

Issuer Criteria

Criteria	Federal Standards	State Statutes or Rules Applicable to Dental Plans
Benefit Design	Includes the essential health benefits described in 1302(b) of the ACA, cost sharing limits as described in 1302 (c), and the metal levels in 1302 (d). Broadly speaking, the essential health benefit package includes ambulatory and emergency services, hospitalization, maternity and newborn care, mental health and substance abuse, prescription drugs, rehabilitative services and devices, laboratory services, preventive services, and pediatric oral and vision services. [§ 156.20]	None. (Mandates only apply to medical plans that include dental coverage, rather than stand-alone dental plans.)
Licensure	The issuer must be licensed and in good standing to offer health insurance in each state in which it offers coverage. [§ 156.200.(b)(4)]	Insurers may not conduct business in the state without a certificate of authority from the department of commerce. [MN Stat. § 60A. 07]. HMO issuers must apply for a certificate of authority from the Minnesota Department of Health. [MN Stat. § 62D. 03] and [MN Rules, 4685.0300]
Quality Improvement Reporting and Strategies	Issuers must implement and report on a quality improvement strategy or strategies consistent with the standards of the ACA, disclose and report information on health care quality and outcomes, and implement appropriate enrollee satisfaction surveys. [§ 156.200(b)(5)]	None.
Risk Adjustment	The issuer must comply with the standards related to the risk adjustment program developed or certified by the U.S. Dept. of Health and Human Services. [§156.200(b)(7)]	None.
Non Discrimination	The issuer, with respect to its QHP may not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation. [§ 156.200(e)]	Making or permitting any unfair discrimination between individuals of the same rating class and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of accident or health insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever, or in making or permitting the rejection of an individual's application for accident or health insurance coverage, as well as the determination of the rate class for such individual, on the basis of a disability, shall constitute...an unfair and deceptive act or practice, unless the claims experience and actuarial projections...establish significant and substantial differences in class rates because of the disability. [MN Stat. § 72A.20] The rates charged by health maintenance organizations and their representatives shall not discriminate except in accordance with accepted actuarial principles.[MN Stat. § 62D.12]
Rating Variation	Issuers may vary premiums for a QHP in accordance with permitted geographic rating areas, age (3-1 ratio), tobacco use (1.5-1 ratio), and whether the coverage is for individuals or families. Issuers may not vary premiums for the same plans offered both inside and outside of the exchange. [§ 156.255].	Individual and Small Group: Rate variations for each issuer are limited by rating bands and can vary between any two policies that have the "same or similar coverage" (index rate). Issuers may vary premiums within a 1.67 to 1 ratio for health status including tobacco use, claims experience, and occupation. Rates may vary by age within a 3 to 1 ratio. Carriers may also use approved geographic rating areas. Annual premium changes based on health status in the small group market may not exceed 15 percent. [MN. Stat. § 62A.65 and § 62L.08] Annual rate filings must include policy and enrollment data, descriptions of the type of policy, benefits, and general marketing strategy, five years of premium and claims experience data, a rate increase history, and the scope and justification of any rate revisions. [MN. Stat.§ 62A.021] While commerce conducts rate review for all plans in Minnesota, final approval for HMO rates is retained by the department of health.
Marketing	A QHP issuer and its officials, employees, agents, and representatives must comply with applicable state laws regarding marketing and may not employ marketing practices that discourage enrollment of people with significant health needs. [§ 156.225]	A dental organization shall make available to an enrollee, upon request, a clear and concise description of the following terms of coverage: 1) the dental care services and other benefits to which the enrollee is entitled under the dental plan; 2) any exclusions or limitation on the services, kind of services, benefits, or kind of benefits to be provided, including any deductible or co-payment features and any requirements for referrals to specialists; 3) a description as to how services, including emergency dental care and out-of-area service, may be obtained; 4) a general description of payment and co-payment amounts, if any , for dental care services, which the enrollee is obligated to pay; and 5) a telephone number by which the enrollee may obtain additional information regarding coverage. [MN.State 62Q.77] The provisions contained in section 62Q.77 shall not require a dental organization to disclose information which the dental organization is already obligated to disclose under applicable Minnesota law governing the operation of the dental organization. Any information a dental organization is required to disclose or communicate under section 62Q.77 to its subscribers, enrollee, participating providers, contracting groups, or dentists may be accomplished by electronic communication including, but not limited to, e-mail, the Internet, Web sites, and employer electronic bulletin boards. [MN Stat.62Q.79] Marketing materials that misrepresent the terms of any policy or make any misrepresentation to a policyholder with the purpose of inducing them to drop coverage shall constitute an unfair and deceptive act or practice. No insurer may design a network of providers, policies on access to providers, or marketing strategy in such a way as to discourage enrollment by individuals or groups whose health care needs are perceived as likely to be more expensive than average. [MN. Stat. § 72A. 20] No advertisement or representation may omit information or use words, phrases, statements, references, or illustrations if the omission of the information or use of the words, phrases, statements, references, or illustrations has the capacity, tendency, or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, loss covered, or premium payable. [MN Rules, 2790.0500] HMO marketing materials must also disclose exclusions and limitations including restrictions on covered services and referral requirements. [MN. Stat. § 62D.09] No health maintenance organization may cause or knowingly permit the use of advertising or solicitation which is untrue or misleading, or any form of evidence of coverage which is deceptive. [MN. Stat. § 62D.12]

Criteria

Federal Standards

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State Statutes or Rules Applicable to Dental Plans

Accreditation

A QHP issuer must maintain accreditation on the basis of the local performance of its QHPs in the following categories by an accrediting agency recognized by HHS: (1) Clinical quality measures; (2) CAHPS patient experience ratings; (3) Consumer access; (4) Utilization management; (5) Quality assurance; (6) Provider credentialing; (7) Complaints and appeals; (8) Network Adequacy and Access; and (9) Patient information programs. [§ 156.275]

None.

Plan Criteria

Criteria	Federal Standards	State Statutes or Rules Applicable to Dental Plans
Network Adequacy	A QHP issuer must ensure the provider network of QHPs: (1) include essential community providers, (2) Maintains a network sufficient in number and types of providers to assure that all services are accessible without unreasonable delay. [§ 156.230]	HMO enrollees must be able to access primary care and mental health services within 30 miles or 30 minutes. The time/distance requirements are 60 minutes and 60 miles for specialty care. The commissioner may grant exceptions based on unfeasibility. [MN. Stat. § 62D.124]
Essential Community Providers	A QHP issuer must have a sufficient number and distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of such providers for low income, medically underserved individuals in the QHP's service area in accordance with the Exchange's network adequacy standards. ECPs serve predominantly low income, medically underserved individuals and meet the covered entities definitions under section 340B(a)(b)(4) of the Public Health Services Act (safety net providers). QHPs do not have to contract with an essential community provider where they do not accept the generally applicable payment rates of the issuer. [§ 156.235]	Health plans who contract with providers must offer contracts to all ECPs in the service area. Health plan companies refusing to contract with ECPs must submit a written explanation to the provider. An ECP which refused a contract may enter the dispute resolution process prescribed by statute. [MN. Rules, 4688] The MN Department of Health has statutory authority to grant essential community provider status. To qualify, providers must have demonstrated ability to integrate applicable supportive and stabilizing services with medical care for uninsured persons and high risk or special needs populations, or other underserved populations. Providers must also have a commitment to serve low income and underserved populations or status as a local government unit, an Indian tribal government, an Indian health services unit, or community health board. [MN Stat. § 62Q.19] Minnesota Rules provides the essential community provider application procedures and criteria for designation by the health department. [MN. Rules, 4688.0020-4688.0040] NOTE: This technically applies, but there are no dental ECPs.
Enrollment and Termination Requirements	Issuers must: Enroll qualified individuals during initial, annual, and other special enrollment periods. [§ 156.265]; Collect, accept, and acknowledge receipt of and transmit to the exchange enrollment information and premium payment in accordance with exchange processes [§ 156.265]; Provide new enrollees with enrollment package compliant with accessibility and readability standards [§ 156.265]; Reconcile enrollment files with the exchange or SHOP no less than once per month [§ 156.265, § 156.285]; Terminate coverage only as permitted by the exchange, and provide termination notices 30 days prior to the last day of coverage. Grace periods for non-payment of premium are consistent with state law for those not receiving tax subsidies and 90 days for subsidy recipients. QHP issuers may pend claims during the last 60 days of the grace period contingent on the payment of premiums. SHOP issuers must provide notices to employers. [§ 156.270 and § 155.430]	In the event of non-payment of premium, Minnesota Statute provides a grace period after the premium due date during which the policy must remain in force. The grace period is 7 days for premiums paid weekly, 10 days for those paid monthly, and 31 days for other installment periods. Enrollees must receive at least five days written notice prior to cancellation. [MN Stat. 62a.04]. Minnesota Statute 62Q.181 requires compliance with the written certification of coverage requirements found at 42 USC sections 300(gg)(e) and 300(gg)-43. Once codified, this section of federal code contains the federal summary benefit notification and certification of coverage requirements of PPACA.
Rating Information	Rates must be set for the entire benefit year (or plan year for the SHOP). [§ 156.210] Issuer must submit required justification for rate increases in advance and post justifications on their website. The exchange must consider rate increases in its QHP determination. In doing so, the exchange may consider the recommendations of state insurance regulators and the rate of premium growth both inside and outside of the exchange. The exchange must receive annual updates from issuers regarding rates, covered benefits, and cost sharing requirements of each QHP. [§ 155.1020]	Minnesota Statute requires prior approval for rate filings in the small group and individual markets. Rate filings may be disapproved for the following reasons: (1) the benefits provided are not reasonable in relation to the premium charged; (2) (filings) contain a rate or provision which is unjust, unfair, inequitable, misleading, deceptive, or encourages misrepresentation of the form; (3) if the proposed rate is excessive or not adequate; (4) the actuarial reasons and data submitted do not justify the rate. Rates must be approved or denied by the Commissioner of Commerce within 60 days after a complete rate filing has been received or they are deemed approved. If the Commissioner takes no action within the 60 days (and the rates are therefore deemed approved), the company may use the rates, subject to the authority of the commissioner to disapprove the rates later. 62A.02
Service Area (Minimum Geographical Area)	The QHP service area must cover a minimum geographical area that is at least an entire county or group of counties unless the exchange determines that serving a smaller area is necessary, nondiscriminatory, and in the best interest of enrollees. The QHP service area must be established without regard to racial, ethnic, language, health status related factors, or other factors that exclude specific high utilizing, high cost, or medically underserved populations. [§ 155.1055]	HMOs applying for a certificate of authority in Minnesota must provide a statement describing the geographic area served by the plan. [MN. Stat. § 62D.03] HMOs wishing to expand their service area must file supporting documentation to the Minnesota Department of Health. These filings must include evidence of provider contracts to meet network adequacy standards in the proposed area [MN. Rules, 4685.3300]