Date: **April 6, 2018**
To: **All Minnesota Health Plan Companies**
RE: **Preliminary Guidance - 2019 Health Insurance Filings**

This letter provides health plan companies guidance for health insurance filings for plans that will be offered, sold, issued, or renewed in Minnesota on or after January 1, 2019 ("Plan Year 2019").

In previous years, the Minnesota Departments of Commerce and Health (Departments) have issued a single comprehensive filing guidance letter that included filing deadlines, policy changes, and other new requirements. This year, in order to provide as much information as early as possible, the Departments will provide two letters. This letter provides anticipated filing deadlines and provides guidance on new statutory and certification requirements applicable to individual and small group health and certified dental filings that are available as of March 30, 2018. A second guidance letter will be issued after the final Notice of Benefits and Payment Parameters (NBPP) is released.

The requirements contained in both letters will be included in the filing reviews by the Departments to ensure compliance for Plan Year 2019. In addition to new requirements, the 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.

- May 11, 2018: Minnesota deadline for filing all SERFF[1] form filings (application, certificate of coverage, master group contract, etc.) for the individual and small group markets, on and off-exchange.
- May 25, 2018: All network filings must be submitted to the MDH network portal.
- June 1, 2018: Minnesota deadline for filing all rate filings and SERFF binder content, except for Summary of Benefits and Coverages (SBCs) and the Enrollment Cap Request Template.
- June 15, 2018: Departments make certain binder elements available to the public through SERFF public access pursuant to Minnesota Statutes section 60A.08, subd. 15(g). This will include the public release of proposed changes to rates.

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

- June 22, 2018: Deadline to submit the Enrollment Cap Request Template for health plan companies seeking an enrollment cap.
- June 29, 2018: Deadline for SBCs.
- August 22, 2018: 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.
- November 1, 2018: Open Enrollment Begins

2019 Federal Changes

All filings must be in compliance with the final Health and Human Services NBPP for 2019 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 include the following:

Federal Register Volume 81, No. 243[2]
On December 19, 2016, the Internal Revenue Service (IRS) issued new guidance that changes the calculation of the second lowest silver plan benchmark for family coverage. For Plan Year 2019 and beyond, the applicable benchmark plan is determined by ranking (1) the premiums for the exchange's silver-level qualified health plans that include pediatric dental benefits and (2) the exchange's premiums for the silver-level qualified health plans that do not include pediatric dental benefits plus the portion of the premium allocable to pediatric dental benefits for stand-alone dental plans.

In constructing this ranking, the premium for the second lowest-cost silver plan that does not include pediatric dental benefits is added to the premium allocable to pediatric dental benefits for the second lowest-cost stand-alone dental plan. Questions and concerns related to understanding, operationalizing and communicating this change to the benchmark premium should be directed to MNsure.

Health Insurance Tax: 2019 Moratorium
On January 22, 2018, the President signed a Continuing Resolution that placed a moratorium on the Health Insurer Tax (HIT) for Plan Year 2019. All medical and dental filings should reflect this moratorium in their rate change explanation. The Departments expect that the HIT will not be reflected in 2019 retention. However, the Departments recognize that some small groups have non-calendar year timing and this moratorium could affect small group plans differently than the individual market. For small group rate filings that fit this exception, a partial HIT could be reflected. For example, non-calendar year plan rates are likely overstated for Plan Year 2018 and understated for Plan Year 2019. If an actuary chooses to reflect some of the HIT in the small group market for Plan Year 2019, the actuary must provide ample actuarial demonstration to justify the fairness and reasonableness of the HIT reflected in Plan Year 2019 rates, adjusting for and disclosing the favorable experience from Plan Year 2018 within the Actuarial Memorandum.

[2] https://www.gpo.gov/fdsys/pkg/FR-2016-12-19/pdf/2016-30037.pdf

Cost Sharing Reductions

There is still uncertainty about whether or not the Cost Sharing Reduction (CSR) payments will be made for Plan Years 2018 and 2019.

Last year, Commerce instructed health plan companies to assume that the CSR payments will not be paid, and thus to reflect their actuarially-justified expected shortfall on only the on-exchange silver premiums. The same instruction will be in place to health plan companies for Plan Year 2019.

If it becomes known that CSR payments will be made to health plan companies for Plan Year 2019 before the final rate review deadline of August 22, 2018, health plan companies will be required to revise their premiums to remove this premium adjustment. Further, if it becomes known by August 22 that CSR payments will also be made to health plan companies on behalf of Plan Year 2018 to Minnesota, where a premium adjustment was allowed to cover the shortfall, health plan companies will be required to credit expected duplicate Plan Year 2018 recoveries on the on-exchange silver premiums for Plan Year 2019.

Individual Mandate Penalty Repealed

In late December 2017, the *Tax Cuts and Jobs Act* passed, which revised Section 5000A of the ACA. This change reduces the shared responsibility payment for individuals failing to maintain minimum essential coverage (MEC) to 0%/$0 starting with Plan Year 2019. Actuaries should explicitly and separately describe the financial rate effect of this federal change, without redaction, in the actuarial memoranda as well as in the Part II justification narrative, if applicable.

Health plan companies will need to continue to identify whether a plan does or does not meet MEC criteria, since it drives the functioning of Special Enrollment Period (SEP) eligibility.

Qualified Small Employer Health Reimbursement Arrangements

The IRS released guidance[3] on October 31, 2017 around the requirements for the provision of Qualified Small Employer Health Reimbursement Arrangements (QSEHRAs). The guidance discusses advanced premium tax credits and has a detailed set of questions and answers covering many topics. Health plan companies are encouraged to review this guidance and revise forms and operations as needed.

Preventive Services

There are a number of items that have been recently added to United States Preventive Services Task Force (USPSTF) List A and B guidelines. Federal guidance indicates that plans must adopt new recommendations or guidelines within one year of recommendation. All preventive care drugs and services must be stated explicitly in the certificate of coverage. It is not sufficient to inform enrollees of covered benefits by simply stating that coverage is consistent with A and B Preventive Task Force guidelines.

[3] https://www.irs.gov/pub/irs-drop/n-17-67.pdf

In November 2016, USPSTF added statin preventive medications to its recommendations, specifically for adults without a history of cardiovascular disease (CVD). USPSTF recommendations relied upon studies that indicated use of atorvastatin, fluvastatin, fluvastatin extended release, lovastatin, pitavastatin, pravastatin, rosuvastatin and simvastatin for prevention of CVD.[4] Preventive use of statin medications is recommended for adults aged 40-75 with one or more CVD risk factors, with a calculated 10-year risk of a cardiovascular event. For individuals meeting these criteria, coverage should be provided with no cost-sharing for the enrollee.

In January 2017, USPSTF added folic acid supplementation to its guidelines, recommending that all women who are planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg of folic acid. Any OTC certificate of coverage exclusions must exempt all preventive OTC exceptions, and the Departments expect that health plan companies have demonstrable processes in place to provide coverage for preventive OTC items with no cost-sharing to the enrollee.[5] This includes assuring that outsourced vendors such as Pharmacy Benefit Managers (PBMs) also have a demonstrable process in place.

Although recommended by USPSTF in 2015, the Departments reiterate the requirements of coverage for all FDA-approved tobacco cessation products and phone counseling. Health plans must cover at least two tobacco cessation attempts per year, at no cost to the enrollee. [6] Tobacco cessation attempts include at least four tobacco cessation counseling sessions lasting at least ten minutes each, and FDA-approved tobacco cessation medications (prescription and prescribed OTC) for 90 days, without the application of prior authorization or cost-sharing. Coverage of tobacco cessation services and products may not require enrollment in any smoking cessation program.

The Departments also reiterate requirements for contraception services coverage. Health Resources Services Administration (HRSA) recommendations indicate that at least one service in each of the eighteen identified contraception categories must be covered. Recognizing that health plan companies may include a number of oral contraceptives on its formulary, at least one of the oral contraceptives must be covered at no cost to the enrollee, free from prior authorization, or step therapy or cost-sharing requirements. Additionally, a number of contraceptive methods and categories include OTC items, including emergency contraception. Finally, there must be a formulary exception process allowing an exception at no cost-sharing if the attending provider determines the non-formulary drug is medically necessary.

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[4] https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/statin-use-in-adults-preventive-medication1

[5] Additional preventive OTC items include low-dose aspirin use for prevention of cardiovascular disease and colorectal cancer for adults aged 50-59, Vitamin D, fluoride supplements, FDA-approved tobacco cessation products, and certain contraception (spermicide, female condom, or emergency contraception), and certain colonoscopy prep products.

[6] https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQ-part-34_10-26-16_FINAL.PDF

Contraception Coverage Exemption
Under recent federal interim final rules, employers that have sincerely held religious beliefs or sincerely held moral convictions inconsistent with providing coverage for some or all contraceptive services can exclude contraception. Employees can also exempt themselves based on their own moral or religious objections. Employees of exempt organizations may still obtain contraceptive coverage directly through the health plan company.

Due to a pending legal case over the revisions recently made to 45 CFR §147.131, there is a nationwide injunction[7] on using the expanded exemptions. The Departments will issue guidance if the injunction is lifted and final rules are issued. In the meantime, master group contracts and certificates of coverage should reflect the prior process for obtaining a religious exemption. Group certificates of coverage should include variable language with and without the exemption, which clearly indicates how an employee of an exempt organization may obtain contraceptive coverage independently, without cost-sharing, through the health plan.

The Departments will have health plan companies submit copies of:

1. The certification/notice that the employer would complete under federal guidance to be eligible for the exemption, and
2. A copy of the letter that will be sent to consumers notifying them of the availability of contraceptive services through the health plan company.

State Law Changes

All filings must be in compliance with all applicable Minnesota laws. State law changes passed following the issuance of this letter will be addressed by The Departments in subsequent correspondence if necessary. Laws passed by the Minnesota legislature that may affect Minnesota plan filings include the following:

Prescriptive Eye Drop Requirements
Health plan companies should review new refill requirements for prescription eye drops and reflect this language in forms filings (see Minn. Stat. §62A.3095). New provisions state that every health plan that provides coverage for prescription eye drops must cover refills of the prescription if the refill is requested by the person insured by the health plan, the prescribing practitioner indicated that additional quantities are needed, and certain other requirements are met.

Contract Provision Requirements
Many standard contract provision requirements for health contracts were revised (see Minn. Stat. §62A.04). This statutory change removes requirements for health plans on loss-of-time benefits, autopsy examination, and change of beneficiary. Certain requirements for health plans on change of occupation, aggregate indemnity, and unpaid premiums are also removed. Changes to references to

[7] U.S. District Court for the Eastern District of Pennsylvania*, Commonwealth of Pennsylvania v. Trump,* Dec. 18, 2017

applicants other than the insured and riders to provide a return of premium benefit are also made. These changes do not apply to HMOs.

Spousal Continuation of Coverage Requirements
Requirements for continuation privileges to former spouses were revised to make them more consistent with federal requirements and more equitable with employee continuation privileges and COBRA (see revisions to Minn. Stat. §62A.21, §62D.105 and §62Q.23). All health plan companies should review the continuation coverage section of certificates of coverage to ensure compliance with changes to the laws.

Cancer Oral Chemotherapy Transparency Requirements
Health plan companies and PBMs should review how the new cancer oral chemotherapy transparency requirements should be reflected in forms language and posted formularies (see Minn. Stat. §62A.3075). This language must be reflected in certificates of coverage.

Life Expectancy Certification
Health plan companies should ensure that changes to Minn. Stat. §62Q.56 allowing advanced practice registered nurses and physician assistants to certify life expectancy for purposes of continuity of care are reflected in forms language and plan operations.

Disclosure
Note that each health plan company is expected to include a brief disclosure of enrollee rights under state and federal mental health parity law in certificates of coverage. Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) compliance will be an area of specific interest this year for The Departments. Health plan companies are required to show compliance with federal and state parity requirements. The Departments ask health plan companies to review plan parameters and the quantitative and non-quantitative treatment limitations reflected in all products for MHPAEA compliance prior to submission.

Actuarial Requirements

For Plan Year 2019, there are no significant changes from the prior year's actuarial requirements:

- Minnesota will continue to use its unique age curve[8] that has been in place since 2014.
- As in past years, due to frequent public inquiry, the Actuarial Memorandum must clearly and separately display the formula inputs, outputs and outcome for spreading MNsure user fees and estimated producer compensation evenly to all products. Actuaries are reminded to separately and explicitly identify how each of the following items is incorporated into rates:

[8] https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Downloads/StateSpecAgeCrv053117.pdf

premium tax, PCORI fees, the Minnesota HMO surcharge, the federal health insurer tax, and commissions.

- Similar to last year, actuaries in the individual health market are required to supply two sets of rate tables, both with and without reinsurance.
- Actuaries should discuss within the actuarial memoranda how federal policy change, such as CSR nonpayment, short-term, limited duration plans, association health plans, the repeal of the individual mandate penalty, and the 2019 moratorium on the health insurer tax affected the rate change request. Each item should be separately discussed and separately quantified.

Redaction

Health plan companies should review Minn. Stat. §13.37 on the types of data that can be considered for redaction and the type of justification needed to receive approval for redactions. Over-redaction can greatly slow the rate approval process.

Mental Health Parity

The final Federal guidance[9] that required complex quantitative testing of parameters under the federal mental health parity law affects nearly all commercial health plan design and pricing work, and has been applicable to the individual and small group markets since Plan Year 2015. In 2013, state law reinforced the effect of Federal law and subsequent guidance (see Minn. Stat. §62Q.47(d)). Following the law is a precept of the actuarial professions' code of conduct. Actuaries should be ready to demonstrate that they have confirmed that the plan parameters are compliant with this law when applicable, including for large group plans, because the code of conduct and the standards of professionalism obligate actuaries to do so in terms of the cost sharing elements and quantitative limit treatment testing.

Network Adequacy Review Requirements

The major change to network adequacy reviews involve waiver requirements, as discussed further below. However, the Health System Access Template will be revised in order to allow the Departments to map provider locations more readily, and a new template will be added for those health plan companies that are leaving a service area.

Health plan companies using a rented network should continue to submit that contract for review via SERFF. The contract must explicitly state that the entity contracting with health care providers accepts responsibility to meet the requirements of Minn. Stat. §62K.10. Health plan companies that do not rent networks 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). The provider network and ECP data should be

[9] https://www.gpo.gov/fdsys/pkg/FR-2013-11-13/pdf/2013-27086.pdf

submitted to the MDH portal using the Minnesota templates found at the Minnesota Department of Health Network Adequacy Instructions web page.

Stand-alone dental networks are also subject to the essential community provider law (see Minn. Stat. §62Q.19 Subd. 3). If a Dental ECP requests a contract and meets other contracting requirements, the provider must be offered participation in all networks offered at same or comparable rates as other network providers.

ECPs must be offered participation in all networks offered, not selective networks determined by the health plan company.

Waiver Changes

The form for requesting waivers of network adequacy standards will change for the Plan Year 2019. The revised form will limit allowable waiver requests to three reasons:

1. There are no providers physically present in part of a service area to meet the geographic access standard;

2. Available providers do not meet the health plan's credentialing standards; and

3. The health plan has made good faith attempts to contract with available providers and the providers have refused the contract.

(See further explanation of reason codes below).

The revised waiver form requires health plan companies to both demonstrate and attest that good faith efforts were made to locate and contract with all available providers in the area in which the waiver is requested. Health plan companies seeking waivers because no providers are available must demonstrate, with evidence -- including sources consulted—that there are no providers physically present in the area where the waiver is being requested. Health plan companies seeking waivers due to the inability to secure a contract must demonstrate, with evidence — including evidence that the health plan company has offered providers same or similar rates as other network providers — that the provider has refused to contract. The Health Department determined that a revision to the waiver form was needed to be consistent with the intent of Minn. Stat. §62K.10, subd. 5 which stipulates the basis for granting waivers against the standards established in §62K.10. Health plan companies submitting waivers must attest that all information is true and accurate in the form. The new waiver reason codes are as follows:

> **Reason Code 1: The health plan company has conducted a good faith search for providers and determined that there are no providers physically present in the service area of the type requested in the waiver.** MDH will not grant a waiver for this reason code unless the health plan company demonstrates, with specific information, that there are no providers physically present in the part(s) of the service area for which the waiver is sought. Specific information may include provider directories and sources consulted, physical geography that affects the

location of providers, or other information that affects the availability and location of providers. As part of this waiver request, the health plan company must also state what steps were and will be taken to address the network inadequacy, (see Minn. Stat. §62K.10, subd. 5) including the use of telemedicine and how the health plan company will assess the availability of providers who begin practice in the service area where the standard cannot currently be met.

Reason Code 2: The provider does not meet health plan company's credentialing requirements. The health plan company must cite the reason(s) why the provider does not meet health plan company's credentialing requirements.

Reason Code 3: The health plan company has made a good faith effort to contract with the provider and offered a contract at the same/similar rate as other providers of the same provider type in the network, and provider has refused to accept a contract. A health plan company representative must attest that the contract was offered at same/similar rates and provider refused to contract.

New Template for Service Area Withdrawals

For Plan Year 2019 and beyond, a health plan company that withdraws from any county that was served in the prior year must submit a Service Area Withdrawal Template via SERFF. This template requires health plan companies to identify the affected counties and describe the transition plan in place (see Minn. Stat. §62D.121, which applies also to non-HMOs due to Section 1252 of the Affordable Care Act). The template includes the health plan company demonstrating how they will notify enrollees of the termination and coverage options available to terminated enrollees. If applicable for Plan Year 2019, the deadline for this form is June 1, 2018.

Quality Reporting System and Quality Information Strategies

For purposes of Quality Rating System requirements, Minnesota will continue to apply Federal posting requirements for the open enrollment season and Plan Year 2019. Health plan companies selling through MNsure must complete a Quality Information Strategies Implementation and Progress Report that includes all of the necessary components and adequately addresses the federal criteria. These requirements do not apply to dental and off-exchange health plan companies. Additional information will be provided in the 2019 Plan Management General Instructions via SERFF. Note that Federal changes to quality requirements are possible.

Plan Management and Final Federal Guidance

The Departments will release a second guidance letter as soon as the Final Notice of Benefit Payment Parameters notice is released. Absent changes to state law following the issuance of this letter:

- The age curve will remain the same as the unique age curve that has been used since 2014
- The Essential Health Benefits benchmark plan will continue to be the 2014 Health Partners Gold Open Access Choice, and

- Minnesota will not be working with Federal regulators towards revising Federal Minimum Loss Ratio rules.

The additional issuer letter will also provide an overview of plan management tools and template revisions and additions, and cover any changes to the dental certification requirements. Based on health plan companies' feedback, the Departments will issue Plan Year 2019 templates via SERFF's Minnesota Plan Management General Instructions page as soon as each template is final. Thus, please continue to monitor SERFF. Also, please be aware that SERFF has adopted a new pricing structure: http://serff.com/serff_newsletter.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 or requirements.

Sincerely,

Fred Andersen
Acting Deputy Commissioner of Insurance
Minnesota Department of Commerce

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