

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.

**RELATOR BENEDICTINE HEALTH CENTER'S
REPLY BRIEF**

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INTRODUCTION

The true fiscal impact of this Court's decision on Benedictine Health Center ("Benedictine") will be well over a million dollars. App. 86, ¶ 11. Although the Minnesota Department of Human Services ("Department" or "DHS") argues that the case involves only the correctness of a \$168,037.44 disallowance, Resp. Brief at 4, Benedictine's first Brief explained how Minnesota's nursing home rate-setting system continues to amplify the effect of that ten-year old decision. Appellant's Brief, 8 - 9. Benedictine's first Brief also explained why that rate-setting system prevented Benedictine from mitigating the continuing effect of the Department's action. *Id.*, 9.

When the Commissioner of Human Services approved his agency's decision to disallow a substantial portion of the costs Benedictine paid to provide group health insurance for its employees, he adopted a decision based on an internal memorandum of his agency, not on a properly promulgated rule.

The purpose of the Administrative Procedure Act is to insure that we have a government of law and not of men. Under that act, administrative officials are not permitted to act on mere whim, nor their own impulse, however well-intentioned they might be, but must follow due process in their official acts and in the promulgation of rules defining their operations.

Monk & Excelsior v. Minn. State Bd. of Health, 225 N.W.2d 821, 825 (Minn. 1975).

The Court of Appeals erred when it determined that the Minnesota Department of Human Services (the "Department" or "DHS") did not rely on that unpromulgated rule to disallow costs of providing group health benefits reported by Benedictine Health Center. Notwithstanding the Department's protestations that its action in this case was compelled

by the plain language of the Medical Assistance (“MA”) program rate-setting statutes and rules, the Department’s position is based on an interpretation of the single word “incurred” that has changed demonstrably depending on the circumstances. The record, and the Department’s own argument, reveals that its rule on the allowable costs of Benedictine’s group health insurance represents a moving target that has shifted, even in the course of this case, according to the impulse of the DHS staff who tried to apply it.

This Court should take this opportunity to make it clear to Minnesota administrative agencies that they cannot avoid their responsibilities under the Administrative Procedure Act by relying on the “interpretation” of single words to change the meaning of properly promulgated rules.

The Department argues that the principle articulated by the United States Supreme Court in *Whitman v. Am Trucking Ass’ns*, 531 U.S. 457 (2001) and echoed in other cases, that Congress does not conceal substantive changes to agency authority in minor words or phrases, it does not hide elephants in mouseholes, in the words of Justice Scalia, *Id.* at 468, does not apply to this case. Resp. Brief at 20. According to DHS, this case is different because the legislature “unambiguously imposed” the requirement that DHS not reimburse Benedictine for expenses it actually paid to maintain its self-insured group health plan.

In fact, the Department’s action in this case is exactly the sort of agency action Justice Scalia found improper. Rather than promulgate a rule to define how Minnesota’s cost-based MA system would pay for self-insured group health insurance costs, the

Department finally settled upon the explanation that Benedictine did not “incur” certain group health insurance costs until an unrelated third-party settled employee claims with the funds Benedictine had paid into its Plan Account. As Benedictine explained in its initial brief, the Commissioner of Human Services (“Commissioner”) and the Court of Appeals were forced to rely on their interpretations of the single word “incur” to distinguish between the otherwise allowable costs of commercial and self-insured group health policies and to determine which costs of self-insured policies to allow. That is exactly the sort of action the United States Supreme Court rejected in *Whitman*: agency interpretation of a single word or phrase, isolated from a complete statutory or regulatory scheme, to claim authority not otherwise authorized by statute or regulation.

ARGUMENT

I. THE COMMISSIONER RELIED ON AN UNPROMULGATED RULE TO DISALLOW BENEDICTINE’S PAYMENTS INTO THE PLAN ACCOUNT OF ITS SELF-INSURED HEALTH BENEFIT PLAN.

The Department argued that the Commissioner’s interpretation of the single word “incurred” required the disallowance of Benedictine’s payments into its Plan Account, until those payments were disbursed by an independent third party to pay Benedictine’s employees’ medical claims. That result reveals a fundamental and cynical misunderstanding of the purpose of self-insurance, it is inconsistent with the language of the relevant rate-setting provisions and it is not supported by the Department’s past

practice set out in the record of this proceeding and the Department's own argument to this Court.

The Department disallowed Benedictine's reported costs because it relied on an unpromulgated rule that defines certain necessary costs of self insurance as not allowable. The DHS argument that this result is mandated by Rule 50¹'s requirement that only "incurred" costs may be recognized for rate-setting purposes represents an effort to rely on the interpretation of single word to change the meaning of the rate-setting rule. The United States Supreme Court has shown the appropriate response to such agency efforts to rewrite their own rules. *Whitman* at 486. And this Court has warned agencies of the error they commit by trying to short circuit the legislatively mandated process to develop statements of general applicability and future effect, intended to make more specific the law administered by the agency. *White Bear Lake Care Center, Inc. v. Minn. Dept. of Pub. Welfare*, 319 N.W.2d 7, 9 (Minn. 1982); *Johnson Bros. Wholesale Liquor Co. v. Novak*, 295 N.W.2d 238, 242-23 (Minn. 1980). In this case, there is no doubt about the existence of the unpromulgated rule, a copy was provided with Benedictine's first Brief. App. 82. The testimony of the Department's deposition witness confirmed that was the rule applied to adjust Benedictine's reported costs in this case. TaBelle deposition 14:8 - 16 (First Skorczeski Aff., Ex. 1).

¹Rule 50 is the popular name of the Minnesota Medical Assistance program's nursing home rate-setting provisions, Minn. R. 9549.0010 - .0080 and Minn. Stat. § 256B.41 - .50.

A. Benedictine Incurred Its Disputed Costs to Provide Employee Group Health Insurance.

When the Department promulgated definitions of allowable costs for MA reimbursement under Rule 50, it included among them the cost of group health insurance. Minn. R. 9549.0040, subpt. 8, D. It did not limit that allowable cost to the cost of paying premiums for commercial health insurance nor to the cost of paying for employees' medical expenses as they arise. Nevertheless, the Department's treatment of Benedictine's payments to its Plan Account means that DHS has parsed that provision to apply to only a portion of the costs of self-insured group health insurance².

Throughout this case, the Department has argued that Benedictine's self-insurance program was no more than the equivalent of setting money aside to pay future medical claims. Resp. Brief at 2, 8, 12, 16, *et seq.* In fact, committing funds to pay future medical claims is a fundamental part of insurance. A commercial insurer's business success depends on enticing insureds into sending it money, via premiums, to set aside to pay future claims. Denigrating that activity suggests the Department misapprehends the whole purpose of *insurance*.

²In spite of the Department's professed concerns about excessive costs of self-insured programs, the Department's deponent confirmed that he saw no evidence of exaggerated payments, payments that were not ordinary, improper motives for any payments, any evidence that Benedictine attempted to manipulate its payments to maximize MA reimbursement or any evidence that it was negligent or careless in determining how much to pay to the Plan Account. TaBelle deposition at 39 - 41 (First Skorczeski Aff., Ex. 1). This case is about the Department's refusal to recognize the "self" component of self insurance.

The Department's argument minimizes the specific obligations Benedictine acquired when it switched from commercial health insurance to a self-insured plan in 1994. In particular, it acquired the obligation to ensure that its employees' health claims would be paid as they arose, even though there was no longer any commercial insurer bound to pay those claims, at least until the limit of the excess coverage policy was reached. Finding of Fact, App. 66. It also acquired the obligation to contribute to the Plan Account in amounts, derived from the calculations of independent actuaries, sufficient to cover claims against the Account. *Id.*

Benedictine incurred self-insurance costs every time it made a payment to the Plan Account. Its parent, Benedictine Health System ("BHS"), which maintained the Account, incurred costs of its self-insurance program every month an actuarially-derived Plan Account payment obligation arose. Benedictine was participating in a plan of self insurance, not a plan of hoping its employees' medical claims were never too high to pay out of its own pocket. The point of self-insurance was that Benedictine incurred costs to assure those claims would be paid as they arose, not to pay the costs as they arose.

The Department has tried to cast this activity as merely a convenient way to save money for expenses that might arise in the future and argues that it has consistently applied Rule 50 to disallow costs of "contingent liabilities" and "future claims." Resp. Brief at 6. The Department goes so far as to argue that allowing Benedictine to claim the cost of its payments to the Plan Account "would be similar to allowing a commercially

insured facility to count as costs funds that it sets aside in one reporting period to pay insurance premiums in a subsequent reporting year.” DHS Brief at 30.

As much as DHS tries to deny it, there is a fundamental difference between those two scenarios. In one case, Benedictine was incurring current costs to protect itself against the expense of otherwise unmanageable employee medical claims, in the other, the commercially-protected facility would be setting aside money to purchase more commercial protection in the future. Benedictine was not depositing excess funds into a savings account. It had obligated itself to its employees to provide a health insurance benefit plan and its monthly payments to the Plan Account were part of the cost of meeting that obligation.

The record in this case also reveals that the Department’s purported concern over the Plan Account being a convenient place for Benedictine to park excess revenues is far from realistic. Benedictine’s Petition for Review identified a Star Tribune report that forty-five Minnesota nursing homes had closed since 2000. *See, Wolfe, “Nursing Homes are Closing Amid a Contracting Industry,” Minneapolis StarTribune, Feb. 27, 2006.* The brief of *Amicus Curiae* Care Providers of Minnesota recounts similar information about the financial status of Minnesota’s nursing homes. *Amicus Curiae* Brief at 1 -2. The testimony of the Department’s deposition witness confirmed that, had Benedictine made excess deposits to its Plan Account, it would have impaired its ability to pay its other routine but necessary operating expenses. TaBelle deposition 41:22 - 42:1 (First Skorczeski Aff., Ex. 1).

Benedictine's payments to the Plan Account were necessary expenses of its self-insurance program and DHS had no evidence of any impropriety regarding those costs. Once Benedictine made payments to the Plan, those funds were no longer available to it to use for other purposes. Benedictine incurred the costs of its payments to the Plan Account each time it made a payment.

B. The Plain Language of Rule 50 Does Not Distinguish Between The Costs of Commercial Insurance and Self-Insurance.

As explained in Benedictine's principal brief, nothing in Rule 50 excludes the costs of self-insurance from the recognition of group health insurance as an allowable cost for MA rate-setting purposes. Benedictine Brief at 13 . Benedictine does not maintain, as the Department asserts, Resp. Brief at 17, that, because Rule 50 recognizes the general cost category of group health insurance as an allowable cost, it is entitled to be paid for the costs of its self-insurance program without further review. Benedictine asked the Department's deposition witness if DHS had identified problems with the accuracy, reasonableness or motivation underlying Benedictine's reported self-insurance costs. He testified that it had not. TaBelle deposition at 39 - 41 (First Skorczeski Aff., Ex. 1). The administrative law judge made the same factual determination. Findings of Fact, App. 66-67. Benedictine is not seeking insulation from DHS review of its costs under Rule 50's general cost principles. The Department testified that it saw no concerns over Benedictine's costs, under those general cost principles.

Rule 50 recognizes the cost of group health insurance as an allowable cost. It is the Department's unpromulgated rule that draws a distinction between paying the costs of commercial insurance and paying the costs of self-insurance. A general cost principle of Rule 50 is that "the substance of the transaction shall prevail over the form . . ." Minn. R. 9549.0035, subpt. 8.D. The substance of Benedictine's payments to the Plan Account was the maintenance of group health insurance for its employees and their families. That substance should prevail over the particular form Benedictine chose to accomplish that goal.

Benedictine acknowledges that promulgated rules need not address every factual scenario where the rules apply. *Cable Communications Bd. v. Nor-West Cable Communications Partnership*, 356 N.W.2d 658, 667 (Minn. 1984). But when a distinction drawn by an agency does not flow from the plain language of the statute it is applying and where the analysis on which the agency relies for its distinction is not based on some long-standing interpretation, *see* § I.C, below, this Court should reverse the agency's actions. *Ebenezer Soc. v. Minn. Dept. Human Services*, 433 N.W.2d 436 (Minn. 1988).

Benedictine also recognizes that neither Minn. Stat. § 256B.431, subd. 22(b) nor subd. 22(e), cited in its first Brief, Benedictine Brief at 20 - 21, applies to the costs at issue in this appeal. The relevance of those two provisions is not that they dictate the result of this case, but that they demonstrate that the Minnesota legislature, unlike DHS, recognized self insurance as a legitimate option to provide important benefits to nursing

home employees and that maintenance of adequate plan reserves is an essential element of self-insurance plans.

C. The Department's Action in this Case Is Not Mandated By the Plain Language of Rule 50.

The Department's own record in this case contradicts its argument that the plain language of Rule 50 compels the conclusion that Benedictine did not incur the costs of self insuring its employees' medical claims until those claims were paid. In reality, the Department relied on its unpromulgated rule to disallow those costs and then developed explanations to justify its actions when challenged.

The Department argues to this Court that the essence of incurring Plan Account costs is paying claims from the Account:

Neither Benedictine nor BHS incurred costs equal to amounts that Benedictine transferred to the plan account, because **funds in the account remained under BHS's control** and inured to BHS's benefit **until paid out for medical claims.**³

Resp. Brief at 17.

³The Department asserts, "Under the terms of the contract, the plan account itself was '*maintained and controlled* by the Benedictine Health System'", Resp. Brief at 8, and "Under the terms of BHS's contract with CCS, the plan account was '*maintained and controlled* by the Benedictine Health System.'" Resp. Brief at 17 [emphasis added]. In spite of the quotation marks, that phrase appears *nowhere* in the CCS contract. Krueger Aff. Ex. B, ¶ V. The contract *did* require BHS to "establish and maintain a Plan Account . . . to be used to disburse benefit payments . . ." *Id.* It was that obligation to establish and maintain an account from which a third party could pay claims that meant Benedictine **had** to make payments to the Plan Account to maintain its group health insurance coverage.

That is not the reason DHS disallowed Benedictine's costs in 1998. According to the Department's audit adjustment, Benedictine's Plan Account payments were disallowed on the basis of Minn. R. 9549.0035, subpt. 8.C. ("For rate-setting purposes, a cost must satisfy the following criteria: . . . the cost is for goods or services actually provided in the nursing facility . . ."⁴) Krueger Aff., Ex. L, p. 4. After Benedictine appealed the disallowance, it received a determination on its appeal from the Commissioner, pursuant to Minn. Stat. § 256B.50, subd. 1c. In the Determination, the Commissioner announced that the disallowance would stand because "amounts paid into a fund reserve [in excess of claims paid] are allowable if, among other conditions, the fund is controlled and administered by an unrelated party," but Benedictine's fund reserve was controlled by a related party. Krueger Aff., Ex. F, p.2⁵.

Notwithstanding the Department's purported long-standing practice, it was not until this case made it to the Office of Administrative Hearings that the Department, through its counsel, articulated to Benedictine the argument that it had not "incurred" the costs of its payments to the Plan Account.

⁴The Department's deposition witness confirmed that the cost of health insurance for employees and their families is, in fact, considered a service actually provided in the nursing facility. TaBelle deposition at 26:11 -16 (First Skorczeski Aff., Ex. 1). The reason cited for the original disallowance was invalid.

⁵Although the Department takes umbrage at Benedictine's suggestion that it "hijacked" portions of Rule 50's provision regarding workers compensation self insurance to apply to Benedictine's self-insured group health plan, Resp. Brief at 7, fn 7, this explanation of the Department's disallowance comes directly from Rule 50's requirements for self-insured workers compensation programs. Minn. Stat. § 256B.431, subd. 22(b)(4)(ii).

Even before this Court, the Department has provided two explanations of how a nursing home may incur costs of a self-insurance program. Throughout this case, DHS has maintained that the plain language of Rule 50 demands that only the cost of **claims actually paid** may be recognized, because only those costs are truly incurred. Resp. Brief at 17, (“funds in the account remained under BHS’s control and inured to BHS’s benefit *until paid out for medical claims. . .*”) [emphasis added]⁶. The Commissioner explicitly found that “DHS’ classification of incurred costs for purposes of *excluding monies remaining in the plan account after claims, insurance and administrative expenses have been paid*, is a reasonable interpretation of Rule 50’s relevant language.” App. 58. However, in a footnote to this Court, the Department mentions that it also recognizes costs reported for claims **incurred but not actually paid** in the same reporting year. Resp. Brief at 18, fn.11. The Department’s position is inconsistent and confusing, the record reflects that even DHS staff disagreed over what costs should be recognized. Krueger aff., Ex. J.

The Department argues that the principle set out in *In re St. Otto’s Home v. Minn. Dep’t of Human Servs.*, 437 N.W.2d 35 (Minn. 1989), does not apply in this case, because its application of Rule 50 to the costs of self-insurance has not changed over time. In fact, the record reveals that the Department’s explanation of how it applied Rule 50 to the

⁶The Court of Appeals accepted that argument, as it found “BHC’s disallowed costs represent *money that has not been spent and remains in its plan account. . .*” [emphasis added]. *In the Matter of the Rate Appeal of Benedictine Health Center*, slip op. at 6 (Minn. Ct. App. January 31, 2006), App. 14.

costs of Benedictine's self-insured group health insurance has changed over the course of this case.

This is not a case where the Department's actions were compelled by the plain meaning of Rule 50. This is a case where the Department, by its own admission at deposition, applied an internal policy to disallow Benedictine's costs. Minnesota courts have long recognized that not every agency policy must be promulgated as a rule, when they merely apply the plain language of the underlying statute or of a promulgated rule. The record in this case makes it clear that DHS has yet to settle on the plain meaning of the requirement to recognize only the costs incurred to provide self insurance.

The Department has no promulgated rule to rely on to distinguish between Benedictine's costs of its self-insured group health program and the costs of commercial insurance. The record reveals that, far from applying the plain language of Rule 50 to disallow the costs Benedictine actually incurred to maintain its self-insurance program, the Department has provided multiple explanations for its actions and even an exception to what it argued is the plain meaning of the term "incurred." The disallowance of Benedictine's self-insurance costs was based on an unpromulgated rule and this Court should reverse the finding of the Court of Appeals to the contrary.

II. THE DEPARTMENT'S DISTINCTION BETWEEN COMMERCIAL INSURANCE AND SELF-INSURED GROUP HEALTH PLANS VIOLATES BENEDICTINE'S CONSTITUTIONAL RIGHT TO EQUAL PROTECTION.

For purposes of satisfying the requirements of Rule 50, Benedictine was similarly situated with any nursing home that provided similar levels of employee health benefits through commercial insurance. The distinctions that the Department attempts to draw between Benedictine and a commercially insured nursing home are not distinctions at all. Those distinctions focus on the Department's contention that nursing homes that pay premiums to a commercial insurer are not likely to see premium reductions in the event of favorable claim experience, Resp. Brief at 29, and the fact that BHS earns interest on Plan Account funds until they are paid out in claims. Resp. Brief at 30.

With regard to the first purported distinction, commercial insurance clients may, in fact, have experienced premium holidays following favorable claims experiences and everyone who reads a newspaper or watches television news certainly knows that commercial insurance premiums rise in the face of unfavorable claim experience. Commercial insurance premiums are obviously sensitive to claims experience.

The Court should also be clear that the essence of the Department's first distinction is that DHS reimbursed the full premium cost of commercially-insured nursing homes because they never provided the state coffers any benefit of premium reductions due to favorable claims experience. That is an absurd result, and statutes are to be interpreted in ways that do not produce absurd results. Minn. Stat. § 645.17 (1).

The second purported distinction, that BHS benefits from interest earned on funds in the Plan Account, is similarly illusory. By contract, interest earned on Plan Account funds was applied, not to the general accounts of BHS, but back to the Plan Account. Krueger Aff., Ex. B, § V. To the extent that the Plan Account needed fewer contributions because it benefitted from interest earned, BHS, Benedictine and all the Plan participants benefitted, because the cost of maintaining the Plan Account at actuarially-recommended levels was been diminished⁷. That is exactly the result commercially-insured nursing homes would expect if their commercial insurers had a particularly successful year investing their reserves. The Department's purported distinctions do not mean that Benedictine and a commercially-insured nursing home were not similarly situated.

The Department's argument about its rational basis to disallow Benedictine's reported costs is similarly faulty. The Department argues the state has a rational interest in seeing that Benedictine was not reimbursed based on inflated estimates of future costs. Resp. Brief at 28, 31. That threat is illusory in this case, because the Department's deposition witness specifically testified that he saw no indication of DHS concern that Benedictine had paid an exaggerated amount into the Plan Account. TaBelle deposition at 39 - 41 (First Skorczeski Aff., Ex. 1), *see, also*, Findings of Fact, App. 66-67⁸. The

⁷DHS would have benefitted, as well, had it reimbursed Benedictine for the costs it incurred to maintain the self-insured group health plan.

⁸The rational-basis test under the Minnesota Constitution requires the state to establish "a reasonable connection between the actual, and not just the theoretical, effect of the challenged classification and the statutory goals." *State v. Russell*, 477 N.W.2d 886, 889 (Minn. 1991).

Department also argues that it has a rational basis not to reimburse Benedictine for costs it had not incurred. Resp. Brief at 31. However, as explained in Section I.A., above, Benedictine incurred costs to provide its self-insured group health plan every time it made a payment to the Plan Account.

The Department had rational bases for concern about some of the facts in this case. The Department should have had a concern that its unpromulgated rule provided an incentive for nursing homes to purchase commercial insurance, instead of self-insured programs, regardless of their respective costs, simply because the costs of commercial insurance would have been reimbursed under Rule 50. It did not. The Department should have had a concern that employers who could not find affordable health insurance programs for their employees would go without, leaving their employees to look to private policies, or to the state, for their insurance, rather than see a substantial portion of the cost of establishing the reserves on which a self-insured program relies go unreimbursed⁹. It did not.

In light of the financial status of the Minnesota nursing home industry, the Department should not adopt a strained interpretation that further burdens facilities. The State should have had a concern that a nursing home attempting to self insure could shift

⁹The Minnesota legislature recognized that concern over the impact of employed but uninsured or underinsured individuals seeking their health insurance from state programs. The Court may take judicial notice that, last legislative session, SF 2672 would have required large Minnesota businesses to pay at least 8% of total employee wages toward health-care expenses or to pay the difference between actual expenditures and 8% of total wages to Minnesota's Health Care Access Fund.

the burden of any unfunded obligations to its employees onto the State of Minnesota under involuntary receivership laws, if it found it could not meet the expense of unreimbursed plan payments. Minn. Stat. § 144A.15, subd. 3. That law, among other requirements, obligates the State's receiver to pay "all valid obligations of the nursing home . . ." It did not.

For purposes of assessing the cost of group health insurance programs, Benedictine and commercially-insured nursing homes were similarly situated. None of the alleged concerns raised by the Department represents a rational basis for the differential treatment Benedictine received with regard to the costs of its group health insurance program. The Department's theoretical concerns about excess costs and abusive reporting practices were all negated by the testimony of its deposition witness about the lack of such actual concerns over Benedictine's reported costs. The Department's differential treatment of Benedictine violated its Constitutional right to equal protection under the law.

CONCLUSION

In 1994, Benedictine changed the way it provided group health insurance to its employees. Under its new self-insured program, it continued to make regular payments to ensure that its employees' medical claims would be paid as they arose. Those payments were not savings deposits intended to pay for future claims, they were current expenditures required to maintain the operation of its self-insurance plan.

Rather than recognize that Benedictine was incurring real costs to participate in the insurance plan, DHS staff relied on an unpromulgated internal policy that disallowed

Benedictine's Plan Account costs not paid out as employee claims during the reporting year. The record reveals that, far from applying the plain language of Rule 50, the Department has advanced multiple explanations for its disallowances, some of which contradict each other.

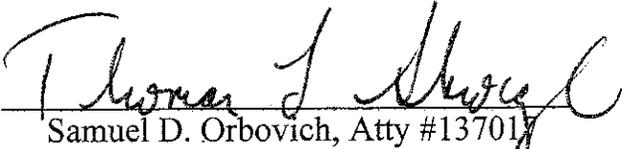
This Court should find that the Court of Appeals erred when it determined that the Department simply applied the plain language of Rule 50 and, instead, hold that the Department's actions in this case were unauthorized, because they were based on an unpromulgated rule.

Similarly, this Court should reverse the determination of the Court of Appeals that the Department's disallowances did not deprive Benedictine of equal protection under the law. The differences between Benedictine and a commercially-insured nursing home are not substantive, both are required to make regular payments to maintain the program that ensures their employees' medical claims are paid as presented, and the Department has articulated no rational basis for its differential treatment. The concerns it articulated over recognizing Benedictine's costs of providing a self-insured health insurance program may have been theoretical, but their practical application to Benedictine were contradicted by the testimony of the Department's deponent.

For all the reasons set out in the record of this proceeding, Benedictine Health Center respectfully requests that the Minnesota Supreme Court reverse the decision of the Court of Appeals and direct the Commissioner of Human Services to allow Benedictine's costs of providing self-insured group health insurance as reported.

Dated: June 30, 2006

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