COMMERCE DEPARTMENT

Self-Insured Political Subdivision Compliance Demonstration for Certification under Minnesota Statutes §471.617 Nongrandfathered Plan(s)

Employer Name:

Applicable Plan Year:

Employer Address:

Plan Representative Name and Title:

Plan Representative e-mail and phone:

Third Party Administrator (TPA):

TPA Representative Name and Title:

TPA Representative e-mail and phone:

Name of Plan(s) Offered:

I have researched the compliance topics cited in this document and I certify that the information provided in the pages that follow are true to my knowledge. If there was any compliance concerns over the coverage the plan offers, I have made note of those concerns in the attachments provided.

Signature		Date:	

equipment, or prescription drug benefits.

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___

62A.3094 COVERAGE OF AUTISM SPECTRUM DISORDERS

The plan provides coverage for the diagnosis, evaluation, multidisciplinary assessment, and medically necessary care of children under 18 with autism spectrum disorders, including (1) early intensive behavioral and developmental therapy based in behavioral and developmental science, including, but not limited to, all types of applied behavior analysis, intensive early intervention behavior therapy, and intensive behavior intervention; (2) neurodevelopmental and behavioral health treatments and management; (3) speech therapy; (4) occupational therapy; (5) physical therapy; and (6) medications. The diagnosis, evaluation, and assessment must include an assessment of the child's developmental skills, functional behavior, needs, and capacities. The coverage must include treatment that is in accordance with an individualized treatment plan prescribed by the enrollee's treating physician or mental health professional. The plan may request an updated treatment plan only once every six months, unless the plan and the treating physician or mental health professional agree that a more frequent review is necessary due to emerging circumstances. An independent progress evaluation conducted by a mental health professional with expertise and training in autism spectrum disorder and child development must be completed to determine if progress toward function and generalizable gains, as determined in the treatment plan, is being made. Definitions for autism spectrum disorders, medically necessary care, and "mental health professional" are provided in the statute.

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___

☐ Not applicable, as the plan does not cover any employees' child dependents.

62Q.451 UNRESTRICTED ACCESS TO SERVICES FOR THE DIAGNOSIS, MONITORING, AND TREATMENT OF RARE DISEASES

"Rare disease or condition" means any disease or condition: (1) that affects fewer than 200,000 persons in the United States and is chronic, serious, life-altering, or life-threatening; (2) that affects more than 200,000 persons in the United States and a drug for treatment has been designated as a drug for a rare disease or condition pursuant to United States Code, title 21, section 360bb; (3) that is labeled as a rare disease or condition on the Genetic and Rare Diseases Information Center list created by the National Institutes of Health; (4) for which an enrollee…

Subd. 2.Unrestricted access. (a) No health plan company may restrict the choice of an enrollee as to where the enrollee receives services from a licensed health care provider related to the diagnosis, monitoring, and treatment of a rare disease or condition, including but not limited to additional restrictions through any prior authorization, preauthorization, prior approval, precertification process, increased fees, or other methods…

Subd. 3.Coverage; prior authorization. (a) Nothing in this section requires a health plan company to provide coverage for a medication, procedure or treatment, or laboratory or clinical testing, that is not covered under the enrollee's health plan. (b) Coverage for a service must not be denied solely on the basis that it was provided by, referred for, or ordered by an out-of-network provider. (c) Any prior authorization requirements for a service that is provided by, referred for, or ordered by an out-of-network provider must be the same as any prior authorization requirements for a service that is provided by, referred for, or ordered by an in-network provider…

Subd. 4.Payments to out-of-network providers for services provided in this state.

Subd. 5.Payments to out-of-network providers when services are provided outside of the state.

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___

62Q.47 ALCOHOLISM, MENTAL HEALTH, AND CHEMICAL DEPENDENCY SERVICES

(b) Cost-sharing requirements and benefit or service limitations for outpatient mental health and outpatient chemical dependency and alcoholism services must not place a greater financial burden on the insured or enrollee, or be more restrictive than those requirements and limitations for outpatient medical services.

(c) Cost-sharing requirements and benefit or service limitations for inpatient hospital mental health services, psychiatric residential treatment facility services and inpatient hospital and residential chemical dependency and alcoholism services must not place a greater financial burden on the insured or enrollee, or be more restrictive than those requirements and limitations for inpatient hospital medical services.

(d) The plan meets the requirements of the federal Mental Health Parity Act of 1996, Public Law 104-204; Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; the Affordable Care Act; and any amendments to, and federal guidance or regulations issued under, those acts.

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___

62Q.50 PROSTATE CANCER SCREENING

The plan covers prostate cancer screening for men 40 years of age or over who are symptomatic or in a high-risk category and for all men 50 years of age or older. The screening consists at a minimum of a prostate-specific antigen blood test and a digital rectal examination.

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62Q.521 POSTNATAL CARE

"Comprehensive postnatal visit" means a visit with a health care provider that includes a full assessment of the mother's and infant's physical, social, and psychological well-being, including but not limited to: mood and emotional well-being; infant care and feeding; sexuality, contraception, and birth spacing; sleep and fatigue; physical recovery from birth; chronic disease management; and health maintenance. The plan covers (1) a comprehensive postnatal visit with a health care provider not more than three weeks from the date of delivery; (2) any postnatal visits recommended by a health care provider between three and 11 weeks from the date of delivery; and (3) a comprehensive postnatal visit with a health care provider 12 weeks from the date of delivery.

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___

62Q.522 COVERAGE OF CONTRACEPTIVE METHODS AND SERVICES.

The plan provides (a) coverage for contraceptive methods and services. (b) A health plan company must not impose cost-sharing requirements, including co-pays, deductibles, or coinsurance, for contraceptive methods or services. (c) A health plan company must not impose any referral requirements,

restrictions, or delays for contraceptive methods or services. (d) A health plan must include at least one of each type of Food and Drug Administration approved contraceptive method in its formulary. If more than one therapeutic equivalent version of a contraceptive method is approved, a health plan must include at least one therapeutic equivalent version in its formulary, but is not required to include all therapeutic equivalent versions. (e) For each health plan, a health plan company must list the contraceptive methods and services that are covered without cost-sharing in a manner that is easily accessible to enrollees, health care providers, and representatives of health care providers. The list for each health plan must be promptly updated to reflect changes to the coverage. (f) If an enrollee's attending provider recommends a particular contraceptive method or service based on a determination of medical necessity for that enrollee, the health plan must cover that contraceptive method or service without cost-sharing. The health plan company issuing the health plan must defer to the attending provider's determination that the particular contraceptive method or service is medically necessary for the enrollee.

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62Q.523 COVERAGE FOR PRESCRIPTION CONTRACEPTIVES; SUPPLY REQUIREMENTS

The plan provides coverage for a prescription contraceptive must provide a 12-month supply for any prescription contraceptive if a 12-month supply is prescribed by the prescribing health care provider. The prescribing health care provider must determine the appropriate duration to prescribe the prescription contraceptives for up to 12 months.

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___

62Q.525 COVERAGE FOR OFF-LABEL DRUG USE

The drug coverage under the plan does not exclude coverage of a medically necessary formulary drug for the treatment of cancer on the ground that the drug has not been approved by the FDA for the treatment of cancer, if the drug is recognized for treatment of cancer in one of the standard reference compendia or in one article in the medical literature. In this case, cost sharing must be no greater than that which typically would apply for the drug.

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62Q.526 COVERAGE FOR PARTICIPATION IN APPROVED CLINICAL TRIALS

The plan does not deny participation by a qualified individual in an approved clinical trial. The plan cannot deny, limit, or impose additional conditions on the coverage of **routine patient costs** for items or services furnished in connection with participation in the trial. The plan does not discriminate against an individual on the basis of an individual's participation in an approved clinical trial. The plan can require a qualified individual to use an in-network provider, if that provider is participating in the trial and the provider accepts the individual as a participant in the trial. These requirements apply to in- and out-of-state clinical trials. See the statute for the definitions of "approved clinical trial," "qualified individual," and "routine patient costs."

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___

62Q.527 NONFORMULARY ANTIPSYCHOTIC DRUGS

The plan provides prescription drug coverage for antipsychotic and other related drugs prescribed to treat emotional disturbance or mental illness regardless of whether the drug is on the formulary, if the prescribing provider indicates to the dispensing pharmacist that the prescription must be dispensed as communicated and the provider certifies in writing to the plan that all equivalent drugs on the formulary have been considered and has determined that the prescribed drug will best treat the patient's condition. The plan does not require the prescribing provider to recertify refills more often than the frequency of similar formulary drugs. The cost sharing must be equivalent to what it should be if the drug were on the formulary. The plan is not required to provide coverage for a drug removed from the formulary for safety reasons. Also, the plan must promptly grant an exception to the formulary for an enrollee when the prescribing provider indicates that the formulary drug causes an adverse reaction, or is contraindicated for the patient, or the provider demonstrates that the prescription drug must be dispensed as written in order to provide maximum medical benefit to the patient.

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___

62Q.53 MENTAL HEALTH COVERAGE; MEDICALLY NECESSARY CARE

With respect to the plan, "medically necessary care" means health care services appropriate, in terms of **type, frequency, level, setting, and duration**, to the enrollee's diagnosis or condition, and diagnostic testing and preventive services. Medically necessary care must be consistent with generally accepted practice parameters as determined by health care providers in the same or similar general specialty as typically manages the condition, procedure, or treatment at issue and must help restore or maintain the enrollee's health or prevent deterioration of the condition.

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___

62Q.535 COVERAGE FOR COURT-ORDERED MENTAL HEALTH SERVICES

To the extent that the plan covers mental health services, the plan covers services ordered by a court of competent jurisdiction under a court order that is issued on the basis of a behavioral care evaluation performed by a licensed psychiatrist or a doctoral level licensed psychologist, which includes a diagnosis and an individual treatment plan for care in the most appropriate, least restrictive environment. The plan must be given a copy of the court order and the behavioral care evaluation. The plan shall be financially liable for the evaluation if performed by a participating provider and shall be financially liable for the care included in the court-ordered individual treatment plan if the care is covered by the plan and ordered to be provided by a participating provider or another provider as required by rule or law. This court-ordered coverage must not be subject to a separate medical necessity determination by the plan under its utilization procedures. The plan may make a motion for modification of the court-ordered plan of care pursuant to the applicable rules of procedure for modification of the court's order. The motion may include a request for a new behavioral care evaluation.

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62Q.55 EMERGENCY SERVICES

The plan complies with the following: if emergency services are provided by a nonparticipating (out-of-network) provider, the plan cannot impose coverage restrictions or limitations that are more restrictive than that which apply to emergency services received from a participating (in-network) provider. Cost-sharing requirements that apply to emergency services received out-of-network must be the same as the cost-sharing requirements that apply to services received in-network and shall count toward the in-network deductible. All coverage and charges for emergency services must comply with the No Surprises Act. "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii), of section 1867(e)(1)(A) of the Social Security Act (which is often referred to as the "EMTALA" standard). In other words, a hindsight review of whether a condition was actually an emergency or not is irrelevant; the prospective prudent layperson viewpoint must be used to derive the emergency services' cost sharing treatment (this is also a federal requirement in effect since September 23, 2010, due to the Affordable Care Act). "Emergency services" means (1) a medical screening examination as under section 1867 of the Social Security Act that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, (2) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under section 1867 of the Social Security Act to stabilize the patient (stabilize has the meaning given in section 1867(e)(3) of the Social Security Act), and (3) emergency services as defined in sections 245.462, subdivision 11, and 245.4871, subdivision 14, which includes coverage for emergency services outside of the hospital and emergency room setting, such as ambulances and crisis intervention personnel for mental health, substance use, suicide prevention, etc.

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___

62Q.66 DURABLE MEDICAL EQUIPMENT COVERAGE

The plan does not use medical coverage criteria for durable medical equipment that limits coverage solely to equipment used in the home.

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___

62A.673 COVERAGE OF SERVICES PROVIDED THROUGH TELEHEALTH.

Subd. 2.Definitions… (a-i)

Subd. 3. Coverage of telehealth. (a) A health plan sold, issued, or renewed by a health carrier in Minnesota must (1) cover benefits delivered through telehealth in the same manner as any other benefits covered under the health plan, and (2) comply with this section.

(b) Coverage for services delivered through telehealth must not be limited on the basis of geography, location, or distance for travel subject to the health care provider network available to the enrollee through the enrollee's health plan.

(c) A health carrier must not create a separate provider network to deliver services through telehealth that does not include network providers who provide in-person care to patients for the same service or require an enrollee to use a specific provider within the network to receive services through telehealth.

(d) A health carrier may require a deductible, co-payment, or coinsurance payment for a health care service provided through telehealth, provided that the deductible, co-payment, or coinsurance payment is not in addition to, and does not exceed, the deductible, co-payment, or coinsurance applicable for the same service provided through in-person contact…
Subd. 4.Parity between telehealth and in-person services.
Subd. 5.Reimbursement for services delivered through telehealth.
Subd. 7.Telemonitoring services

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___

62A.042 FAMILY COVERAGE

The plan covers newborn infants immediately from the moment of birth and thereafter. The plan covers newborns for illness, injury, congenital malformation, or premature birth. The coverage includes inpatient or outpatient coverage for medical, dental, orthodontic and oral surgery incurred for the management of **cleft lip and cleft palate**. Newborn infants includes grandchildren who are financially dependent upon a covered grandparent and who reside with that covered grandparent continuously from birth. The plan does not require notification as a condition for this coverage. However, the plan is entitled to all premiums that would have been collected had the plan been aware of the additional dependent.

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment
☐ Not applicable, as the plan does not cover any employees' child dependents.

62A.047 CHILDREN'S HEALTH SUPERVISION SERVICES AND PRENATAL CARE SERVICES

The plan provides coverage for children health services and prenatal care without a deductible, copayment, or other coinsurance or dollar limitation requirement. Children health services means pediatric preventive services including immunizations, developmental assessments and laboratory services from birth to age six.

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment
☐ Not applicable, as the plan does not cover any employees' child dependents.

62A.048 DEPENDENT COVERAGE

This provision must be followed if the plan covers children of employees. The plan allows dependent children who do not reside with the participant to be covered on the same basis as if they reside with the participant. The plan provides coverage to dependents covered by a qualified court or administrative order, and enrollment of a child cannot be denied on the basis that the child was born out of wedlock, the child is not claimed as a dependent on a parent's federal income tax return, or the child does not reside with the parent or in the plan's service area.

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___
☐ Not applicable, as the plan does not cover any employees' child dependents.

62A.14 DISABLED CHILDREN

This provision must be followed if the plan covers children of employees. The plan cannot terminate the coverage of a child at age 26 (due to the Affordable Care Act) if the child is and continues to be

both (a) incapable of self-sustaining employment by reason of developmental disability, mental illness or disorder, or physical disability and (b) chiefly dependent upon the employee for support and maintenance, provided proof of such incapacity and dependency is furnished by the employee within 31 days of the child's attainment of age 26 and beyond as may be required by the plan, but not more frequently than annually after the two-year period following the child's attainment of age 26. Any notice regarding termination of coverage due to attainment of the limiting age must include information about this provision.

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___
☐ Not applicable, as the plan does not cover any employees' child dependents.

62A.141 COVERAGE FOR DISABLED DEPENDENTS

If the plan covers children of employees, the plan covers disabled dependents that is and continues to be both (1) incapable of self-sustaining employment by reason of developmental disability, mental illness or disorder, or physical disability and (2) chiefly dependent upon the employee for support and maintenance. The plan does not contain any provision concerning preexisting condition limitations, insurability, eligibility, or health underwriting approval concerning disabled dependents.

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___
☐ Not applicable, as the plan does not cover any employees' child dependents.

62A.148 GROUP INSURANCE; PROVISION OF BENEFITS FOR DISABLED EMPLOYEES.

An employer may not terminate, suspend or deny benefits payable under a policy to any covered employee due to absence caused by total disability. This includes coverage of the employee's dependents. The employee is responsible for no more than the premium charged prior to the total disability. During the first two years, total disability must be determined by the inability of an employee to perform the duties of the employee's own occupation. After the first two years, the total disability definition can be based on the inability of the employee to engage in any paid employment or work for which the employee may be reasonably qualified.

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___

62A.151 HEALTH BENEFITS FOR EMOTIONALLY DISABLED CHILDREN

If the plan covers children of employees, the plan provides health service benefits for the treatment of emotionally disabled children in a residential treatment facility licensed by the commissioner of human services on the same basis as inpatient hospital. "Emotionally disabled child" has the meaning set forth by the commissioner of human services in the rules relating to residential treatment facilities.

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment
☐ Not applicable, as the plan does not cover any employees' child dependents.

62A.27 COVERAGE OF ADOPTED CHILDREN

If the plan covers children of employees, the plan must cover adopted children on the same basis as other dependents effective from the date of placement for adoption. The plan does not require notification as a condition for this coverage. However, the plan may collect all premiums that would

have been collected had the plan been aware of the additional dependent.

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment
☐ Not applicable, as the plan does not cover any employees' child dependents.

62A.302 COVERAGE OF DEPENDENTS

This provision must be followed if the plan covers children of employees. The plan must define "dependent" no more restrictively than the definition provided in section 62L.02, subdivision 11. With respect to a child who has not attained age 26, the plan shall not define child dependent in any other terms other than a relationship between a child and the employee or spouse of the employee. The plan does not deny or restrict coverage for a child who has not attained 26 years of age based on financial dependency on the employee, residence with the employee or with any other person, marital status, student status, employment status, or any combination of these factors. The plan cannot deny or restrict coverage of a child based on eligibility for other coverage, except if the child is age 26 or older. The plan may exclude coverage for a grandchild, unless the grandparent becomes the legal guardian or adoptive parent of that grandchild or the grandchild meets the requirements of section 62A.042.

NOTE: In terms of allowing employees and separately, their dependents, to terminate from a plan at the timing they desire, many political subdivisions have relied on ERISA's life event rules. ERISA does not apply to government plans. In addition, many plans are also referencing Section 125 cafeteria plan provisions, however, these provisions are not a part of their benefit plan structure. All political subdivision plans are subject to applicable state laws, even if they are self-insured. The Commerce Department would view the facts and circumstances of cases where an enrollee wishes to disenroll and cannot due to a plan's rules in light of state laws, including the section 62A.02, subdivision 3, which requires that premiums are reasonable in relation to benefits provided.

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment
☐ Not applicable, as the plan does not cover any employees' child dependents.