minn. Stat. § 62K.075) require monthly updates to provider networks; however, federal regulation 45 CFR §156.230(b) also newly requires monthly updates to the full list (including provider new patient capacity, location, contact information, specialty, medical group, and institutional affiliations changes) and extends the reporting requirements to standalone dental plans.

- Coverage of Telemedicine Services (Minn. Stat. §62A.672): Telemedicine services must be treated in the same manner as any other benefits covered. This change was reflected in Plan Year 2017 filings.

\textsuperscript{10} Refers to the “21\textsuperscript{st} Century Cures Act,” see: https://www.congress.gov/bill/114th-congress/house-bill/34/text
\textsuperscript{13} Minn. Stat. § 62Q.55 subd. 3 (3)
\textsuperscript{14} (Which indirectly reference EMTALA via reference to section 1867 of the Social Security Act, see Minn. Stat. § 62Q.55 subd. 2 and 3)
\textsuperscript{15} See 45 CFR § 147.138 (b)(4)(ii), noting that the reference to 1867 of the Social Security Act is the EMTALA prudence standard.
While certain state changes are addressed elsewhere in this letter, the 2017 legislative session’s effect on individual and small group filings also includes the following items:

- Unauthorized provider services (Minn. Stat. § 62Q.556): New law requires application of in-network cost sharing in certain circumstances, notwithstanding advance written consent, such as services received from an out of network (OON) provider at an in-network facility, and an in-network provider sending specimens to an OON lab. In light of this legislative change, health plan companies must review policy form language as well as claims, appeals, and arbitration processes. The Departments will add a template to the binder where descriptions on how health plan companies will know whether an enrollee gave a provider advanced written notice under Minn. Stat. § 62Q.556 subd. 1(c), and how to meet the reimbursement negotiation attempt requirements of Minn. Stat. § 62Q.556 subd. 2(b). This provision takes effect on January 1, 2018.

- Appeal of waiver of network adequacy requirements (Minn. Stat. § 62K.10): Modification of Minn. Stat. § 62K.10, inserts a new subdivision, which allows providers, “aggrieved by the issuance of the waiver” granted by the Commissioner of Health under Minn. Stat. § 62K.10, subd. 5 to appeal the waiver granted using the contested case procedures under Minnesota Statutes, Chapter 14. The new language stipulates that a, “contested case proceeding must be initiated within 60 days after the date on which the commissioner grants a waiver.” Without further guidance in the legislation, the Departments interpret this to mean that waivers are granted upon approval of the provider network, and concurrent with the final approval of premium rates. To make the intent of this statute actionable, all approved provider network waiver requests will be posted on the Minnesota Department of Health website concurrent with the posting of provider network service areas and premium rates. If a waiver is nullified through a contested case proceeding and no judicial review is sought, the health carrier must submit a modified provider network filing within 30 days after the deadline for seeking judicial review.

- For those counties in which a health carrier actively markets an individual health plan, the health carrier must offer, in the same counties, at least one individual health plan with a provider network that includes in-network access to more than a single health care provider system. Minn. Stat. § 62K.10 subd. 1a, See 2017 Session Laws, Chapter 13. A template has been added to the plan management supporting documents tab to demonstrate compliance with this new requirement. This requirement may not be waived.

For-profit HMOs:

- For-profit domestic and foreign corporations are now allowed to apply for HMO licensure in Minnesota. Both foreign and domestic for profit corporations must apply for licensure under Minnesota HMO law, and must comply with all applicable HMO laws. Please contact Tom Major at MDH if this is a desired action affecting Plan Year 2018 filings.
Actuarial Requirements

In the 2017 legislative session, legislation passed providing premium subsidies in the individual market. An additional rate table is required on the individual market health insurance filings to help the Departments and federal regulators understand the financial effects of the new program and to assist with waiver documentation and processes. This will be an ongoing requirement, and is not unique to plan year 2018 as might be presumed due to the contingent nature of the reinsurance program upon federal waiver approval. Affected Actuarial Memoranda should be expanded to adequately justify the difference between the two rate tables submitted.

Actuaries should review and follow CMS’s Plan Year 2018 URRT instructions. The most recent version of the URRT is version 4.2. Note that HIOS can now display rich characters for the Part II narrative (such as quotations, $, and %), and allows for bullet point outline formats in the description. While the rate table template now allows for a “rating method” choice between “age-based rates,” and “family-tier rates,” only certain dental issuers may use family-tier rates. Medical plans may not use family-tier rates since every rate for every family member must reflect Minnesota’s age curve.

The following list clarifies continuing actuarial issues:

- For the individual medical market, two sets of rates should be provided on HIOS and SERFF: one assuming the Section 1332 waiver is approved and one assuming the Section 1332 waiver is not approved.

- An actuarial statement of good standing is requested for all filings. In terms of demonstrating good financial standing, the Actuarial Memorandum should not publicly discuss Risk-Based Capital or capital information not already available to the public. Such information can be provided on a trade secret basis.

- Actuaries should evaluate whether an enrollment cap is necessary or not, as there is an exception to guarantee issue based on financial strength and network capacity.

---

17 https://www.qhpertificiation.cms.gov/s/Unified%20Rate%20Review
18 However, “<”, “>”, “=" and “/” are still not allowed with the rich character upgrade.
19 Off exchange dental, and on exchange small group dental, may use family-tier rates.
20 Dental issuers should consult the plan management instructions for the allowed rating relativities in the family tier structure.
21 Some states have gained approval from HHS to allow family tiering and family composite rating. Minnesota has not.
Actuaries should describe both how much enrollment growth could be withstood, assuming that pricing assumptions are met as expected, as well as how much enrollment growth could be withstood if the company experiences a material underwriting loss, such as 10 percent.

Any such request should be clearly identified as a request in the, “Enrollment Cap Request and Justification” section now provided in the binder, and is subject to regulatory approval.

If financially based, documentation must be provided in enough detail such that another actuary can determine the reasonability of the request based on the facts and circumstances applicable and unique to the requesting health plan company.

Due to frequent public inquiry, the Actuarial Memorandum should clearly, and separately, display the formula inputs, outputs, and outcome for spreading estimated MNsure user fees and estimated producer compensation evenly to all products.

Issuers are reminded to provide separate identification and justification of how the state premium tax, HMO surcharge, PCORI fees and federal health insurer tax is incorporated into rates. Given the 2017 moratorium on the health insurer tax, small group issuers should specifically evaluate, we expect actuaries to identify and justify how the moratorium was partially credited to 2018 (versus 2017). If federal law is timely passed to extend the moratorium, the Departments expect to see rate justifications that credit that moratorium as well.

**Minnesota Network Adequacy Review Requirements**

All carriers must submit complete provider network adequacy documentation for networks that are to be newly certified and for provider networks that will be recertified, including provider files, geographic access maps, network adequacy attestation documents, requests for waivers, and requests for waivers for Essential Community Providers (ECPs).

Carriers must submit provider network and ECP information using the Minnesota provider network template. The provider network template can be found at the Minnesota Department of Health (“MDH”) Network Adequacy Instructions web page. As with medical provider networks, stand-alone dental networks are subject to Minn. Stat. §62Q.19 subd. 3 applying to ECP’s. If a dental ECP requests a contract, and meets other contracting requirements, they must be offered participation in all networks of the health plan company.
Plan Management General Instructions

Ongoing operational and administrative instructions of Minnesota’s rate, form, and binder requirements are provided within the Minnesota Plan Management General Instructions of SERFF (located in the binder). The document has been changed throughout to address clarifications and corrections from prior versions.

In the plan management instructions, the Departments have changed language around reconciling state guarantee renewal rights with the federal uniform modification rules to address newer state guidance from 2016 that allowed for application of Minn. Stat. §62D.121 (as always applicable to HMOs) to apply consistently to health service corporations and insurers. Minnesota Statutes section 62D.121 addresses changes of service areas.

Minnesota will use the federal crosswalk template rather than a unique Minnesota Crosswalk Template. All renewals must be described on one version of the crosswalk, including off-exchange renewals (manual entry will be required as the federal tools do not provide off exchange functionality). A separate QHP-only version is also required for health plan companies selling plans through MNsure.

Note that the federal crosswalk provides the opportunity for zip code level renewals within a county; the Departments (for nondiscrimination concerns) and MNsure (for operational concerns) presume that there is a one-to-one relationship between 2017 and 2018 plan renewals at the county level – not the zip code level. If a health plan company wishes to have a zip code level renewal within a county, permission must be sought and granted from the applicable Department and MNsure (if applicable) in advance. A template to request this permission has been added; the deadline for this form in the binder is May 17, 2017.

The major plan management changes since last year are as follows:

• The Departments will revert to the federal crosswalk template, though two versions are needed for those issuers selling both off- and on-exchange.

• The Departments have created a new template to request zip code level renewals within a county, which is only required when such levels of renewals are requested.

• The Metal Level Compliance Spreadsheet has been revised because of federal guidance changes, as well as to collect information regarding catastrophic plan renewals to bronze plans for those who turn age 30, since this information is not collected on the federal crosswalk.

• A new template has been added to allow the issuer to describe compliance with the new unauthorized provider services statutes (new state law effective January 1, 2018).

• A new template has been added for the issuer to demonstrate compliance with the new state requirement under Minn. Stat. §62K.10 subd. 1a that at least one plan must have access to
more than one health system.

- A template has been added for justifying and documenting an enrollment cap, which is required only when an enrollment cap is requested. If the template is completed and documentation submitted to substantiate a “trade secret” claim under Minnesota Statutes, section 13.37, subd. 1a, this template will be considered as trade secret. Publicly available documentation will be posted on SERFF in cases where enrollment caps are approved.

- While the template has not changed, this year the Departments will request three separate years of provider compensation information (two years were collected last year): plan years 2016, 2017 and 2018.

- Pursuant to Minn. Laws 2017 Chapter 13 Article 1 Sec. 13, the Departments will require submission of a rate table that assumes that the Minnesota Premium Security Plan does not exist. This will be an annual requirement going forward, and is needed to operationalize HHS’s analysis for financial waiver support. Both the value of the reinsurance subsidy and the morbidity impact should be reflected in this rate table. This rate table cannot be marked trade secret.

The Departments have not revised Minnesota’s SERFF plan management instructions, as SERFF is awaiting final federal guidance to be released in order to finalize certain templates and section descriptions. The Departments expect to revise materials as soon as possible, and will release a message through SERFF when changes have been made.

**Posting of Filings**

As in the past, Minnesota will post a link to [Healthcare.gov](http://healthcare.gov) on its regulator website. Healthcare.gov posts fields from the proposed Part I URRT, text from the Part II Narrative and the entire redacted Part III Actuarial Memorandum. Based on preliminary information supplied from CMS, the Departments expect that proposed rates on healthcare.gov will be posted on August 1, 2017.

Pursuant to 2017 legislative changes, the Departments plan to make initially submitted rate tables, plan & benefits templates, URRTs, the redacted actuarial memorandum, the Part II rate increase justification narrative, and service areas available to the public within 10 business days. No interim changes will be made available to the public. Upon approval, the Departments will continue to post rate, form, and binder data based upon state and Federal laws, and in accordance with the implementation date selected by the health plan company on each filing reported within SERFF, but in no case later than 30 days prior to the first day of open enrollment.

---

22 Minn. Stat. § 60A.08, subd. 15 (g)
23 Minn. Stat. § 62A.02, subd. 2 (c)
Network adequacy data becomes public only after approved by MDH, which will generally be completed after the health plan's rate filing has been approved. If MDH receives a request for network data after the network filing and corresponding rates have been approved in a plan management binder, it will be provided to the requesting party.

**Quality Information Strategies (QIS)**

For the purposes of the 2018 QIS requirements, Minnesota will use federal quality templates.24

**Overview of Filing Requirements and Resources**

In preparing 2018 health and certified dental plan filings, issuers should review key statutory requirements that govern filings, per the applicable licensed product, to ensure all new 2017 statutory requirements are incorporated. These include, but are not limited to requirements in the following chapters:

Chapter 62A. Accident and Health Insurance25
Chapter 62C. Nonprofit Health Service Plan Corporations26
Chapter 62D. Health Maintenance Organizations (HMO)27
Chapter 62E. Comprehensive Health Insurance28
Chapter 62K. Minnesota Health Plan Market Rules29
Chapter 62L. Small Employer Insurance Reform30
Chapter 62Q. Health Plan Companies31
Chapter 62V. MNsure32

Companies should refer to all relevant Minnesota Statutes and Rules as well as applicable Federal law in developing form and rate filings submitted to the Departments for approval.

---

25 https://www.revisor.mn.gov/statutes/?id=62A
26 https://www.revisor.mn.gov/statutes/?id=62C
27 https://www.revisor.mn.gov/statutes/?id=62D
28 https://www.revisor.mn.gov/statutes/?id=62E
29 https://www.revisor.mn.gov/statutes/?id=62K
30 https://www.revisor.mn.gov/statutes/?id=62L
31 https://www.revisor.mn.gov/statutes/?id=62Q
32 https://www.revisor.mn.gov/statutes/?id=62V
Dental (QDP) Certification Requirements

MNsure will publish revised qualified dental plan (QDP) certification requirements in the next two weeks on its website. On and off exchange dental issuers should review those certification requirements.

Additional Resources

Checklist guides for the Commerce Department Major Medical and Dental Coverage: [https://mn.gov/commerce/industries/insurance/filings-examinations/rate-form-filings/](https://mn.gov/commerce/industries/insurance/filings-examinations/rate-form-filings/)

MNsure Plan Certification Guidance for Qualified Dental Plans (newly revised): [www.mnsure.org](http://www.mnsure.org)

MDH Network Adequacy filing instructions: [http://www.health.state.mn.us/divs/hpsc/mcs/networkadequacy.htm](http://www.health.state.mn.us/divs/hpsc/mcs/networkadequacy.htm)

Provider Network Adequacy System: [https://apps.health.state.mn.us/networkadequacy-submission/home.seam](https://apps.health.state.mn.us/networkadequacy-submission/home.seam)

CMS 2018 QHP certification review website: [https://www.qhpcertification.cms.gov](https://www.qhpcertification.cms.gov)

Accreditation Requirements: [http://www.health.state.mn.us/divs/hpsc/mcs/accreditation.htm](http://www.health.state.mn.us/divs/hpsc/mcs/accreditation.htm)


Please contact Maybeth Moses (Commerce) at maybeth.moses@state.mn.us or Tom Major (Health) at tom.major@state.mn.us if you have any questions about the process.

Sincerely,

Fred Andersen
Acting Deputy Commissioner of Insurance
Minnesota Department of Commerce

Gilbert Acevedo
Assistant Commissioner, Health Systems Bureau
Minnesota Department of Health