

Issuer Criteria

Criteria	Federal Standards	State Statutes or Rules
Benefit Design Standards	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 pediatrics. [§ 156.20]	Specific coverage requirements are located throughout state statute (many in Chapter 62Q). Existing state statute contains cost sharing provisions for HMO plans. (Please note issues related to essential health benefits are being evaluated as part of the Governor's Health Care Reform Task Force's Access Workgroup.)
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 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)]	Minnesota Rules part 4685 require the development of a quality assurance plan to evaluate clinical and organizational components of health maintenance organizations. This includes evaluating the consumer perception of health care quality as measured through consumer satisfaction surveys. [MN Rules, 4585.1105 - 4685.1300.]
Risk Adjustment Standards	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)]	No risk adjustment requirements or programs for commercial products.
Non Discrimination Standards	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 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. § 70A.20]
Rating Variation Standards	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 Standards	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]	Making, issuing, or circulating any estimate, illustration, or circular misrepresenting the terms of any policy issued or to be issued to a policyholder or making 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 or health plan company 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. This subdivision does not prohibit underwriting and rating practices that comply with Minnesota law. [MN. Stat. § 72A. 20] Minnesota's marketing prohibitions applying to any insurance advertisement intended for presentation distribution or dissemination in the state. 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]
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]	No specific accreditation requirement. In accordance with authority to conduct reviews of managed care plans, the Minnesota Department of Health may accept compliance with accreditation standards of several nationally recognized organizations including NCQA and URAC as evidence that the organization is meeting state standards. [MN Stat. § 62Q.37]

Plan Criteria

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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] Minnesota Rules prescribe additional provider accessibility and availability standards for HMO products addressing provider adequacy standards for primary and specialty care including behavioral health and chemical dependency services. [MN. Rules, 4685.1010]
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]
Enrollment and Termination Requirements	Issuers must: Enroll qualified individuals during initial, annual, and other special enrollment periods [§ 156.725]; 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 and provide summaries of benefits and coverage documents [§ 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 and grace periods including termination by SHOP issuers, notices to employers [§ 156.270].	Health Maintenance Organization enrollees are entitled to evidence of coverage including a clear statement containing benefit exclusions, limitations, cost sharing, and the method for dispute resolution. [MN Stat. 62d.07] 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 300gg(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.
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]	No service area requirements in state statute or rules.