

CASE NO. A05-0873

STATE OF MINNESOTA
IN SUPREME COURT

IN THE MATTER OF THE RATE APPEAL OF BENEDICTINE HEALTH CENTER,

Appellant,

vs.

MINNESOTA DEPARTMENT OF HUMAN SERVICES,

Respondent.

AMICUS CURIAE BRIEF OF CARE PROVIDERS OF MINNESOTA, INC.

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INTRODUCTION

Care Providers of Minnesota, Inc. (“Care Providers”) submits this Amicus Curiae Brief to provide the Court a broader perspective on how its decision may impact Minnesota’s nearly 400 nursing homes, as it considers Benedictine Health Center’s (“Benedictine”) appeal of the Minnesota Department of Human Service’s (“DHS”) retroactive adjustment to its nursing home rates.¹

Care Providers is a non-profit trade association representing over 350 for-profit and non-profit organizations that provide skilled nursing care, assisted living services, independent senior housing, boarding care, intermediate care for persons with mental retardation, home health care, adult day care, and other services to over 22,000 people in Minnesota. It is appearing as Amicus Curiae because this Court’s decision will have potentially profound effects not only on Benedictine, but on other nursing homes in Minnesota whose interests Care Providers represents.

Minnesota’s nursing homes face continual and consistent financial pressure and forty-five have closed since 2000.² According to a 2005 study prepared by Larson, Allen, Weishair & Co., LLP, nursing homes across Minnesota face the risk of closure due to inadequate operating margins and a low amount of cash on hand.³ At the same time,

¹ Pursuant to Minn. R. Civ. App. P. 129.03, Care Providers certifies that no party to this matter authored this Amicus Brief in whole or in part. Care Providers further certifies that no other persons or entities made a monetary contribution to the preparation or submission of this Amicus Brief.

² Wolfe, “*Nursing Homes are Closing Amid a Contracting Industry*,” Star Tribune, Feb. 27, 2006.

³ The referenced study can be found at:

<http://www.careproviders.org/members/2006/Imperative2005FINAL32006.pdf>

over the last four legislative sessions, the Minnesota State Legislature has either frozen nursing home rates at levels that do not cover costs, or provided rate increases tied largely to increases in staff wages, without any real recognition of the higher and higher amounts nursing homes have to pay for necessities such as heating, food, supplies, insurance, and maintenance of aging buildings. Given that Minnesota's nursing homes rely to an enormous extent on the rates paid through the Minnesota Medical Assistance Program,⁴ it is easy to appreciate the devastating effect an adjustment to those rates can have – particularly a retroactive one that will result in a significant repayment obligation.

Many Minnesota nursing homes participate in the State's alternative payment system ("APS"), established in 1995. Although the APS system provided an alternative to the cost-based Rule 50 payment system, facilities' initial APS rates are nonetheless based on their most recent Rule 50 rates, which are then adjusted under the APS system in subsequent years. When DHS audits the historical cost report of an APS facility and determines that some portion of the costs were not allowable, the base rates are re-calculated. This re-calculation then "ripples through" the facility's APS rates. Since a re-calculation of the base Rule-50 rate affects each subsequent APS year, the effect of an adjustment to the Rule 50 rate has a compound effect on all subsequent years – an effect

⁴ Since 1976 Minnesota has had a statute known as the rate equalization law for nursing homes. *See* Minn. Stat. § 256B.48, subd. 1(a) (2004). Under this law, facilities cannot charge private paying residents more (or less) than the rate the State pays under the Medical Assistance Program. Care Providers estimates that approximately 90 percent of Minnesota nursing homes' resident days are controlled by Medical Assistance rates.

which could be overwhelming for a Minnesota nursing home that already operates on a razor thin margin with very little cash on hand.

This Court's consideration of Benedictine's appeal is important in two significant ways. First, if the Court of Appeals' decision is affirmed, DHS will implement a retroactive rate adjustment through a unique combination of its own reliance on an internal memorandum (never promulgated as an administrative rule) and the Court of Appeals' definition of a single statutory term. None of the nursing homes regulated by DHS had any indication that these two actions would together result in a mechanism for determining incurred costs for nursing homes with self-insured employee health benefits. This type of process turns the concept of rulemaking on its head, and leads to result-oriented decisions, cobbled together without any input from the affected regulated entities. This Court has an opportunity to bring clarity to the issue of when a rulemaking process is required.

Second, a decision from this Court rescinding DHS' unpromulgated rule will strengthen nursing homes' abilities and willingness to find creative solutions to address the ever increasing costs of providing the services on which so many of Minnesota's senior citizens depend. The provision of employee health benefits is a prime example. Self-insurance programs have represented a way for some nursing homes to provide health benefits to employees during a time when many nursing homes are not able to obtain affordable coverage for long term care facilities, primarily due to historical loss ratios of the long term care industry, adverse selection by employees, and the demographics of the nursing home's work force. DHS' determination to disallow a

fundamental cost element of Benedictine’s self-insurance plan effectively penalizes Benedictine (and potentially other similarly situated nursing homes) for taking steps to control health insurance costs. A decision that upholds the disallowance of these costs may have a chilling effect on nursing homes’ ability to adapt and change their ways of doing business.

In order for Minnesota’s nursing home industry to survive and grow to meet the needs of the increasing number of our State’s elderly citizens, it needs to be able to rely on a fair and open process of rate determination that allows for industry input. Care Providers is concerned that a decision affirming the Court of Appeals will tacitly endorse interpretation of select words or phrases in a statute as a substitute for formal rulemaking, thus injecting an unfortunate measure of unpredictability into the rate setting process. Clear guidelines from this Court about when rulemaking is required will be of benefit not only DHS and the entities it regulates, but will also benefit the myriad other Minnesota agencies and the individuals and entities they regulate.

ARGUMENT

A. The Court of Appeals’ Decision Endorses a Process that Amounts to Unpromulgated Rulemaking in Violation of Minnesota Law.

A rule is broadly defined under Minnesota law as “every agency statement of general applicability and future effect . . . adopted to implement *or make specific the law enforced or administered by that agency* or to govern its organization or procedure.” Minn. Stat. § 14.02, Subd. 4 (2004) (emphasis added). “[T]he legislative scheme in so defining rule was to include agency activities within the general definition of ‘rule’ and

then to exclude such specific activity as it deemed beneficial to the concerns of efficient government and public participation.” *McKee v. Likens*, 261 N.W.2d 566, 577 (Minn. 1977).

Courts in Minnesota have long held that rules not promulgated in accordance with Minnesota’s Administrative Procedures Act are invalid and cannot be used as the basis for agency action. *White Bear Lake Care Ctr., Inc. v. Minn. Dept. of Public Welfare*, 319 N.W.2d 7, 9 (Minn. 1982). While generally an agency’s interpretation of a statute which coincides with the plain meaning of that statute is not deemed rulemaking (*See Application of Peoples Nat. Gas Co.*, 389 N.W.2d 903, 906 (Minn. 1986)), an agency’s statutory interpretation constitutes unauthorized rulemaking where the statutory term is subject to more than one interpretation. *Sa-Ag, Inc. v. Minn. Dept. of Transp.*, 447 N.W.2d 1, 5 (Minn. Ct. App. 1989).

There is no question that Rule 50 does not differentiate between fully insured employee health coverage and self-insured health coverage for purposes of cost reporting. The rule provides no detail as to the elements of a self-insurance plan that will be allowed as costs – it only instructs nursing homes to report costs for group health and dental insurance in the payroll taxes, fringe benefits, and clerical training cost category. Minn. R. 9549.0040, Subp. 8D (2005). The rules generally provide that to be allowable, costs must be (1) ordinary, necessary and related to patient care; (2) what a prudent and cost conscious business person would pay for the service in the open market in an arms length transaction; and (3) for goods or services actually provided in the nursing facility. Minn. R. 9549.0035, Subp. 8A-C (2005). There does not appear to be any question that the

payments Benedictine made into the dedicated plan account satisfied these general requirements.

DHS takes the position that its interpretation is consistent with the requirement under Chapter 9549 that historical operating costs reported to the Commissioner have to have been “incurred . . . during the reporting year immediately preceding the rate year . . .” Minn. R. 9549.0020, Subp. 25 (2005). Although DHS’ desire to reduce this case to its most simplistic is understandable, this Court should resist the temptation to authorize DHS’ actions under the general cloak of statutory or rule interpretation.

What DHS has actually done through its interpretation of the term “incurred” is to create a specific rule as to what constitutes an “incurred cost” in the context of self-insured group health benefits. Self-insurance, however, is a unique expenditure, regulated by both State and Federal law. The administrative rules that list health insurance as an allowable cost provide no specific guidance as to what allowable self-insurance costs can comprise.⁵ Despite the absence of any statutory language, DHS developed an internal memorandum in 1992, establishing allowable costs for self-insured health benefits.⁶ DHS’ attempt to support that decision with its interpretation of the single term “incurred” amounts to post-hoc rationalization.

⁵ While Minnesota law does not address cost reporting for self-insured health benefits, Section 256B *does* outline guidance for workers’ compensation self-insurance cost reporting. *See* Minn. Stat. § 256B.431, Subd. 22(b) (2004). Thus, the Legislature certainly could have imposed specific requirements on self-insured health benefits had it wished to do so.

⁶ The actual DHS Memorandum is included in Benedictine’s Appendix at p. 82.

Had a rulemaking process been followed, members of Minnesota's nursing home industry could have participated with DHS in determining the appropriate method for reporting costs for self-insured employee health benefits in light of how such plans actually work. Sound public policy dictates that an agency should not be allowed to establish a rule through an internal memorandum and then categorize that rule as an interpretation of the law, years later. The decision in this case should focus not on the narrow interpretation of the word "incurred," but should instead focus on the *result* of that interpretation, recognizing that a term used in a statute can have materially different effects, depending on the context in which it is being applied. When an agency interprets and applies a general term to a specific statute or rule in a manner that creates requirements not provided under existing law, the agency has engaged in rulemaking and must follow Minnesota's Administrative Procedures Act.

B. Contributions to a Self-Insured Group Health Benefit Plan are "Incurred" by Plans subject to ERISA.

The Court of Appeals' decision upholding DHS' interpretation may adversely affect Minnesota nursing homes whose self-funded employee benefit plans are governed by the Federal Employee Retirement and Security Act (ERISA). As this Court is well aware, ERISA governs a significant number of employee benefit plans in Minnesota, and establishes plan rules, required communications, fiduciary duties, and required procedures in dealing with plan assets and plan participants.

According to the Court of Appeals' and DHS' interpretation of the word "incurred," an employer's contribution to an employee benefit plan is not "incurred" until

the funds are used to pay an actual claim. This approach fails to recognize the unique aspects of self-funded plans, the requirements of ERISA, and the treatment of funds that become assets of an ERISA plan. Many employers governed by ERISA establish a dedicated plan account from which the plan administrator pays for the benefits the employer is obligated to provide pursuant to the self-insurance plan. In many instances, both employer and employee contributions are deposited into this account. Once deposited, the funds become “plan assets,” which may not be directed to non-plan purposes without running afoul of ERISA’s fiduciary duties and/or other contractual obligations.

ERISA itself provides that “a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and . . . for the exclusive purpose of: (i) providing benefits to participants and their beneficiaries; and (ii) defraying reasonable expenses of administering the plan . . .” 29 U.S.C. § 1104(a)(1)(A)(i-ii). Once funds to pay benefits are transferred into a plan account, a self insured employer is not free to access those funds. Rather, the funds must be used to pay for benefits. *See* U.S. Dept. of Labor ERISA Opinion Letter 92-24A, Nov. 6, 1992 (welfare plan generally has a beneficial interest in particular assets if employer establishes a plan trust or sets up a separate account with a bank in the name of the plan).

There is no question that the act of depositing funds into a plan account is of considerable significance in determining whether those deposits become an asset of the plan. The Ninth Circuit Court of Appeals has observed that “*until the employer pays the employer contributions to the plan, the contributions do not become plan assets . . .*”

Cline v. Indus. Maint. Eng'g Co., 200 F.3d 1223, 1234 (9th Cir. 2000) (emphasis added);
See also In re Louisiana Pacific Corp., ERISA Litigation, 2003 WL 21087593, at *5 (D.
Or. 2003) (“Fiduciary obligations do not arise until the contribution is made by the
employer to the plan.”).⁷

Thus, by making a contribution to a self-funded ERISA plan, an employer has “incurred” that expense, because under ERISA principles establishing fiduciary duties, as well as under traditional principles of property and trust law, the plan has acquired an ownership interest in those funds, the use of which is restricted to payment of plan expenses. Whether or not the funds have actually been paid in connection with an employee claim does not alter the fact that under ERISA the self-insured employer has made the payment and does not have the legal ability to apply those payments to anything but plan purposes. The intricacies of self-funded health benefit plans, and in particular the different ways in which such plans can be set up, demonstrates the fundamental problems caused by DHS’ interpretation of the word “incurred” in a vacuum, without the benefit of broader input from the regulated community. It also highlights the ways in which a formal rulemaking process would have been very helpful.

Given today’s financial climate for nursing homes, agencies such as DHS have to allow nursing homes to pursue innovative and new ways of meeting their obligations within the existing legal framework without fear that the decisions they make today

⁷ More recently, the Tenth Circuit Court of Appeals, applying traditional principles of property, contract and trust law, held that an ERISA plan’s contractual right to *unpaid* employer contributions constitutes a plan asset. *In re Luna*, 406 F.3d 1192, 1199-1200 (10th Cir. 2005).

might cost them significantly and unexpectedly in the years to come. The unfortunate result of DHS' application of the term "incurred" may be to penalize nursing homes such as Benedictine that set up self-funded health benefit plans in order to provide more cost-effective coverage for their employees.

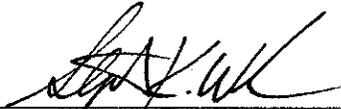
CONCLUSION

Care Providers respectfully submits that the Court of Appeals' decision in this matter should be reversed. This Court should take this opportunity to make clear that an agency's reliance on the interpretation of a general word or phrase to create specific requirements found nowhere in statute or rule amounts to unpromulgated rulemaking under Minnesota law.

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Respectfully Submitted,

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