

No. A05-0873

STATE OF MINNESOTA
IN SUPREME COURT

In the Matter of the Rate Appeal of
Benedictine Health Center,

Petitioner,

vs.

Minnesota Department of Human Services,

Respondent.

RESPONDENT'S BRIEF

ORBOVICH & GARTNER, CHTD.

SAMUEL D. ORBOVICH

Atty. Reg. No. 137017

THOMAS L. SKORCZESKI

Atty. Reg. No. 178305

408 St. Peter St., Suite 417

St. Paul, MN 55102-1187

(651) 224-5074

ATTORNEYS FOR APPELLANT

MIKE HATCH

Attorney General

State of Minnesota

ERIKA SCHNELLER SULLIVAN

Assistant Attorney General

Atty. Reg. No. 0288056

445 Minnesota Street, Suite 900

St. Paul, Minnesota 55101-2127

(651) 296-1427 (Voice)

ATTORNEYS FOR RESPONDENT

(Counsel continued on next page)

HALLELAND, LEWIS, NILAN &
JOHNSON

STEPHEN K. WARCH, ESQ.

600 U.S. Bank Plaza South

220 South Sixth St.

Minneapolis, MN 55402-4501

(612) 338-1838

ATTORNEYS FOR CARE
PROVIDERS OF MINNESOTA, INC.

TABLE OF CONTENTS

	Page
TABLE OF AUTHORITIES.....	iii
LEGAL ISSUES.....	1
STATEMENT OF THE CASE.....	2
STATEMENT OF FACTS.....	4
I. RULE 50.....	4
II. BENEDICTINE’S GROUP HEALTH INSURANCE COSTS.....	8
ARGUMENT.....	12
I. SUMMARY OF THE ARGUMENT.....	12
II SCOPE OF REVIEW.....	14
III. THE DEPARTMENT’S DETERMINATION THAT BENEDICTINE DID NOT INCUR COSTS EQUAL TO THE AMOUNT SET ASIDE TO PAY FUTURE MEDICAL CLAIMS IS NOT AN UNPROMULGATED RULE.....	14
A. The Disallowance Of Funds Held To Pay Future Estimated Medical Claims Comports With Rule 50’s Plain Language Requirement To Reimburse Facilities Based On Their Historical Costs.....	16
B. The Historical Cost Requirement Applies To Benedictine’s Reported Costs For Health Insurance.....	17
C. The Department’s Disallowance Of Benedictine’s Future Estimated Medical Claims Is Consistent With The Prior Decisions Of This Court.....	21
D. The Disallowance Of Funds Set Aside To Pay Future Medical Claims Is Consistent With The Legislature’s Intent As Demonstrated By Other Legislative Enactments.....	23

IV.	DISALLOWING REIMBURSEMENT FOR FUNDS HELD BY A RELATED PARTY TO PAY FUTURE MEDICAL CLAIMS DOES NOT OFFEND EQUAL PROTECTION PRINCIPLES.	27
A.	Benedictine Failed To Establish That It Is Similarly Situated To A Commercially Insured Facility With Respect To Costs Incurred For Group Health Insurance.	28
B.	Disallowing Reimbursement For Funds Segregated To Pay Future Medical Liabilities Is Rationally Related To The State's Interest In Ensuring Reimbursement Based On Actual And Not Inflated Costs.	30
	CONCLUSION	32

TABLE OF AUTHORITIES

	Page
FEDERAL CASES	
<i>Am. Bar Assoc. v. Fed. Trade Comm'n</i> , 430 F.3d 457 (D.C. Cir. 2005)	20
<i>Boyle v. Anderson</i> , 68 F.3d 1093 (8th Cir. 1995).....	27
<i>Caswell v. City of Bloomington</i> , No. 05-2519, -- F. Supp.2d --, 2006 WL 1174025, at *4,*5 (D. Minn. April 28, 2006).....	29
<i>Food & Drug Admin. v. Brown & Williamson Tobacco Corp.</i> , 529 U.S. 120, 120 S. Ct. 1201 (2000)	20
<i>Heckler v. Cmty. Health Servs. of Crawford County, Inc.</i> , 467 U.S. 51, 104 S. Ct. 2218 (1984).....	23
<i>Klinger v. Dep't of Corr.</i> , 31 F.3d 727 (8th Cir. 1994).....	1, 28
<i>North Mem'l Med Ctr. v. Gomez</i> , 59 F.3d 735 (8th Cir. 1995).....	23
<i>Whitman v. American Trucking Ass'ns, Inc.</i> , 531 U.S. 457, 121 S. Ct. 903 (2001)	19, 20
STATE CASES	
<i>Beaulieu v. RSJ, Inc.</i> , 552 N.W.2d 695 (Minn. 1996).....	15
<i>Cable Commc'ns Bd. v. Nor-West Cable Commc'ns P'ship</i> , 356 N.W.2d 658 (Minn. 1984).....	1, 14, 15, 21
<i>In re St. Otto's Home v. Minnesota Department of Human Services</i> , 437 N.W.2d 35 (Minn. 1989).....	22
<i>Jasper v. Comm'r of Pub. Safety</i> , 642 N.W.2d 435 (Minn. 2002).....	14, 26

<i>Jones v. Minn. State Bd. of Health</i> , 221 N.W.2d 132 (Minn. 1974).....	15, 22
<i>Kuiters v. County of Freeborn</i> , 430 N.W.2d 461 (Minn. 1988).....	28
<i>Mapleton Cmty. Home, Inc. v. Minn. Dep't of Human Servs.</i> , 391 N.W.2d 798 (Minn. 1986).....	21
<i>Matter of Harhut</i> , 385 N.W.2d 305 (Minn. 1986).....	28
<i>Spannaus v. Lutsen Resorts, Inc.</i> , 310 N.W.2d 495 (Minn. 1981).....	1, 29
<i>Vlahos v. R & I Constr. of Bloomington, Inc.</i> , 676 N.W.2d 672	25
<i>Wacha v. Kandiyohi County Welfare Bd.</i> , 242 N.W.2d 837 (Minn. 1976).....	15
<i>White Bear Care Ctr., Inc. v. Minn. Dep't of Pub. Welfare</i> , 319 N.W.2d 7 (Minn. 1982).....	22

FEDERAL STATUTES

29 U.S.C. § 1002(33).....	4
42 U.S.C. § 1396a(a)(13)	4
U.S. Const. Amend. XIV.....	28

STATE STATUTES

Minn. Stat. § 14.69	14
Minn. Stat. § 176.181	25
Minn. Stat. § 256B.41-.50	4, 5
Minn. Stat. § 256B.421, subd. 6.....	passim
Minn. Stat. § 256B.431	23, 24, 26, 27
Minn. Stat. § 256B.431, subd. 22(b)(5)(i).....	24

Minn. Stat. § 256B.431, subd. 22(e)	26
Minn. Stat. § 256B.434	4
Minn. Stat. § 256B.50, subd. 1c(a).....	2
Minn. Stat. § 645.08(1)	16, 17

STATE RULES

Minn. R. 9549.0010–9549.0080	6
Minn. R. 9549.0020, subp. 22	6
Minn. R. 9549.0020, subp. 25	1, 5, 6
Minn. R. 9549.0020, subp. 36	5
Minn. R. 9549.0030, subp. 1	5
Minn. R. 9549.0035, subp. 7	1, 31
Minn. R. 9549.0035, subp. 8	6
Minn. R. 9549.0040.....	19
Minn. R. 9549.0041.....	5, 16
Minn. R. 9549.0041, subp. 1	5
Minn. R. 9549.0041, subp. 13.B	2
Minn. R. 9549.0020, subp. 19	5

LEGAL ISSUES

- I. Where rate-setting law unambiguously reimburses only costs actually incurred during the prior reporting year, did the Department of Human Services' disallowance of costs reported by Benedictine Health Center for funds it set aside to pay future medical claims constitute an invalid unpromulgated rule?

The Commissioner of Human Services determined: No.

The Court of Appeals held: No.

Minn. Stat. § 256B.421, subd. 6

Minn. R. 9549.0020, subp. 25

Minn. R. 9549.0035, subp. 7.

Cable Commc'ns Bd. v. Nor-West Cable Commc'ns P'ship, 356 N.W.2d 658 (Minn. 1984)

- II. Did the disallowance of costs claimed by Benedictine Health Center for funds set aside to pay future medical claims violate the Equal Protection Clauses of the United States and Minnesota Constitutions by treating Benedictine differently than a commercially insured nursing facility?

The Commissioner did not rule on this issue.

The Court of Appeals held: No.

United States Constitution, Amendment XIV

Minnesota Constitution, Article I, § 2

Klinger v. Dep't of Corr., 31 F.3d 727 (8th Cir. 1994)

State by Spannaus v. Lutsen Resorts, Inc., 310 N.W.2d 495 (Minn. 1981)

STATEMENT OF THE CASE

This rate appeal involves the narrow question of whether the Department of Human Services (“Department”) properly applied nursing home rate-setting law to disallow a portion of costs reported by Benedictine Health Center (“Benedictine”) for group health insurance in the reporting years ending September 30, 1994 and September 30, 1995.¹ After conducting a field audit of Benedictine’s reported costs, the Department found that Benedictine improperly sought Medical Assistance (“MA”) reimbursement for funds that it set aside in the account of a related party to pay for its employees’ future medical claims. The Department allowed as costs amounts that Benedictine paid for stop loss insurance, administrative fees, and medical claims incurred in the prior reporting year, but disallowed that portion of Benedictine’s reported costs representing funds that remained in the related party account at the end of that period.

Benedictine appealed the field audit disallowance. In accordance with Minn. Stat. § 256B.50, subd. 1c(a), the Department issued a written appeal determination providing Benedictine with a detailed calculation of the disallowance. (Affidavit of Diane Kruger, 9/27/02 (“Krueger Aff.”), Ex. F.) Benedictine requested de novo review of the

¹ Amicus Care Providers of Minnesota implies, but fails to explain how, the court of appeals decision will result in retroactive adjustments to costs reported by any of its member nursing homes. (Amicus Br. 2, 3.) Nursing home operating costs have not been reimbursed based on reported costs since the July 1, 1998 rate year. See Minn. Stat. § 256B.431, subds. 28, 31, 39. The four year period for auditing those cost reports expired long ago. See Minn. R. 9549.0041, subp. 13.B. Amicus also fails to point to any pending appeal, other than Benedictine’s, where health insurance cost reimbursement is at issue.

disallowance through contested case hearing before the Office of Administrative Hearings. (*Id.*)

The Administrative Law Judge (“ALJ”) heard Benedictine’s appeal on cross-motions for summary disposition and recommended that the Department’s disallowance be affirmed. (App. at 59-70.) In August 2003, the Commissioner issued an order adopting the ALJ’s recommendation but noting that an issue remained regarding the exact amount of the disallowance. (App. at 51-58.) The Commissioner therefore remanded this issue to the ALJ in the event that the parties were unable to agree upon the correct disallowance amount. (*Id.* at 54.)

The parties were unable to agree, and in September 2004, Benedictine served a motion for partial summary disposition, asserting for the first time that the ALJ lacked jurisdiction on remand to determine the correct dollar amount of the appealed disallowance for insurance costs. In November 2004, the ALJ recommended that the Commissioner deny Benedictine’s motion and adopt the Department’s calculation of the correct disallowance amount.² (App. at 34-49.) On April 1, 2005, the Commissioner

² Benedictine implies in its brief that the Commissioner acted improperly in making a correction during the pendency of the contested case. (Pet’r Br. 3.) The court of appeals squarely rejected this contention and Benedictine has not sought further review of this issue. (App. at 18-20) (holding that the Commissioner properly conducted a de novo review of appealed cost items to determine the correct amount of the disallowance). Thus, this issue is not properly before the Court.

issued an order finding that the correct amount of the disallowance for the appealed reporting years was \$168,037.44. (App. at 25-33.)³

Benedictine appealed the Commissioner's order by writ of certiorari to the court of appeals. (App. at 21, 22.) In a decision issued January 31, 2006, the court of appeals affirmed the Department's disallowance. (App. at 9-20.) Benedictine filed a Petition for Review, which this Court granted on April 18, 2006.⁴

STATEMENT OF FACTS

I. RULE 50.

Benedictine is a nursing facility that has chosen to receive public reimbursement as a participant in the Title XIX Medical Assistance program in Minnesota. *See* 42 U.S.C. § 1396a(a)(13); Minn. Stat. § 256B.41–.50 (2004). During the time period relevant to this appeal, the Department determined MA reimbursement rates for participating nursing

³ This appeal accordingly only involves the correctness of this \$168,037.44 disallowance. Benedictine's assertion that upholding the Department's decision will result in the collection of a million dollar overpayment pursuant to Minn. Stat. § 256B.434 apparently refers to Benedictine's continued receipt of inflated reimbursement during the nearly eight years that this appeal has been pending. (*See* Pet'r Br. 3, fn 4, 5; App. at 86.) If the Court affirms the Department's determination of allowable costs for the two reporting years at issue, Minnesota Statutes section 256B.434, subdivision 6 *requires* that the Department halt this ever increasing overpayment of public dollars by correcting Benedictine's rates "retroactively in accordance with the appeal decision."

⁴ In granting review, the Court directed the parties to address the relevance of ERISA to resolving the issues before the Court. Benedictine has represented that ERISA does not govern its self-insurance plan. (Pet'r Br. 6, 7.) According to Benedictine, its self-insurance plan qualifies as a "church plan" exempted from ERISA's requirements. (*Id.*); 29 U.S.C. §§ 1002(33), 1003(b)(2). The Department does not dispute this assertion here. The Department reserves the right to seek leave to address ERISA further, however, should Benedictine argue in its reply brief that ERISA is dispositive of the issues before the Court.

facilities in accordance with state statutes and rules collectively known as “Rule 50.” *See* Minn. Stat. §§ 256B.41 – 256B.50 (2004); Minn. R. 9549.0010–9549.0080 (2005).

Under Rule 50, the Department established prospective reimbursement rates for nursing facilities based on individual facilities’ historical operating costs. Minn. R. 9549.0041, subps. 1, 2. To receive reimbursement, nursing facilities were required to submit annual cost reports listing their historical operating costs. *Id.* Rule 50 defines “historical costs” as those “costs incurred by the nursing facility during the reporting year immediately preceding the rate year for which the payment rate becomes effective.” Minn. R. 9549.0020, subp. 25; Minn. Stat. § 256B.421, subd. 6.

After receiving a facility’s cost report, the Department conducted a “desk audit” to determine whether reported costs were allowable and properly classified under Rule 50.⁵ Minn. R. 9549.0020 subp. 19. The Department used the historical costs reported by the facility on its cost reports for each reporting year ending September 30, to issue prospective reimbursement rates, effective on the July 1 following the close of the reporting year. *See* Minn. Stat. § 256B.421, subd. 11; Minn. R. 9549.0041, subp. 1; Minn. R. 9549.0020, subp. 36.

The Department could also conduct a “field audit,” which is a more extensive on-site review of financial records and supporting documentation of the nursing facility

⁵ Costs were to be reported in specified cost categories using the “accrual method of accounting in accordance with generally accepted accounting principles,” except that Rule 50 controlled where there was a conflict between Rule 50 and generally accepted accounting principles. Minn. R. 9549.0041, subps. 6, 8; Minn. R. 9549.0030, subp. 1.

and any related organization to determine compliance with Rule 50. *See* Minn. R. 9549.0020, subp. 22. Upon completion of a field audit, the Department might adjust a nursing home's reimbursement rates by reclassifying costs to a different cost category or disallowing costs not properly reimbursed under Rule 50.

To be allowable under Rule 50, a cost was required to satisfy several general principles. Most fundamentally, nursing facilities could only report historical costs, or costs actually "incurred" during the prior reporting year. Minn. Stat. § 256B.421, subd. 6; Minn. R. 9549.0020, subp. 25.⁶ In addition, the reported costs had to be ordinary, necessary and related to resident care. Minn. R. 9549.0035, subp. 8A. The cost had to represent what a prudent and cost conscious business person would pay for the goods or services in the open market in an arm's length transaction. *Id.* at subp. 8B. And the cost had to be for goods and services "actually provided" in the nursing facility. *Id.* at subp. 8C. Minn. R. 9549.0035, subp. 8A. Similarly, if a facility purchased services directly or indirectly from a related organization, the facility was required to report only the costs incurred by the related organization for the service. Minn. R. 9549.0035, subp. 7.

Since the adoption of Rule 50 in 1985, the Department has consistently applied the its provisions to disallow costs that facilities report for contingent liabilities or future claims. *Krueger Aff.* ¶ 6. In the context of health insurance, the Department has allowed

⁶ While the Legislature amended Rule 50 in 1993 to specifically provide for reimbursement of reserves held to pay future *workers compensation* claims, that exception does not apply here. *See* Minn. Stat. § 256B.431, subd. 22(b).

costs that facilities report for premium payments to commercial insurance carriers, reasoning that when a facility pays a premium to an unrelated third party it *incurs* a cost equal to the premium amount paid in that reporting year. (Krueger Aff. ¶¶ 6, 9; Exs. G, J.) In contrast, when facilities chose to set aside funds to pay for future or *contingent insurance claims*, they did not necessarily incur costs equal to the total amount of funds they set aside in that reporting year. Accordingly, it has been the Department's longstanding practice under Rule 50 to allow the following costs for facilities that self-insure for health insurance:

- 1) Actual claims paid during the applicable reporting year.
- 2) Administrative costs.
- 3) Stop-loss, or reinsurance premiums.

*Id.*⁷

Under this longstanding practice, the Department has disallowed costs to the extent that a facility's reported costs exceeded the above cost items. Conversely, where a

⁷ Benedictine's assertion that the Department adopted this "new" interpretation of Rule 50 by "hijacking" portions of a workers compensation amendment enacted in 1993 is contrary to the undisputed facts in the record. *See* 1993 Minn. Laws 1st sp. sess., ch. 1, art. 5, § 97 (amending Rule 50). The Department's longstanding position on reimbursement for funds held by facilities to pay future claims far predates the 1993 amendment. (*See* Krueger Aff. ¶ 6, Ex. J) (including internal memoranda and manuals for auditor training as well as letters dating back to January 1989 explaining to facility administrators that funds reserved to pay medical claims in subsequent reporting periods were not allowable costs).

facility's claims, administrative costs and stop loss premiums exceeded its reported costs, the Department has increased the facility's allowable costs.⁸

II. BENEDICTINE'S GROUP HEALTH INSURANCE COSTS.

The issue in this case is whether the Department properly disallowed costs that Benedictine reported for reserves held in the account of a related party for the payment of its employees' future medical claims. Benedictine began participating in a self-insurance plan to provide medical coverage to its employees in January 1994. (Krueger Aff. ¶ 11; Ex. A.) Under the plan, Benedictine's corporate parent, Benedictine Health Systems ("BHS"), set up an account to fund medical insurance for employees of its member organizations. (*Id.*) Benedictine and BHS are "related organizations" as defined by Minnesota Rules 9549.0035, subpart 7. (App. at 66.)

BHS contracted with Comprehensive Care Services ("CCS"), a division of Blue Cross Blue Shield of Minnesota, to process claims against the account funds. (Krueger Aff. ¶ 11; Ex. B ¶ II.) Under the terms of the contract, the plan account itself was "maintained and controlled by the Benedictine Health System." (*Id.* Ex. A; Ex. C ¶ D; Ex. B ¶ V.) Three of the five authorized signers on the plan account were BHS employees. (Affidavit of Thomas Skorczeski, 9/27/02 ("Skorczeski Aff.") Ex. 3 Resp. No. 6.) The BHS Benefits Review Committee had ongoing review and evaluation of the

⁸ For example, the Department increased the allowable costs of self-insurance reported in 1995 by St. Mary's Regional Care Center, another nursing facility related BHS, after finding that St. Mary's claims exceeded reported costs. St. Mary's did not appeal that adjustment. (See Krueger Aff. Ex. G, St. Mary's Audit Adjustment Worksheet.)

medical plan (*id.* Resp. No. 5), and the payment of any claim processed by CCS was subject to final approval by BHS. (Krueger Aff. Ex. B ¶ II(a).) The funds in the plan account accrued interest at money market checking account rates and all interest was credited to BHS's account for use in paying future medical claims. (*Id.* ¶ V.)

Benedictine participated in the plan by sending funds on a monthly basis to BHS's plan account. (Skorczeski Aff. Ex. 3 Resp. No. 4.) Monthly funding levels were approved by BHS based on an actuary's estimates of the future health insurance costs of participating member organizations. (Krueger Aff. Ex. C ¶ C.) If actual claims paid from the account were less than the amount set aside to cover future estimated claims, the funding levels "might be reduced the next year, but would not reflect this difference in a 100% proportioned manner . . . [T]he overage or underage in that year's funding would influence, but not dictate the next year's funding level." (Skorczeski Aff. Ex. 3 Resp. No. 7.)

Benedictine made three types of payments into the related party account to provide its employees with group health coverage:

- 1) Deposits to pay for employees' future medical claims
- 2) Deposits to pay CCS's administrative costs; and
- 3) Deposits to pay stop-loss insurance premiums in the event that medical claims exceed defined levels

(*Id.* Resp. No. 6.)

Benedictine filed cost reports with the Department for the reporting years ending September 30, 1994 and September 30, 1995, claiming that it incurred costs equal to the amounts that it had set aside during those two years to cover its projected future liability

for medical claims. (Krueger Aff. Ex. E ¶ 3.) Benedictine failed to mark the “self-insured” box on its costs reports to indicate that it was self-insured for group medical insurance, and the Department’s desk audit did not result in a disallowance of any of Benedictine’s reported medical insurance costs. (*Id.* ¶ 5; Ex. D.) On a checklist filed with its 1994 and 1995 costs reports, Benedictine represented that questions relating to self-insurance were not applicable. (*Id.* ¶ 4; Ex. K.)

After conducting a field audit of Benedictine’s reported costs for the 1995 and 1996 rate years, the Department issued a field audit report adjusting amounts that Benedictine claimed as medical insurance costs on the grounds that only actual costs incurred, including claims paid, administrative expenses and stop-loss insurance, and not estimated future claims, are allowable costs under Rule 50.⁹ (*Id.* ¶ 8; Ex. L at 7, 12.) The Department determined that the amount reported by Benedictine for the reporting year ending September 30, 1994 exceeded actual claims and administrative costs, resulting in a disallowance of \$115,730. (*Id.* Ex. L at 7.) For the reporting year ending September 30, 1995, the Department determined that the amount that Benedictine paid in claims exceeded the amount that it reported on its cost report, resulting in a \$51,082 *upward* adjustment to Benedictine’s costs for group health insurance. (*Id.* at 12.)

⁹ Benedictine claims that it did not have time to mitigate the cost disallowance by switching to commercial insurance because the Department adjusted the costs in a field audit after Benedictine entered the Alternative Payment System. (Pet’r Br. 10). Benedictine fails to mention, however, that the adjustment was not made earlier because Benedictine neglected to correctly report its self-insured status to the Department.

Benedictine appealed the field audit adjustment, and the Department conducted an appeal review pursuant to Minn. Stat. § 256B.50, subd. 1c. During the review, the Department obtained additional information from Benedictine, which revealed two errors in the field audit disallowance amount. (Second Affidavit of Diane Krueger, 7/23/04, (“Second Krueger Aff.”) ¶¶ 3, 12; Exs. N, O, F at 3.) The Department issued a written appeal determination explaining that the adjustment did not include costs incurred for stop-loss premiums, but also failed to offset employee contributions to insurance costs. The Department informed Benedictine that that the net effect of the corrections was an increase in the total disallowance amount for the two reporting years. (*Id.* Ex. F at 3.) The written appeal determination concluded by offering to waive the corrective adjustment solely “[f]or purposes of resolving this appeal.” (*Id.*) Benedictine chose to appeal rather than accept the Department’s settlement offer, and the Department initiated a contested case hearing.

In a recommendation dated March 14, 2003, the ALJ recommended that the Department’s decision be affirmed after finding that the plain language of Rule 50 prohibited reimbursement of Benedictine’s reported costs for future or contingent medical claims. (App. at 59-70.) In a subsequent recommendation dated November 19, 2004, the ALJ also rejected Benedictine’s challenge to the Department’s authority to correct an error in the appealed disallowance. (App. at 34-49.) The Commissioner adopted the ALJ’s recommendations by orders dated August 4, 2003 and April 1, 2005. (App. at 25-33, 51-58.)

Benedictine appealed to the court of appeals, arguing that the Department's disallowance resulted from the application of an unpromulgated rule and violated Benedictine's equal protection rights. Benedictine also contended that the Commissioner lacked authority to correct the amount of an appealed disallowance in the course of a de novo contested case. The court of appeals held in a January 31, 2006 decision that the disallowance of costs claimed for funds held to pay future claims was not an unpromulgated rule because it complied with the plain language requirement that a cost actually be incurred during the applicable reporting year for the cost to be reimbursable. The court also held that the Department's decision to withhold reimbursement for funds set aside to pay future medical claims did not violate equal protection, because it did not treat similarly situated facilities differently. Finally, the court held that the commissioner was authorized to correct an error in the course of a de novo contested case appeal.

ARGUMENT

I. SUMMARY OF THE ARGUMENT.

Benedictine contends that the courts of appeals decision must be reversed because the Department applied an unpromulgated rule to disallow Benedictine's reported costs for group health insurance and violated Benedictine's right to equal protection under the Minnesota and United States Constitutions. Both of these arguments should be rejected.

The plain language of Rule 50 requires that, to be reimbursable, a cost must be incurred in the year it is reported. The Department's determination that Benedictine did not incur costs by holding funds in reserve to cover future estimated medical liabilities is

not an invalid unpromulgated rule because it follows the plain language of applicable Rule 50 provisions.

Benedictine erroneously contends that the disallowance of its costs must be reversed because the historical cost requirement simply does not apply to its reported costs for health insurance. The plain language of Rule 50 unambiguously requires that the Department establish nursing home rates based only on costs previously incurred. Benedictine is similarly wrong that the Department lacks authority to apply the historical cost rule without first promulgating each application of the rule. By the Rule's plain language, the Department is obligated to apply the "cost incurred" requirement in each case where it sets a nursing home's rates, even if doing so yields differing results. Finally, Benedictine's claim that the disallowance is contrary to legislative intent as evidenced in two statutory provisions is incorrect, as neither statute addresses reimbursement of health insurance reserves.

Benedictine's argument that the disallowance violates equal protection principles by treating commercially insured and self-insured providers differently is similarly without merit. Equal protection does not require that the Department's application of Rule 50 treat different matters the same way. Benedictine has failed to show that it is similarly situated, with respect to the costs it incurs for health insurance, to a facility that pays premiums to an unrelated commercial insurer. Any difference in treatment of a commercially insured facility and a self-insured facility therefore results directly from the different costs incurred and does not violate equal protection.

II. SCOPE OF REVIEW.

Judicial review of the Commissioner of Human Services' decision is governed by Minnesota Statutes section 14.69 (2004). Under this standard, the Court determines whether the agency's decision is:

- a) in violation of constitutional provisions; or
- b) in excess of the statutory authority or jurisdiction of the agency; or
- c) made upon unlawful procedure; or
- d) affected by other error of law; or
- e) unsupported by substantial evidence in view of the entire record as submitted; or
- f) arbitrary or capricious.

Minn. Stat. § 14.69 (2004).

Benedictine's challenge to the Department's application of Rule 50's historical cost requirement to undisputed facts presents a pure question of law. Where the language of a rule or statute is unambiguous, its proper interpretation is a question of law that this Court reviews de novo. *Jasper v. Comm'r of Pub. Safety*, 642 N.W.2d 435, 440 (Minn. 2002). Similarly, Petitioner's claim that Rule 50, as applied to its costs, violates equal protection presents a question of law which is subject to de novo review. *Id.*

III. THE DEPARTMENT'S DETERMINATION THAT BENEDICTINE DID NOT INCUR COSTS EQUAL TO THE AMOUNT SET ASIDE TO PAY FUTURE MEDICAL CLAIMS IS NOT AN UNPROMULGATED RULE.

The court of appeals properly upheld the Department's disallowance under this Court's well-established rule that an agency interpretation that is consistent with the plain language of its regulations is not invalid as an unpromulgated rule. *Cable Commc'ns Bd. v. Nor-West Cable Commc'ns P'ship*, 356 N.W.2d 658, 667 (Minn. 1984); *Jones v.*

Minn. State Bd. of Health, 221 N.W.2d 132, 134 (Minn. 1974); *Wacha v. Kandiyohi County Welfare Bd.*, 242 N.W.2d 837, 839 (Minn. 1976). Benedictine urges the Court to reverse this well-reasoned precedent and announce a new doctrine that would prohibit administrative agencies from applying the plain language of their regulations unless the regulations address in detail every factual scenario where they may apply. The Court should reject this request and uphold the Department's disallowance.

This Court has previously noted that, “[i]f [an] agency’s interpretation of a rule corresponds with its plain meaning . . . the agency is not deemed to have promulgated a new rule.” *Cable Commc’ns Bd.*, 356 N.W.2d at 667. Where the language of a statute, according to its common and approved usage, is unambiguous, its plain meaning controls. *State by Beaulieu v. RSJ, Inc.*, 552 N.W.2d 695, 701 (Minn. 1996). In such circumstances, statutory construction is not permitted. *Id.*¹⁰ Here, the plain language of Rule 50 unambiguously requires that a nursing facility’s reimbursement rates be based on costs actually incurred in the past, and not a facility’s estimate of costs it might incur in the future.

¹⁰ If the Court finds, however, that the meaning of “incur” is ambiguous, it should uphold the Department’s interpretation as one of longstanding. *See* 356 N.W.2d at 667; (Krueger Aff. Ex. J.) The parties briefed this issue below, (*see* Dep’t Mem. Supp. Partial Summ. Disp. 9/27/02 at 12-14), but the Commissioner did not make findings on this question because he found no ambiguity in the rule. (*See* App. at 51-58.)

A. The Disallowance Of Funds Held To Pay Future Estimated Medical Claims Comports With Rule 50's Plain Language Requirement To Reimburse Facilities Based On Their Historical Costs.

Under Rule 50, nursing facilities received reimbursement based on their historical costs, which are defined as “*costs incurred* by the nursing facility during the reporting year immediately preceding the rate year for which the payment rate becomes effective. . . .” Minn. Stat. § 256B.421, subd. 6 (emphasis added); Minn. R. 9549.0020, subp. 25 (setting forth identical language); *see also* Minn. R. 9549.0041, subps. 1, 2.B (setting forth basic cost-reporting requirements). Similarly, the cost of services purchased from a related organization were only allowable “at the cost incurred by the related organization.” Minn. R. 9549.0035, subp. 7. The sole issue in this case is whether the Department properly applied this historical cost requirement to disallow costs claimed for funds held by Benedictine’s parent company to pay future medical claims.

Courts construe statutory “words and phrases according to the rules of grammar and according to their common and approved usage.” Minn. Stat. § 645.08(1). Since Rule 50 does not define the term “incur,” the court of appeals properly considered the term’s common dictionary meaning: “[t]o suffer or bring on oneself a liability or expense.” (*See App. at 14.*) Under this definition, there is no basis to find that a nursing facility has “incurred” a cost for health insurance based upon the nursing facility’s *estimates* of what it thinks its *future* medical claims will be. Benedictine accordingly cannot demonstrate that it incurred a cost for, or became liable for, estimated future

medical claims when it segregated funds in a related party account to pay future medical claims.

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. Under the terms of BHS's contract with CCS, the plan account was "maintained and controlled by the Benedictine Health System." (Krueger Aff. Ex. C.) CCS processed and paid medical claims of employees from the fund account, but the payment of any claims from the account was subject to BHS review and final approval. (*Id.* Ex. B ¶ II.(a).) Three of the five authorized signatories on the plan account were BHS employees. (Skorczeski Aff. Ex. 3, Resp. No. 6.) BHS received the benefit of interest that accrued on the account funds. (Krueger Aff. Ex. B ¶ V.) The Department therefore properly determined that neither Benedictine nor BHS incurred costs by setting aside funds to pay future medical claims.

B. The Historical Cost Requirement Applies To Benedictine's Reported Costs For Health Insurance.

Benedictine makes the novel argument that its group health insurance costs are exempt from the clear and unambiguous historical cost requirement because group health insurance is a reimbursable category of cost under Rule 50. According to Benedictine, because Rule 50 recognizes the general *category* of group health insurance cost, Department was required to reimburse all group health insurance costs that it reported

without further review. (Pet'r. Br. 13.) Under Benedictine's analysis, once a facility reported costs in a recognized category for reimbursement, it was entitled to public reimbursement regardless of whether the reported costs were incurred during the prior reporting year, in an earlier reporting year, or not at all.

This method of statutory interpretation turns Rule 50's historical cost principle on its head and renders the Department's audit function meaningless. While it is not disputed that Rule 50 recognizes costs for group health insurance, it is equally clear that Rule 50 unambiguously prohibits reimbursement of any costs that have not been incurred in the applicable reporting year, including group health insurance costs.¹¹

Under Rule 50, the Department was charged with establishing a nursing home's reimbursement rates based on its historical costs. *See* Minn. Stat. § 256B.421, subd. 6. Rule 50 facilities received a prospective annual reimbursement rate based on costs that they incurred in the immediately preceding reporting period. *Id.* at subd. 11. The historical cost requirement is accordingly not, as Benedictine contends, an ambiguous phrase that the Department has misconstrued out of context. It is a bedrock principle of

¹¹ Benedictine's contention that it can incur a cost before it is actually paid similarly misses the point. It is not disputed that under the accrual method of accounting, a facility may incur a liability before it makes a payment on the liability. (*See* Krueger Aff. Ex. J, Note from Nursing Home Rate-Setting Meeting dated February 8, 1995 (clarifying that the Department would recognize costs reported for claims incurred during the applicable reporting year but not paid until the subsequent reporting year.)) Here, however, Benedictine failed to establish that its incurred medical claims equaled the amounts it set aside. Instead, it has been Benedictine's steadfast contention that the Department was required to recognize as costs all funds it set aside to pay future claims.

Rule 50. Benedictine's assertion that this principle does not apply to its costs is unfounded.

Indeed, disallowing reimbursement for funds segregated in a related party account to pay future medical claims gives effect to all the statutory and rule provisions that the Department must apply to determine allowable costs for health insurance. To be allowable, the cost must both fall within a recognized cost category and it must be incurred in the applicable reporting period. *See* Minn. Stat. § 256B.421, subd. 6; Minn. R. 9549.0040, subp. 8. The Department's application of the rule gives effect to both these requirements.

Moreover, the cases that Benedictine relies on to claim that the Department may not consider whether it incurred the costs it reported are inapposite. Benedictine relies primarily on the United States Supreme Court's decision in *Whitman v. American Trucking Ass'ns, Inc.*, 531 U.S. 457, 121 S. Ct. 903 (2001). In *American Trucking*, the Supreme Court was asked to decide whether the plain language of federal law required the EPA to consider implementation costs when it established national ambient air quality standards. The applicable federal statute required the EPA to set air quality standards "the attainment and maintenance of which . . . are requisite to protect the public health" 531 U.S. at 465, 121 S. Ct. at 908 (quoting 42 U.S.C. § 4709(b)(1)).

American Trucking creatively argued that the EPA's statutory obligation to set standards to protect "public health" included a wholly unrelated obligation to consider costs of implementing those standards. *Id.* The Court squarely rejected this attempt to

create a new substantive requirement to consider costs where “[n]owhere are the costs of achieving such a standard made part of that initial calculation.” *Id.* If Congress wanted to require the EPA to consider implementation costs, it would have stated this requirement in unambiguous terms. It would not “hide elephants in mouseholes.” 531 U.S. at 468, 121 S. Ct. at 910.

This case could not be more different than *American Trucking*. While the federal statute in *American Trucking* contained *no language* authorizing the EPA to consider implementation costs in setting standards, here, *the plain language* of Rule 50 *unambiguously requires* that Department determine a facility’s “historical costs,” which the statute defines as “costs incurred” in the applicable reporting year. Minn. Stat. § 256B.421, subd. 6; Minn. R. 9549.0020, subp. 25. The Department did not conjure up the requirement to consider costs incurred in an unauthorized expansion of its rate-setting authority as *Benedictine* suggests. The legislature unambiguously imposed it.¹² The Department’s authority to apply the historical cost requirement to disallow *Benedictine*’s future medical liabilities should therefore be affirmed

¹² Similarly, the other federal cases cited by *Benedictine* have no bearing on the Department’s authority to determine costs incurred by *Benedictine* as required by the plain language of Rule 50. (See Pet’r Br. 14, 15) (citing *Food & Drug Admin. v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 120 S. Ct. 1201 (2000) and *Am. Bar Assoc. v. Fed. Trade Comm’n*, 430 F.3d 457 (D.C. Cir. 2005)). These two cases involved challenges to federal agency jurisdiction to regulate in the areas of tobacco and law respectively. In each case, the courts found that Congress did not unambiguously grant the federal agency authority over the particular subject areas. These cases have no application here, where the legislature has unambiguously charged the Department with setting nursing facilities rates based on a determination of the costs they incurred in the past.

C. The Department's Disallowance Of Benedictine's Future Estimated Medical Claims Is Consistent With The Prior Decisions Of This Court.

Benedictine also misinterprets this Court's prior decisions to impose an unworkable requirement that agencies promulgate every application of their rules for every conceivable set of facts. (See Pet'r Br. 18, 19) (citing *Mapleton Cmty. Home, Inc. v. Minn. Dep't of Human Servs.*, 391 N.W.2d 798, 801 (Minn. 1986)). According to Benedictine, the Department must have applied an unpromulgated rule in this case because the language of Rule 50 does not contain separate provisions regarding reimbursement of costs for facilities that self-insure for group health insurance. (Pet'r Br. 8.) Benedictine asks the Court to find that the Department is powerless to apply the plain language of Rule 50 without first promulgating a rule for every possible application of Rule 50's most fundamental cost principles. The Court should decline this request. The absence of a specific rule distinguishing between commercial insurance and self-funded insurance does not obviate the Department's obligation to apply all relevant Rule 50 provisions to the relevant facts of each case, even when doing so may bring differing results.

The Department's application of Rule 50's historical cost requirement is fully consistent with this Court's precedent regarding an administrative agency's authority to apply the plain language of its regulations. This Court has recognized an agency's authority to apply its rules even where the particular regulation does not spell out each possible application. See, e.g., *Cable Communications Bd.*, 356 N.W.2d at 668 (upholding agency use of a three-part test to interpret a regulatory terms "substantially

contested”); *Jones*, 221 N.W.2d at 134 (upholding agency application of regulation establishing license requirements to the facts of individual case where “consistent with the statutory scheme and with the regulations implementing it”); *Cf. White Bear Care Ctr., Inc. v. Minn. Dep’t of Pub. Welfare*, 319 N.W.2d 7, 9 (Minn. 1982) (invalidating agency interpretation of cost change rule that conflicted with Rule 50’s plain language).

Contrary to Benedictine’s contentions, the Department’s application of the plain language of Rule 50 in this case is not invalid under the unfair surprise doctrine announced by the Court in *In re St. Otto’s Home v. Minnesota Department of Human Services*, 437 N.W.2d 35 (Minn. 1989). In *St. Otto’s Home*, the Court reversed an agency application of the term “common ownership” that coincided with the plain language of the rule where the agency had abandoned its past practice and adopted a new, more restrictive, interpretation of the plain language without warning or notice to the public. *Id.* at 45. *St. Otto’s Home* does not support the reversal of a disallowance based on the plain language of Rule 50 where the agency’s application of the rule has not changed over time.

Here, the record demonstrates that the Department’s application of Rule 50 to disallow contingent liabilities and future claims coincides with Rule 50’s plain language and the Department’s longstanding practice. (Krueger Aff. Ex. J.) Since the inception of Rule 50, the Department has consistently applied the plain language of Rule 50 to disallow costs reported when a facility has segregated funds to pay future medical liabilities. (*Id.*)

Moreover, facilities that choose to participate in Medicaid are expected to be familiar with the fundamental principles that govern their public reimbursement. *Heckler v. Cmty. Health Servs. of Crawford County, Inc.*, 467 U.S. 51, 63-64, 104 S. Ct. 2218, 2225-26 (1984); *see also North Mem'l Med. Ctr. v. Gomez*, 59 F.3d 735, 739 (8th Cir. 1995) (participants in the Medicaid program have a duty to familiarize themselves with the program's legal requirements). The historical cost requirement establishes the fundamental framework for nursing home reimbursement under Rule 50. The Department's determination that Benedictine did not incur costs when it segregated funds to pay future medical claims should therefore be affirmed.

D. The Disallowance Of Funds Set Aside To Pay Future Medical Claims Is Consistent With The Legislature's Intent As Demonstrated By Other Legislative Enactments.

Benedictine also incorrectly argues that the disallowance of funds it held in reserve is contrary to legislative intent as evidenced in two statutory provisions, Minnesota Statutes section 256B.431, subdivision 22(b)¹³ (addressing reimbursement of workers compensation insurance costs) and subdivision 22(e) (addressing allocation of health insurance costs by self-insured entities). The Department's disallowance is not contrary to these provisions, because they do not address or require Rule 50 reimbursement for reserves held to pay future health care liabilities.

¹³ Benedictine's citation to subdivision 22(d)(4)(ii) and (iii) of this statute appears to be a typographical error, as paragraph (d) neither refers to reserves nor contains subparagraphs (4)(ii) and (iii). (Pet'r Br. 21.)

1. Subdivision 22(b): Reimbursement for Workers Compensation Insurance.

Benedictine's reliance on Minnesota Statutes section 256B.431, subdivision 22(b) to establish an intent to reimburse its self-insurance reserves is erroneous, as this provision has nothing to do with reimbursement of health insurance costs. Subdivision 22(b), which was enacted in 1993, lists the circumstances in which the legislature determined Rule 50 should reimburse costs of workers compensation insurance. In listing these circumstances, the legislature specifically provided for reimbursement of funds held in reserve for the payment of future workers compensation claims, provided that certain conditions were in place to protect public expenditures. *See* Minn. Stat. § 256B.431, subd. 22(b). To ensure protection of public dollars held in such reserves, the legislature required that all public dollars held in a workers compensation reserve be reimbursed to the state in the event that the facility ceases operations. Minn. Stat. § 256B.431, subd. 22(b)(5)(i).

The legislature's decision to specifically provide for reimbursement for reserves *in the context of mandatory workers compensation insurance* fails to establish any intent to reimburse reserves in the separate context of private health

insurance.¹⁴ Indeed, subdivision 22(b) neither mentions health insurance reserves, nor provides for their reimbursement. This provision therefore should not be read to require reimbursement for contingent liabilities not mentioned in its plain language. *Vlahos v. R & I Constr. of Bloomington, Inc.*, 676 N.W.2d 672, 681 (Minn. 2004) (stating that courts will not “supply words that the legislature either purposefully omitted or inadvertently left out.”) If the legislature intended to alter Rule 50’s general reimbursement requirements to reimburse costs reported for contingent health care liabilities it would have specifically done so.

Moreover, adopting Benedictine’s analysis of this provision would provide public reimbursement for contingent liabilities for health insurance without any protection of those public expenditures. In providing reimbursement for workers compensation reserves, the legislature imposed a “settle up” requirement to protect public expenditures in the event that a facility went out of business or otherwise ceased operations. Benedictine asks the Court to conclude that the legislature intended, through its silence, to pay for contingent or future medical claims without any similar requirement. Such a result is contrary to both the language of Rule 50 and sound public policy.

¹⁴ The legislature’s decision to subsidize self-insurance reserves for workers compensation furthers the state’s particular interest in ensuring that nursing facilities could continue to meet their statutory obligation to insure for workers compensation in the face of skyrocketing insurance premiums in the early 1990s. *See* Minn. Stat. § 176.181, subd. 2 (mandating that all employers either purchase workers compensation insurance or self-insure). *See also* Minn. Dep’t of Labor & Industry, State Workers’ Compensation Costs Continue To Drop (Nov. 22, 1999) *available at* www.doli.state.mn.us/wcpr99.html (documenting that employers’ average premium costs skyrocketed in the late 1980s, reaching all time highs by 1994).

2. Subdivision 22(e): Allocation of Self-Insurance Costs.

Benedictine is similarly wrong that the disallowance of its future medical costs conflicts with the legislature's intent in enacting Minnesota Statutes section 256B.431, subdivision 22(e). Paragraph (e) provides that, effective July 1, 1998, facilities that form groups to self-insure for health insurance may allocate their "directly identified costs of self-insurance" among the facilities according to a statutory ratio. *See* Minn. Stat. § 256B.431, subd. 22(e). Benedictine's contention that this provision allows Rule 50 reimbursement for funds it set aside to pay future medical liabilities is without merit. (Pet'r Br. 30.) To be sure, the plain language of this provision allows facilities to allocate the costs *that have been incurred* for self-insured health insurance. However, this provision does not alter the requirement that facilities report only those costs that have actually been incurred in the applicable reporting period. Moreover, even if this provision did alter the historical cost requirement, it had no application to costs that Benedictine reported in 1994 and 1995, as it became effective years later in 1998.

Finally, the Court asked the parties to address the effect of ERISA on the meaning of the term "incurred" as used in Rule 50. As noted by Benedictine, ERISA does not govern its self-insured health plan and, accordingly, should not govern the Court's analysis of the Department's disallowance in this case. *See Jasper*, 642 N.W. 2d at 439

(stating that the Court neither issues advisory opinions nor decides cases merely to establish precedent).¹⁵

Even if ERISA did apply, however, it would not require the State to accept that Benedictine incurred costs for self-insured health insurance equal to the amount of its payments to its parent company's plan account. ERISA does not impair the state's authority to apply rules of general applicability to determine the costs incurred by facilities that elect to participate in Medicaid and receive public reimbursement. *See, e.g., Boyle v. Anderson*, 68 F.3d 1093, 1110 (8th Cir. 1995) (holding that ERISA does not preempt a state's generally applicable health care provider tax).

IV. DISALLOWING REIMBURSEMENT FOR FUNDS HELD BY A RELATED PARTY TO PAY FUTURE MEDICAL CLAIMS DOES NOT OFFEND EQUAL PROTECTION PRINCIPLES.

Benedictine asserts in the alternative that the application of Rule 50 in this case violates the Equal Protection Clauses of the United States and Minnesota Constitutions because it treats self-insured and commercially insured nursing homes differently.¹⁶ Benedictine failed to establish, however, that entities that set aside funds for payment of future or contingent medical costs and entities that pay insurance premiums to unrelated

¹⁵ Further, as noted earlier in this brief, the central question in this appeal is not likely to arise again, because the Department has not established nursing home rates based on reported historical costs since 1998. *See* Minn. Stat. § 256B.431, subds. 28, 31, 39.

¹⁶ The Court asked the parties to address whether, under ERISA, self-insured and fully insured plans are similarly situated for purposes of Benedictine's equal protection claim. The Court need not inquire further into this matter since Benedictine has represented that its plan is not governed by ERISA. As a general matter, however, the Department agrees with Benedictine that self-insured and fully insured entities are not similarly situated under ERISA. (*See* Pet'r Br. 23.)

organizations are similarly situated with respect to costs that they incur. Because these self-insured and commercially insured entities do not incur the same costs, there is no unequal treatment, and thus, no violation of equal protection principles. Even if Benedictine could establish that it is similarly situated to a commercially insured entity in all material respects, the state has a legitimate interest in treating their costs differently to ensure that providers are not reimbursed based on inflated estimates of their future expenses.

The Equal Protection Clause of the United States Constitution provides that no state shall “deny to any person within its jurisdiction the equal protection of the laws.” U.S. Const. Amend. XIV, § 1. In particular, equal protection requires that persons similarly situated be treated alike. *Matter of Harhut*, 385 N.W.2d 305, 310 (Minn. 1986). “The scope of protection afforded under the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution and . . . the Minnesota Constitution is identical.” *Kuiters v. County of Freeborn*, 430 N.W.2d 461, 463 (Minn. 1988). The Court employs the same analysis in addressing equal protection challenges under the state constitution as it does under the United States Constitution.

A. Benedictine Failed To Establish That It Is Similarly Situated To A Commercially Insured Facility With Respect To Costs Incurred For Group Health Insurance.

As a threshold matter, the challenger in any equal protection case bears the burden of showing that he has been treated differently than others who are similarly situated.

Klinger v. Dep’t of Corr., 31 F.3d 727, 731 (8th Cir. 1994); *see also Caswell v. City of*

Bloomington, No. 05-2519, -- F. Supp.2d --, 2006 WL 1174025, at *4,*5 (D. Minn. April 28, 2006) (granting defendant's motion for summary judgment where plaintiff failed to establish he was similarly situated to others in all relevant respects). It is axiomatic that "[e]ssential to a ruling that equal protection has been denied by discriminatory administration of the laws is a finding that the person treated disparately are similarly situated." *State by Spannaus v. Lutsen Resorts, Inc.*, 310 N.W.2d 495, 497 (Minn. 1981).

Benedictine has failed to establish that the disallowance of costs it reported for funds held in reserve to pay future medical claims violates equal protection, because it did not demonstrate that it is similarly situated to a nursing home that pays monthly group health insurance premiums. The court of appeals correctly held that Benedictine, as a self-insured entity, does not incur insurance costs in the same way that a commercially insured entity does, because it does not pay a monthly premium to an unrelated third party. Instead, Benedictine has chosen to place funds into a plan account held by a related organization to cover estimated *future* medical claims. If deposited amounts exceed actual claims, the amount of Benedictine's monthly contribution to the plan account may be reduced.¹⁷ An entity that pays a health insurance premium to a commercial carrier is not likely to see a similar reduction in premiums where its premium payments exceed actual medical claims. Once paid to a commercial insurer, the insured is

¹⁷ Indeed, Benedictine acknowledges that its monthly deposits were reduced to zero at one time because of a surplus in the plan account. (Pet'r Br. 22) (citing Krueger Aff. Ex. B at 3).

not guaranteed to receive a future return in the way of reduced future premiums or otherwise.

Moreover, as explained above in section II, BHS retains control of and earns interest on the plan funds until medical claims are actually paid. BHS is signatory to the account and has final approval of payment of claims. BHS accordingly derives a significant benefit by choosing not to pay set monthly premiums. Benedictine fails to establish that a commercially insured entity enjoys a similar benefit.

Finally, allowing Benedictine to count as costs funds it sets aside to pay future medical claims 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. In both cases, the facility has segregated funds for the payment of future or contingent liabilities. However, in neither situation has the facility incurred a cost under Rule 50.

B. Disallowing Reimbursement For Funds Segregated To Pay Future Medical Liabilities Is Rationally Related To The State's Interest In Ensuring Reimbursement Based On Actual And Not Inflated Costs.

Even if Benedictine could establish that it similarly situated to a commercially insured entity in the manner it incurs costs for health insurance, the Department has a rational basis to disallow reimbursement for funds held to pay claims in subsequent reporting periods. The state has an interest in limiting public reimbursement to those

costs that have actually been incurred by a nursing facility.¹⁸ This interest is stated in the plain language of Rule 50's historical cost and related party provisions as well as in the Rule's general reimbursement principles. Denying costs reported when a facility elects to segregate a portion of its funds to pay future medical claims ensures that the state is not required to reimburse facilities based on a facility's overstated estimate of those future costs.

Benedictine contends that not recognizing the "cost" of segregating funds to pay future or contingent medical claims runs counter to the public policy of encouraging employers to "maintain sufficient Plan Assets." (Pet'r Br. 26.) Benedictine fails to acknowledge, however, nursing facilities' inherent self-interest in ensuring that they retain assets sufficient to cover their future liabilities. While it may be a good business practice for facilities to ensure that they have adequate cash on hand to meet their future obligations, the plain language of Rule 50 simply does not reimburse such contingent liabilities. Indeed, requiring the Department to reimburse facilities based on estimates of future liabilities would encourage providers to overstate their future liabilities to

¹⁸ Benedictine erroneously suggests that the department is unfairly requiring Benedictine to return money which would have been a profit to a commercial carrier, and which would have been recognized as a reimbursable cost if Benedictine had purchased commercial insurance. (Pet'r Br. 26, 27). Benedictine fails to point to anything in the record establishing that the amounts it paid into reserves equal that amount it would have paid to a commercial carrier for premiums. Moreover, even if it could establish this fact, Benedictine would not be entitled to public reimbursement for the "profits," as Rule 50 does not pay for profits generated through related party transactions. *See* Minn. R. 9549.0035, subp. 7.

maximize public reimbursement. Such a result runs counter to the sound public policy enunciated in the plain language of Rule 50's historical cost and related party provisions.

CONCLUSION

For the foregoing reasons, the Department respectfully requests that the Court affirm the court of appeals decision in all respects.

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Respectfully submitted,

MIKE HATCH
Attorney General
State of Minnesota



ERIKA SCHNELLER SULLIVAN
Assistant Attorney General
Atty. Reg. No. 0288056

445 Minnesota Street, Suite 900
St. Paul, Minnesota 55101-2127
(651) 296-1427 (Voice)
(651) 296-1410 (TTY)

ATTORNEYS FOR RESPONDENT