

**SMALL EMPLOYER GROUP PLANS
MANDATED PLANS
CHECKLIST FOR CODE 62**

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The small employer insurance reform act requires that every health carrier that is operating in the small employer market must offer the two mandated health benefit plans to all small employers that satisfy the eligibility criteria.

The two mandated health benefit plans are identified as:

DEDUCTIBLE-TYPE SMALL EMPLOYER PLAN 62L.05, Subd 2

CO-PAYMENT-TYPE SMALL EMPLOYER PLAN 62L.05, Subd 3

All health benefit plans offered to small employers must be offered on a guaranteed issue and reissue basis to all small employers that retain eligibility as a small employer.

All health benefit plans offered to small employers must be identified as a "**SMALL EMPLOYER PLAN**".

This checklist sets forth the requirements for the mandated health benefit plans.

Please note: All small employer plans must include the guaranteed issue and other requirements for a "health benefit plan" as identified in the MN Chapter 62L and further identified in the checklist for Small Employer Group Plans -- code (62) as noted above.

PLAN VARIATIONS -- M. S. 62L.05, Subd 5. [See Checklist code 34]

In addition to the plans referenced above Comprehensive Medical Expense policies that offer a higher level of coverage may be offered in the small employer market. The law that allows such Plan Variations is M. S. 62L.05, Subd 5. This checklist does not apply to those Plans. Policy Forms subject to M. S. 62L.05, Subd 5 must meet the levels specified in Checklist Code 34 in addition to the small employer group insurance "guaranteed issue" and "employee eligibility" requirements.

62A.02 Policy Form and Rate Filings

The Loss Ratio is defined as incurred claims experience or incurred health care expenses over earned premiums. Insurers must forward an actuarial memorandum.

62A.02 Subd. 2 File and Use

Refer to [Bulletin 2002-5](#)

- **How to file rate filings intended for implementation under file and use.**

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As amended by HF 2988, section 8 (chapter 330), Laws of 2002, a rate filed with respect to a policy of accident and sickness insurance as defined in M. S. 62A.01 by an insurer licensed under M. S. Chapter 62A, may be used on or after the date of filing with the commissioner. Rates that are not approved or disapproved within the 60-day time period are deemed approved.

62A.021 Subd. 1(f) Loss Ratio Standards

This section applies to health plans not subject to the requirements of Bulletin 2002-4.

- For health benefit plans assessed 3% or more of the total annual amount assessed by MCHA, the minimum loss ratio is 82 percent.
- For health benefit plans assessed less than 3% of the total annual amount assessed by MCHA, and there are fewer than 10 employees, the minimum loss ratio is 71 percent.
- For health benefit plans assessed less than 3% of the total annual amount assessed by MCHA, and there are 10 employees or more, the minimum loss ratio is 75 percent.

62A.021 Subd. 1(g) 60% Loss Ratio

Refer to [Bulletin 2002-4](#)

- **The kinds of insurance that are required to comply with the 60% minimum loss ratio.**

As amended by HF 2988, section 9 (chapter 330), Laws of 2002, the loss ratio shall be 60% for a policy or certificate of accident and sickness insurance as defined in M. S. 62A.01, offered by an insurance company licensed under M. S. Chapter 60A that is assessed less than 10% of the total annual amount assessed by the Minnesota Comprehensive Health Association, including the assessment of affiliates.

62L.03 Availability Of Coverage

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Subd. 1 Must Offer And Renew On A Guaranteed Issue Basis

Subd. 3 Minimum Participation And Contribution

**Subd. 4 Underwriting Restrictions – 12 Month Pre-Existing
Condition Limitation**

Regarding policy provisions for “Actively at Work” or “Actively Working”:

The Minnesota guarantee issue requirements for small employer insurance reform requires coverage for all "eligible" employees of any covered small employer. Except as otherwise authorized for late entrants, in 62L.03 Subd 4, preexisting conditions may be excluded by a health carrier for a period not to exceed 12 months from the enrollment date of an eligible employee or dependent, and such a period may be reduced by the receipt of credit for prior qualifying coverage as defined in 62L.03.

Subd. 5 Cancellations And Failures To Renew

62A.306 Prohibition On Use Of Gender

The premium rate or any other underwriting decision, including initial issuance, may not be based upon the gender of any person covered or to be covered. Also marital status may not be used.

62L.05 Small Employer Plan Benefits

**Subd. 1 Must Offer Deductible-Type And Copayment-Type Small
Employer Plans**

\$3,000 limitation for individual maximum out-of-pocket costs per year

\$6,000 limitation for family maximum out-of-pocket costs per year

\$1,000,000 lifetime benefit (as amended by CH 215, sec. 7, Laws of 2001)

Subd. 2 Deductible-Type Small Employer Plan

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Deductible-type small employer plans must be equal to 80 percent of the charges for health care services, supplies, or other articles covered under the small employer plan, in excess of an annual deductible which must be \$2,250 per individual and \$4,500 per family. (as amended by CH 215, sec. 7, Laws of 2001)

80% coverage after \$2,250 deductible per individual or \$4,500 deductible per family

Subd. 3 Copayment-Type Small Employer Plan

Co-payment-type small employer plans must be equal to 80% of the charges for health care services, supplies, or other articles covered under the small employer plan, in excess of the co-payments:

80% coverage after copayment of:

\$15 per outpatient visit, \$15 per home health agency visit, \$50 per hospital outpatient visit, \$300 per inpatient hospital admission

Subd. 4 Benefits For "Mandated" Plans

1. Inpatient and outpatient hospital services, excluding services provided for the diagnosis, care, or treatment of chemical dependency or a mental illness or condition, other than those conditions specified in clauses (10), (11), and (12). The health
2. care services required to be covered under this clause must also be covered if rendered in a nonhospital environment, on the same basis as coverage provided for those same treatments or services if rendered in a hospital, provided, however, that this sentence must not be interpreted as expanding the types or extent of services covered;
3. Physician, chiropractor, and nurse practitioner services for the diagnosis or treatment of illnesses, injuries, or conditions;
4. diagnostic X-rays and laboratory tests;

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5. ground transportation provided by a licensed ambulance service to the nearest facility qualified to treat the condition, or as otherwise required by the health carrier;
6. services of a home health agency if the services qualify as reimbursable services under Medicare;
7. services of a private duty registered nurse if medically necessary, as determined by the health carrier;
8. the rental or purchase, as appropriate, of durable medical equipment, other than eyeglasses and hearing aids;
9. child health supervision services up to age 18, as defined in section 62A.047;
10. maternity and prenatal care services, as defined in sections 62A.041 and 62A.047;
11. inpatient hospital and outpatient services for the diagnosis and treatment of certain mental illnesses or conditions, as defined by the International Classification of Diseases-Clinical Modification (ICD-9-CM), seventh edition (1990) and as classified as ICD-9 codes 295 to 299;
12. ten hours per year of outpatient mental health diagnosis or treatment for illnesses or conditions not described in clause (10);
13. 60 hours per year of outpatient treatment of chemical dependency; and
14. 50 percent of eligible charges for prescription drugs, up to a separate annual maximum out-of-pocket expense of \$1,000 per individual for prescription drugs, and 100 percent of eligible charges thereafter.

Subd. 5 Plan Variations (For Policies Being Filed As An Alternative To "Mandated" Plans)

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1. Must comply with all provisions of chapters 62A, 62C, 62D, 62E, 62H, 62N, and 64B that otherwise apply to the health carrier, except as expressly permitted by paragraph (b) (see checklist for Comprehensive Major Medical, Code 34).
2. As an exception to paragraph (a), a health benefit plan is deemed to be a small employer plan and to be in compliance with paragraph (a) if it differs from one of the two small employer plans described in subdivisions 1 to 4 only by providing benefits in addition to those described in subdivision 4, provided that the health benefit plan has an actuarial value that exceeds the actuarial value of the benefits described in subdivision 4 by no more than two percent. "Benefits in addition" means additional units of a benefit listed in subdivision 4 or one or more benefits not listed in subdivision 4.

Subd. 6. Choice Products Exception

For purposes of products issued under this subdivision, out-of-pocket costs in a secondary network may exceed the out-of-pocket limits described in subdivision 1.

A health carrier may offer a small employer plan which provides for different benefit coverages based on whether the benefit is provided through a primary network of providers or through a secondary network of providers so long as the benefits provided in the primary network equal the benefit requirements of the small employer plan as described in this section. [Refer to M. S. 62L.05, Subd 6 for the entire exception provision.]

Subd. 7 Benefit Exclusions

May exclude a benefit, service, supply, or article not expressly specified in subdivision 4 from a small employer plan.

Subd. 8 Continuation Coverage

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Small employer plans must include continuation of coverage provisions required by Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) Public Law Number 99-272, as amended, and by state law.

Reference

- 62L.02, Late Entrant, Section (2) [Subd 19]
- 62A.145 Survivor, Definition
- 62A.146 Continuation Of Benefits To Survivors
- 62A.16 Scope Of Certain Continuation And Conversion Requirements
- 62A.17 Continuation Of Coverage Upon Termination
- 62A.20 Continuation Coverage Of Current Spouse And Children
- 62A.21 Continuation And Conversion Privileges For Insured Former Spouses And Children
- 62Q.18 Portability Of Group Coverage

Subd 9 Dependent Coverage

Other state law and rules applicable to health plan coverage of newborn infants, dependent children who do not reside with the eligible employee, handicapped children and dependents, and adopted children apply to a small employer plan. Health benefit plans that provide dependent coverage must define "dependent" no more restrictively than the definition provided in section 62L.02.

Reference

- 62A.042 Family coverage; coverage of newborn infants.
- 62A.048 Dependent coverage.
- 62A.14 Handicapped children.
- 62A.141 Coverage for handicapped dependents.
- 62A.27 Coverage of adopted children.

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Subd 10 Medical Expense Reimbursement:

Health carriers may reimburse or pay for medical services, supplies, or articles provided under a small employer plan in accordance with the health carrier's provider contract requirements including, but not limited to:

Salaried arrangements, capitation, the payment of usual and customary charges, fee schedules, discounts from fee-for-service, per diems, diagnosis-related groups (DRGs), and other payment arrangements.

Coinsurance, deductibles, out-of-pocket maximums, and maximum lifetime benefits must be calculated and determined in accordance with each carrier's standard business practices.

Subd 11 Plan Design

- Health carriers may offer small employer plans through provider arrangements, including the use of open, closed, or limited provider networks.
- Health carriers may only use product and network designs currently allowed under existing statutory requirements.
- The provider networks offered may be specifically designed for the small employer market and may be modified at the carrier's election so long as other applicable regulatory requirements are met.
- Health carriers may use professionally recognized provider standards of practice when they are available, and may use utilization management practices otherwise permitted by law, including, but not limited to:

Second surgical opinions;

Prior authorization;

Concurrent and retrospective review;

Referral authorizations;

Case management; and

Discharge planning.

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- Health carriers may contract with groups of providers with respect to health care services or benefits, and may negotiate with providers regarding the level or method of reimbursement provided for services rendered under a small employer plan.

62L.08 Restrictions Relating To Premium Rates - Checklist of Items to be included in Rate Filings for Small Employer Health Benefit Plans

- I. New Rate Sheets, including all information needed in determining the rates charged.
- II. General Policy Data
 - A. Number of Minnesota Policyholders.
 - B. Brief description of the type of policy, benefits, general marketing method and issue age limits.
- III. Premium Rate Restrictions
 - A. Demonstration that the premium restrictions of Minnesota Statutes, section 62L.08, are met.
- IV. Experience Data
 - A. Premium and claim experience for the last five years in Minnesota. Include earned premiums, incurred claims, and earned/incurred loss ratios. Both Minnesota only and nationwide experience must be provided, if the Minnesota experience is not large enough to be credible.
- V. Complete history of all past rate increases since July, 1993 on small employer insurance *that were effective in Minnesota including the exact effective date.*
- VI. Rate Increase
 - A. Scope and reason for rate revision including a statement of whether the increase applies only to new business, only to in-force business, or to both.
 - B. Descriptive relationship of proposed rate scale to current rate scale, especially noting maximum increases if different than averages.

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C. The description of the derivation of the rate increase **must** address the considerations required in the determination of reasonableness.

VII. Loss Ratio Standards

A. The anticipated future premiums and claims by month for the period that rates will be effective, and a detailed description of how they were calculated.

B. A demonstration that the loss ratio standards of Minnesota Statutes, section 62A.021, are met. Such demonstration may include consideration of:

1. The concentration of experience at early policy durations where select morbidity (low claims from healthy insureds) is applicable and where loss ratios are expected to be substantially lower than at later policy durations. (Expected durational selection factors must be provided.)
2. Credibility of the Minnesota experience.
3. Where credible experience is not available, calculation of expected claim cost based on other sources such as experience in other states, consultant data, government data, and so on.

VIII. Certification by a qualified actuary that, to the best of the actuary's knowledge and judgment, the rate submission is in compliance with the applicable laws and regulations of the state and the benefits are reasonable in relation to the premiums.

Subd. 8 Gender Based Rates Prohibited

62L.12 Prohibited Practices

Subd. 1 Prohibition On Issuance Of Individual Policies

Subd. 2 Exceptions

62M.01- 62M.16 Applies If Plan Contains A Utilization Review Provision

62Q.18 Portability Of Group Coverage

62Q.52 Must Allow Direct Access To Obstetricians And Gynecologists

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62Q.66 **May Not Limit Coverage Solely To Durable Medical Equipment
Used In The Home**

62Q.68-73 **Dispute Resolution Process Requirements**