11-0900-6030-1

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE MINNESOTA DEPARTMENT OF HEALTH

In the Matter of the Proposed
Amendments to Rules Relating
to Health Maintenance Organization
Enrollee Copayment, Termination, and
Supplemental Benefits Provisions,
Minnesota Rules Chapter 4685.

REPORT_OF_THE
ADMINISTRATIVE_LAW_JUDGE

The above-entitled matter came on for hearing before Administrative Law Judge Barbara L. Neilson on January 22, 1992, at 9:00 a.m. in the Veteran's Services Building, Fifth Floor, Conference Room D, 20 West Twelfth Street, St. Paul, Minnesota.

This Report is part of a rulemaking proceeding held pursuant to Minn. Stat. ÞÞ 14.131 to 14.20 (1990), to hear public comment, determine whether the Minnesota Department of Health ("the Department") has fulfilled all relevant substantive and procedural requirements of law applicable to the adoption of the rules, determine whether the proposed rules are needed and reasonable, and determine whether or not modifications to the rules proposed by the Department after initial publication are substantially different from those originally proposed.

Paul Zerby, Special Assistant Attorney General, Suite 500, 525 Park Street, St. Paul, Minnesota 55155, appeared on behalf of the Department at the hearing. The Department's hearing panel consisted of Lawrence R. Colaizy, Health Policy Analyst for the Department; Mackenzie Peterson, the Department's Director of HMOs; and Sharon K. Mitchell, the Department's Acting Supervisor of Regulatory Compliance and Health Policy Analyst.

Twenty-one persons attended the hearing. Seventeen persons signed the hearing register. The Administrative Law Judge received ten agency exhibits and two public exhibits as evidence during the hearing. The hearing continued until all interested persons, groups or associations had an opportunity to be heard concerning the adoption of these rules.

The record remained open for the submission of written comments until February 11, 1992, twenty calendar days following the date of the hearing. Pursuant to Minn. Stat. Þ 14.15, subd. 1 (1990), three business days were allowed for the filing of responsive comments. At the close of business on February 14, 1992, the rulemaking record closed for all purposes. The

Administrative Law Judge received nine post-hearing written comments from interested persons. The Department submitted written comments responding to matters discussed at the hearing and in post-hearing comment. In its written comments, the Department proposed further amendments to the proposed rules.

This Report must be available for review by all affected individuals upon request for at least five working days before the Department takes any further action on the rules. The Department may then adopt a final rule or modify or withdraw its proposed rule. If the Department makes changes in the rule other than those recommended in this report, it must submit the rule with the complete hearing record to the Chief Administrative Law Judge for a review of the changes prior to final adoption. Upon adoption of final rule, the agency must submit it to the Revisor of Statutes for a review of the form of the rule. The agency must also give notice to all persons who requested to be informed when the rule is adopted and filed with the Secretary of State.

Based upon all the testimony, exhibits, and written comments, the Administrative Law Judge makes the following:

FINDINGS OF FACT

Procedural_Requirements

1. On November 26, 1991, the Department filed the following documents with the Chief Administrative Law Judge:

(a) a copy of the proposed rules as certified by the Revisor of Statutes;
(b) a copy of the Department's proposed
(c) a copy of the proposed Notice of Hearing;
(d) the Statement of Need and Reasonableness (SONAR); and
(e) an estimate of the number of persons expected to attend the hearing and the expected length of the Department's presentation at the hearing.

2. On November 27, 1991, the Department filed a statement indicating that it did not intend to provide discretionary additional public notice of the hearing.

3. On December 11, 1991, the Department mailed the Notice of Hearing to all persons and associations who had registered their names with the Department for the purpose of receiving such notice.

4. On December 16, 1991, a copy of the proposed rules and the Notice of Hearing were published in 16 State Register 1474.

Dept. Ex. 8.

5. On December 27, 1991, the Department filed the following documents with the Administrative Law Judge:

(a) the Notice of Hearing as mailed;
(b) a copy of the State Register containing the Notice of Hearing and the proposed rules;
(c) a copy of the Notice of Solicitation of Outside Opinion published in 12 State Reg. 1109 (November 23, 1987), together with materials received by the Department in response to the solicitation;
(d) An affidavit stating that the Notice of Hearing was mailed on December 11, 1991, to all persons on the Department's mailing list and certifying that the Department's mailing list was accurate and complete as of that date; and
(e) the executed Order for Hearing.

Statutory_Authority

7. In its Notice of Hearing, the Department cites Minn. Stat. ÞÞ 62D.20 and 62D.05 (1990) as its statutory authority to promulgate the proposed rules. Minn. Stat. Þ 62D.20 (1990) provides that the Commissioner of Health may "promulgate such reasonable rules as are necessary or proper to carry out the provisions of sections 62D.01 to 62D.30," including rules providing "minimum requirements for the provision of comprehensive health maintenance services . . . and reasonable exclusions therefrom" and rules addressing "the issue of appropriate prior authorization requirements . . . ." Under Minn. Stat. Þ 62D.05, subd. 6(b) (1990), the Commissioner is authorized to adopt, enforce, and administer rules relating to supplemental benefits provided by HMOs. Based on these statutory provisions, the Administrative Law Judge concludes that the Department has the statutory authority to promulgate rules relating to HMOs.

Nature_of_the_Proposed_Rules

6. Health Maintenance Organizations (HMOs) provide health care services to persons who have enrolled as members and paid a fee. The services provided and setting terms of enrollment are the subject of Minnesota Rule Chapter 4685. For some services, HMOs charge a "copayment" to cover a portion of the cost. Reports and other filings are required of HMOs to ensure compliance with the statutory and rule requirements on terms of service. Supplemental benefits are offered by HMOs for an additional fee to cover a portion of the cost of medical services which are not offered as part of the comprehensive services offered as part of the normal HMO contract. When an enrollee discontinues payment or moves outside the coverage area, an HMO must follow an established procedure to terminate enrollment. The proposed rules amend or replace existing rules on these aspects of HMO operation. The HMOs offer a wide variety of services and costs to enrollees. For that reason, the rules are developed as a framework providing structure within which the services are delivered and fees charged.

Small_Business_Considerations_in_Rulemaking

8. Minn. Stat. Þ 14.115, subd. 2 (1990), provides that state agencies proposing rules which may affect small businesses must consider methods for reducing adverse impact o

Fiscal_Notice

9. Minn. Stat. Þ 14.11, subd. 1 (1990), requires agencies proposing rules that will require the expenditure of public funds in excess of $100,000 per year by local public bodies to publish an estimate of the total cost to local public bodies for the two-year period immediately following adoption of the rules. The Department stated in its Notice of Hearing that the proposed rules will not require any expenditures by local governmental units. No one disputed the Department's contention. The fiscal notice requirements of Minn. Stat. Þ 14.11, subd. 1 (1990), thus are not applicable to this proceeding.

Impact_on_Agricultural_Land

10. Minn. Stat. Þ 14.11, subd. 2 (1990), requires that agencies proposing rules that have a "direct and substantial adverse impact on agricultural land in the state" comply with the requirements set forth in Minn. Stat. ÞÞ 17.80 to 17.84 (1990). Because the proposed rules will not have a direct and substantial adverse impact on agricultural land within the meaning of Minn. Stat. Þ 14.11, subd. 2 (1990), these statutory provisions do not apply.

Outside_Information_Solicited

11. In formulating these proposed rules, the Department published a notice soliciting outside opinions in the State Register in November, 1987. Draft rules were distributed for informal comment on August 7, 1989, and April 19, 1991.

Substantive_Provisions_

12. The Administrative Law Judge must determine, inter alia, whether the need for and reasonableness of the proposed rules has been established by the Department by an affirmative presentation of fact. The Department prepared a Statement of Need and Reasonableness (SONAR) in support of the adoption of the proposed rules. At the hearing, the Department primarily relied upon its SONAR as its affirmative presentation of need and reasonableness. The SONAR was supplemented by the comments made by the Department at the public hearing and its written post-hearing comments.

The question of whether a rule is reasonable focuses on whether it has a rational basis. The Minnesota Court of Appeals has held a rule to be reasonable if it is rationally related to

the end sought to be achieved by the statute. Broen_Memorial_Home v._Minnesota_Department_of_Human_Services, 364 N.W.2d 436, 440 (Minn. App. 1985); Blocker_Outdoor_Advertising_Company_v. Minnesota_Department_of_Transportation,347 N.W.2d 88, 91 (Minn. App. 1984). The Supreme Court of Minnesota has further defined the burden by requiring that the agency "explain on what evidence it is relying and how the evidence connects rationally with the agency's choice of action to be taken." Manufactured_Housing Institute_v._Pettersen, 347 N.W.2d 238, 244 (Minn. 1984).

This Report is generally limited to the discussion of the portions of the proposed rules that received significiant critical comment or otherwise need to be examined. Because some sections of the proposed rules were not opposed and were adequately supported by the SONAR, a detailed discussion of each section of the proposed rules is unnecessary. The Administrative Law Judge specifically finds that the need for and reasonableness of the provisions that are not discussed in this Report have been demonstrated by an affirmative presentation of facts, and that such provisions are specifically authorized by statute. Any change proposed by the Department from the rules as published in the State Register which is not discussed in this Report is found not to constitute a substantial change.

Proposed_Rule_4685.0801_-_Copayments

13. Copayments are payments made by HMO enrollees on a per-use basis for covered medical services. Proposed rule part 4685.0801 describes methods of calculating copayments, establishes maximum limitations, provides for disclosure of copayments in the enrollee contract, and requires that HMOs report certain information to the Department in order to demonstrate compliance with the rules. The rule part

Subpart_1_-_Copayments_on_Specific_Services

14. Subpart 1 permits HMOs to require copayments on comprehensive services offered by the HMO, provided certain standards are met. The subpart generally limits the copayment to a maximum of 25 percent of the "provider's charge for the specific service or good received by the enrollee," and defined the "provider's charge" to mean "the fees charged by the provider which do not exceed the fees that provider would charge any other person regardless of whether the person is a member of the [HMO]." The provisions of the existing rule limit the copayment to 25 percent of the provider's "costs or charges."

The Coalition on Health Care Issues for Persons with Disabilities and the Arthritis Foundation objected to the provisions of the proposed rule which limit the copayment to the "provider's charge." The Coalition asserts that many HMOs provide services by negotiating a fee schedule with individual medical professionals and that the copayment should be based on the actual costs incurred by the HMO rather than the provider's normal charge for the service. The Arthritis Foundation objected to the proposed subpart due to a concern that the rule would result in a de facto increase in the amount of allowable copayments.

The proposed rules are intended to clarify that the provider's charge is a proper basis for calculating the copayment. In its SONAR, the Department pointed out that an HMO's actual costs may be difficult to calculate, particularly in capitated or staff model HMOs, and that HMOs consider their fee schedules to be proprietary and confidential. In addition, as the Department emphasized in its post-hearing comment, all HMOs currently base their copayment calculations on providers' charges and not the cost of services provided. The change in the rule is merely intended to clarify to enrolles the method that is currently used, and will not change the manner in which copayments are calculated. Subpart 1 has been demonstrated to be needed and reasonable.

Subpart_2_-_Flat_Fee_Copayments

15. The existing rules do not specify methods by which copayments should be established, provided that they do not exceed 25 percent of the provider's cost or charge for the service. Current HMO contracts utilize both service-specific copayments and flat fees based upon categories of related service. The Department has determined that both methods are useful in developing HMO products. Accordingly, flat fee copayments based upon categories of similar services or goods are allowed under subpart 2 of the proposed rules. The method of establishing copayments for specific services is discussed in subpart 3 of the proposed rule.

Subpart 2 requires that the flat fees must be calculated independently for Medicare plans, group plans, and individual plans, but permits the aggregation of providers' charges data within each category. Subpart 2 also requires that the flat fee copayment cannot exceed 25 percent of the average provider's charges for similar services or goods received by enrollees. The proposed rules thus apply the same copayment limitations to prescription drug copayments as they apply to other required services. The proposed rule does, however, permit HMOs to request Departmental approval of copayments exceeding the 25 percent limitation for prescription drug benefits for Medicare- related products. The existing rules merely require that prescription drug copayments be "reasonable."

The Coalition on Health Care Issues for Persons with Disabilities and the Minnesota Affiliate of the American Diabetes Association expressed concern that this provision of the proposed rules could lead to higher prescription copayments for their constituents. The American Diabetes Association suggested that the proposed rules could result in prescription copayments for some persons afflicted with diabetes increasing from $7 to $21 per refill. The example of copayment ca

Blue Plus, an affiliate of Blue Cross and Blue Shield of Minnesota, objected to the 25 percent limitation on copayments for prescription drugs. Blue Plus maintains that the rule is unreasonable because it requires HMOs to provide a level of drug coverage that insurance carriers are not required to provide.

Blue Plus also questions the retention of the "reasonableness" standard for Medicare products but not other products. In the SONAR and in its post-hearing comments, the Department explained that HMOs were originally permitted more latitude in setting drug copayments because, at the time the current rules were drafted, coverage of prescription drugs was typical in HMO contracts but not in health insurance contracts. The exclusion of prescription drugs from HMO copayment limits was based on the need to keep HMO products competitive with insurance products. Since insurance contracts generally include prescription drug coverage analogous to coverage of prescription drugs in HMO outpatient health services, there is presently no reason to exclude prescription drugs in HMO services from the copayment limitations.

Medica expressed concern that the requirement in the proposed rules that copayments be separately calculated for group, individual, and Medicare plans will result in significantly higher copayments for senior citizens. The Department noted in its post-hearing comments that other HMOs have commented that the separation of the copayment calculations will not have an adverse effect on their enrollees at this time. The Department has declined to revise the proposed rules based upon its view that the fees must be established independently for thses plans in order to have a copayment based on the utilization of people who are similarly situated. Medica also suggested that clarifying language be added to subpart 2 (page 2, line 21) stating that submission of a contract containing a copayment shall not constitute submission for reapproval. The Department responded in its post-hearing comments that such language is unnecessary because copayments are generally approved separately from the contracts which contain them and the proposed rule already specifies that prescription drug copayments which are currently approved and excceds the 25 percent limit of the proposed rule "shall remain approved until the [HMO] submits the copayment for reapproval for any reason."

The Department has demonstrated that subpart 2 is needed and reasonable, as proposed.

Subpart_3_-_Categories

16. Subpart 3 of the proposed rules indicates that, for the purpose of calculating copayments, "a category of similar services or goods is any group of related services for which a single copayment is sought." The proposed rule sets forth examples of the types of services or goods which may be included in categories that HMOs may use as a basis for calculating flat fee copayments. The SONAR notes that HMOs may in fact choose to use categories that are more specific than those set out as examples and that they may create other categories of related services, as long as the services within the category are "sufficiently similar to demonstrate a reasonable relationship between the services included in the category and the copayment requested." SONAR at 16. The categories selected by the HMO are important because the variety of costs for services within each category are averaged to arrive at the flat fee copayment authorized by subpart 2.

Medica suggested that the Department further clarify its intention that HMOs have flexibility in developing appropriate categories by specifying that "[e]xamples of categories include, but_are_not_limited_to, the following or any subset of the following . . . ." (Emphasis added.) The Department declined to include the suggested language in subpart 3. The proposed rule already makes it clear that the categories are merely examples and HMOs are not required to utilize that approach. The language of th

The Minnesota Association of Chiropractors suggested that chiropractic services be deleted from the proposed rule's list of examples of non-physician services, that items B and C of subpart 3 be revised to refer to inpatient and outpatient "medical" physician care, and that a new item be added specifically referring to "outpatient chiropractic physician care." The Department agreed that it was appropriate to remove the reference to chiropractic services from the text of subpart 3 following item H and revised the reference in item C to "outpatient health services" rather than "outpatient physician care." The Department declined to add a new category for outpatient chiropractic physician care because it deemed it unnecessary. The Department has made the inclusion of chiropractic services clear in the supporting documentation of this rulemaking. The new language incorporated in subpart 3 meets the intent of the commentator's objection and does not constitute a substantial change from the rule as originally proposed.

Subpart 3, as amended, is needed and reasonable.

Subpart_4_-_Determination_of_Average_Charge

17. Proposed subpart 4 requires that HMOs follow specified steps in determining the average aggregate charge for a category of similar services and submit their analysis to the Department when they seek approval of the copayment. Items A through D of subpart 4 identify the information required to be compiled and submitted to the Department. Item E requires that any inflation adjustments made by the HMO be based upon the medical care component of the consumer price index or a similar national or regional index. Item F specifies that the "average" charge will be the median charge.

MedCenters, First Plan HMO, Group Health Inc., Medica, and Blue Plus objected to the inflation adjustment provisions on the ground that a national or regional index does not adequately reflect the local health care situation. MedCenters urged that other factors, such as rising costs due to new technology, demographics, or labor disputes should be taken into account as well. Medica suggested that the inflation adjustment language of the proposed rule be stricken and replaced with language indicating that, "[i]f costs are adjusted for inflation, the HMO must base its inflation adjustments on actual experience in the categories outlined in subpart 3 above." Group Health, First Plan HMO, Blue Plus and Medcenters suggested that reasonably anticipated local trends, supported by signed actuarial opinions,

be permitted to be used to anticipate inflation and changes in the delivery of health services which will have an impact on costs. Medcenters suggested that trends could identify local cost changes which are less than the national inflation rate, and those savings could be passed on to enrollees. The Department indicated in its post-hearing comments that it does not dispute that these trend factors are actuarially accepted methods of cost recovery. However, the Department does not believe "that the method for calculating a flat fee copayment should be evaluated only from a cost recovery perspective" and emphasized that "[a]ccess to care and fairness to the consumer must also be considered." Department's post-hearing comments at 7. The Department asserted that using trends might encourage inefficient practices by building those inefficiencies into the inflation factor, and risks placing an unfair burden on consumers. Id. The Department continues to believe that the consumer price index is a conservative and reasonable base for inflation adjustments, and emphasizes that the CPI is an independently-created index and its medical component includes medical care commodity and medical care services factors.

The Department need not choose any particular method, so long as the method it chooses is in fact reasonable. The Administrative Law Judge cannot substitute her judgment for that of the agency in rulemaking proceedings whe
4(E) has been shown to be needed and reasonable.

18. Blue Plus argued that the Department has failed to establish why the median is the proper calculation to determine the dollar amount of copayments. The Department in the past has approved copayment filings by Blue Plus based upon average charge data which excluded outliers (charges which are significantly higher or lower than the large majority of the charges). The Minnesota Medical Association commented that the statement in the proposed rules that "[t]he average charge will be the median charge" is confusing, and urges the Department simply to use the term "median."

In its post-hearing comments, the Department stated that the use of the median strikes a balance between allowing HMOs the flexibility to use flat fee copayments as a cost recovery mechanism and regulating the copayments so that they are as fair as possible to consumers and do not unnecessarily inhibit access to health care. The Department indicated that the median is less affected by "high cost low utilized technologies and aggregate inflation rates than the arithmetic mean." Department Post-hearing Comments at 7. Calculation of the median charge is a straightforward calculation which does not involve the exclusion of charges deemed to be "outliers" or any other discretionary adjustmentsare excluded; half of the charges will exceed the median charge and half will be less than the median charge. The Department characterizes this approach as conservative and stable. The Department did not provide a specific response to the suggestion of the Minnesota Medical Association that the rules simply use the term "median charge," rather than referring to "average charge."

The Department has demonstrated that it is needed and reasonable to base the calculation of flat fee copayments on the median charge. Although the proposed rules are not rendered unreasonable by their references to "average" charge and the definition of the "average" charge as the "median" charge, the Administrative Law Judge urges the Department to consider avoiding any potential confusion by using the term "median charge" consistently throughout the regulations. Such a revision would merely serve to clarify the rule and would not constitute a substantial change from the rule as originally proposed.

19. Blue Plus also questioned the adequacy of sample sizes used in calculating copayments separately for Medicare, group, and individual contracts. It suggested that a minimum of 1000 contractholders be required to assure reliability. The Department declined to establish a minimum number in the proposed rules, but did add the following new sub-item (3) to subpart 4, item A:

> (3) If a health maintenance organization wants to use a flat fee copayment but has an insufficient population size for their data to be statistically reliable, the health maintenance organization may submit copayment requests based on statistically reliable data from other populations within the HMO.

The new language accommodates HMOs with multiple populations in setting flat fee copayments. The Department also pointed out that, for very small populations, the HMO may wish to require a straight percentage copayment or, in the alternative, the entire population could be used for the justification of a flat fee copayment, rather than a sample. The proposed rule, as modified by the Department in its post-hearing comments, has been shown to be needed and reasonable. The new language does not constitute a substantial change from the rule as originally proposed.

Subpart_5_-_Required_Disclosure

20. Subpart 5 requires HMOs to include a notice describing copayment charges in its Medicare, individual, and master group contracts and certificates or evidences of coverage. As originally proposed, subpart 5 required the inclusion of the following services upon which the flat fee copayment is based, and suggested that HMOs be permitted to list examples of services included. As the Department pointed out in its post-hearing comments, the subpart merely requires that "the notice must include a general, narrative description of the types of services which were included in determining the average charge," and thus clearly does not mandate inclusion of an exhaustive list.

Subpart 5, as amended, has been shown to be needed and reasonable. The modification made to the language of the proposed rule clarifies the rule and does not constitute a substantial change.

Subpart_6_-_Exclusions

21. Subpart 6 of the proposed rules permits any amount of copayment to be imposed with respect to services that are not required to be covered by the health plan, as long as the copayment does not exceed the provider's charge for that service. The Minnesota Chiropractic Association objected to this subpart based upon an argument that requiring an enrollee to pay a copayment equal to the charge for the treatment in essence means that there is no coverage of that service at all. In its post-hearing comments, the Department emphasized that Minn. Stat. Þ 62D.07, subd. 3 (1990), prohibits misleading statements in HMO contracts, and indicated that any copayment level which created a misleading perception of the coverage that is actually available or did not clearly set out the amount of copayment required could be denied on the basis of the statutory provision.

Subpart 6 clearly does permit HMOs to pass along to enrollees the entire amount of the charge for certain services. Nevertheless, if a service can be excluded from HMO coverage, it would not be appropriate to require the HMO to pay a portion of the cost. Enrollees may choose to receive an excluded service from the HMO even though they are faced with a "100 percent" copayment. Minn. Stat. 62D.07, subd. 3 (1990), will provide protection from deceptive statements in this regard. The Department has demonstrated that subpart 6 is needed and reasonable.

Subpart_7_-_Out-of-plan_Services

22. Subpart 7 provides that providers who do not have arrangements with the HMO may impose copayments on out-of-plan emergency care, including inpatient care, in the form of a reasonable deductible of not more than $150, plus a copayment of 25 percent, plus all charges which exceed an annual aggregate amount of not less than $90,000. These limitations are needed and reasonable to enable HMOs to manage their costs and also assure enrollees that the costs of emergency care will be substantially paid under the HMO coverage.

Subpart_8_-_Preventive_Health_Care_Services

23. Subpart 8 of the proposed rules prohibits the imposition of copayments on preventive health care services as defined in part 4685.0100 of the rules, including child health supervision, periodic health screening, and prenatal care. The SONAR indicates that, pursuant to Minn. Stat. 62A.047 (1990), prenatal care and child health supervision are considered to be primarily preventive in nature and cannot be subject to a copayment. No one objected to this subpart of the proposed rules. The Department has demonstrated that subpart 8 is needed and reasonable to encourage appropriate preventive care and carry out the intent of Minn. Stat. 62A.047 (1990).

Proposed_Rule_4685.1910_-_Uniform_Reporting;

Proposed_Rule_4685.1940_-_NAIC_Blank_for_Health_Maintenance Organizations,_Report_#_2:__Statement of_Revenue_and_Expenses;
Proposed_Rule_4685.1955_-_Supplemental_Benefits

24. During the Minnesota Legislature's 1989 session, Minn. Stat. Þ 62D.05, subd. 6, was amended to allow HMOs to offer supplemental benefits which are underwritten by the HMO. The amendment directed the Department to promulgate rules relating to supplemental benefits. Prior to the passage of the amendment, HMOs could onl

Part 4685.1910 of the existing rules discusses HMO annual reporting requirements. The Department seeks to amend the rule to alert HMOs that they must comply with reporting requirements set forth in the proposed supplemental benefits rule (part 4685.1955). Part 4685.1940 of the existing rules requires HMOs to submit a National Association of Insurance Commissioners form relating to revenue and expenses. The Department seeks to amend this rule by inserting a new item E which would require the HMO to submit a separate State of Revenue and Expenses for its supplemental benefit operations. The Department has demonstrated that these provisions are needed and reasonable to ensure that adequate reports are filed by HMOs who choose to finance their own supplemental benefits.

Proposed rule part 4685.1955 consists of nine subparts setting out definitions, requirements of coverage, information which must be provided to consumers, limitations on out-of-pocket expenditures, and reporting requirements. Only those subparts which attracted significant comment will be discussed.

Subpart_1_-_Definitions

25. Subpart 1 of proposed rule 4685.1955 defines supplemental benefit, comprehensive supplemental benefit, and limited supplemental benefit. Supplemental benefit is defined in item A as "an addition to the comprehensive [HMO] services required to be offered under a health maintenance contract which provides coverage for nonemergency, self-referred medical services which is either a comprehensive supplemental benefit or a limited supplemental benefit according to items B and C." Comprehensive supplemental benefit is defined in item B as "supplemental benefits for at least 80 percent of the usual and customary charges for all covered supplemental benefits, except emergency care, required for a qualified plan . . . or a qualified Medicare supplement plan . . . ." Limited supplemental benefit is defined in item C as "any supplemental benefit which provides coverage at a lower level of benefits than comprehensive supplemental benefits with a cost coverage below that of comprehensive supplemental benefits."

The American Diabetes Association and the Coalition on Health Care Issues for Persons with Disabilities objected to the proposed provision authorizing a limited supplemental benefit. In its post-hearing comments, the Department pointed out that the creation of a limited supplemental benefit merely allows an

additional optional plan. The availability of such a plan may encourage some employers and HMOs who would not offer a comprehensive plan to offer some level of supplemental benefits.

The Department has shown that subpart 1 is needed and reasonable to regulate the provision of supplemental benefits by HMOs.

Subpart_2_-_General_Requirements_on_Provisions_of_Coverage

26. Subpart 2 sets forth the general requirements which must be met by HMOs providing supplemental benefits. Item A requires that the contract or evidence of coverage for supplemental benefits must include a statement that supplemental benefits are not used to fulfill comprehensive health maintenance services requirements. Item B prohibits HMOs providing supplemental benefits from discriminating against or otherwise limiting reimbursement for services of credentialed practitioners, unless the certificate of coverage identifies the practitioners whose services are not covered, and provides that practitioners described in item C cannot be excluded from coverage. Item C provides that, where the supplemental benefit provides reimbursement for a service which is within the lawful scope of practice of licensed osteopaths, optometrists, chiropractor, or registered nurse, the enrollee is entitled to access to that service on an equal basis regardless of who provides the service. The subpart thus includes provisions from Chapter 62A of the Minnesota Statutes which prohibit insurance contracts from excluding certain types of practitioners

Item B of the proposed rules was supported by the Minnesota Nurses Association and the Minnesota Chiropractic Association. Medica objected to the language in items B and C which specifies that certain practitioners cannot be excluded from coverage. Medica stressed the importance of controlling health care costs, and urged that the Department permit HMOs to provide supplemental benefits through limited provider networks of practioners who are credentialed under state law. Medica contends that, while the Legislature required the Department to give consideration to existing laws and rules administered by the Department of Commerce, it did not require the Department to follow these laws and rules.

In its SONAR, the Department stated that "[t]he intent of the Minnesota Legislature in allowing HMOs to fund their own supplemental benefits was to provide greater flexibility in financing such benefits, not to change the types of services that are covered by supplemental benefits." SONAR at 30. Minn. Stat. Þ 62D.05, subd. 6(b) (1990), directs the Department to consider the existing laws and rules administered and enforced by the Department of Commerce with respect to health insurance plans. Because the Department is not required by statute to adopt any specific approach to supplemental benefit providers, it has the discretion to choose to adopt or decline to adopt the approach of the Department of Commerce. Based upon its review of the rules and laws administered by the Department of Commerce and its

consultations with Commerce Department personnel, the Department has concluded that the nondiscriminatory approach set forth in the proposed rules is appropriate. The Department determined that, "[s]ince supplemental benefits are designed to allow enrollees to receive services from providers outside of the HMO network it is reasonable to permit them to see any providers who supply the services required as a part of their practice." Department's Post-Hearing Comments at 12. The Department is concerned that excluding these providers could restrict the services available outside the HMO network and unreasonably limit the use of the supplemental benefits. Id. The Department thus has demonstrated that the proposed rules are needed and reasonable.

27. Item D prohibits HMOs from denying supplemental benefit coverage solely on the basis of lack of prior authorization or failure to obtain a second opinion. Item D does, however, permit an HMO to impose an assessment of up to 20 percent of the usual and customary charges for the service received where prior authorization or a second opinion is not obtained. The Coalition on Health Care Issues for Persons with Disabilities objected to the assessment as violating Minn. Stat. Þ 62D.11, subd. 4 (1990). That statute prohibits an HMO from denying or limiting coverage for failure to obtain prior authorization or a second opinion. The proposed rules do not, however, remove services from coverage. Instead, they permit the HMO to impose an assessment which must be paid by the enrollee to receive that coverage. The prior authorization and second opinion requirements provide incentives for enrollees to participate in HMOs' managed care systems and thereby aid HMOs in
reducing costs. Imposition of an assessment in such situations is a needed and reasonable approach and strikes an appropriate balance between the rights of the enrollee and the needs of the HMO.

MedCenters and First Plan HMO suggested that the assessment for failure to obtain prior authorization or a second opinion be set at 25 percent rather than 20 percent. The 25 percent figure is presently permitted with respect to insurance contracts regulated by the Department of Commerce. As discussed in the previous Finding, the Department is not required to adhere to the approaches of other agencies who regulate health insurance. The 20 percent figure represents a significant portion of the supplemental benefit and should provide a

Subpart_3_-_Disclosure_of_Comprehensive_Supplemental Benefits;
Subpart_4_-_Disclosure_of_Limited_Supplemental_Benefits

28. Proposed subparts 3 and 4 identify the specific information which must be disclosed by HMOs which offer comprehensive supplemental benefits and limited supplemental benefits. The information required to be disclosed includes a description of services that are covered; services that are excluded; the levels of coverage available; applicable copayments, deductibles, or maximum lifetime benefits; any preauthorization procedure required; any assessment for failure to obtain preauthorization; and the procedure established for filing claims.

The Department proposes to require the disclosure of detailed information in order to ensure that enrollees clearly understand what benefits are offered as supplemental benefits and become aware of the claims filing procedures. Because enrollees covered under supplemental benefits may be going outside the HMO network and filing claims for the first time, the Department particularly stressed the importance of the information provided with respect to the claim filing procedures. SONAR at 33. The Department has established that the disclosure provisions are needed and reasonable.

Group Health Inc. objected to the portion of subpart 3 which expressly excludes emergency care from supplemental benefit plans. Group Health asserts that the exclusion of emergency services conflicts with Minn. Stat. Þ 62D.04, subd. 1(f) (1990). That provision permits HMOs to purchase insurance to cover the cost of providing nonelective emergency services or services provided outside the plan area. The statute does not address the contention that enrollees should be entitled to purchase such insurance. The proposed rule does not preclude HMOs from purchasing insurance for the payment of emergency services.

In response to Group Health's comments, the Department points out that Minn. Stat. 62D.02, subd. 7 (1990), requires that emergency services be included in comprehensive health maintenance services coverage. Department's Post-Hearing Comments at 13. The Department acknowledges that out-of-network emergency services may resemble a supplemental benefit because they may involve deductibles which would not have been required if the services were received in-network. Minn. Rule 4685.0800, subp. 4 (1991), provides that copayments may be imposed on out- of-area services and emergency care by providers who do not have arrangements with the HMO in the form of a copayment, a reasonable deductible, and payment of all charges which exceed a specified annual aggregate amount not less than $25,000. The Department emphasizes, however, that Minn. Stat. 62D.05, subd. 6(4)(b) (1990), requires that supplemental benefits may not attempt to serve as substitutes for comprehensive health maintenance services. The Department maintains that these statutory and regulatory provisions require that out-of-network emergency services be provided as a part of comprehensive health maintenance services and, therefore, such services cannot be provided as a supplemental benefit. Department's Post-Hearing Comments at 13.

Because emergency services are not eligible for supplemental benefit treatment, the Department has demonstrated that subdivisions 3 and 4 are needed and reasonable as proposed.

Subpart_5_-_Consumer_Information

29. Subpart 5 of the proposed rules requires that all supplemental benefits contracts and evidences of coverage must contain a statement of consumer rights. This statement is intended to advise enrollees of their rights and obligations in clear and complete language. The provision is very similar to the qualified HMO services statement required by Minn. Rule . The information must be presented in the manner described

in items A or B of subpart 5 or in substantially similar language approved by the Commissioner of Health. At t

Subpart_6_-_Out-of-Pocket_Expenses

30. Proposed subpart 6 requires that the out-of-pocket expenses for supplemental benefits be included in the total out-of-pocket expenses for the entire package of benefits provided, and specifies that the total out-of-pocket expenses for a plan, including those associated with supplemental benefits, may not exceed the maximum allowable under Minn. Stat. 62E.06 (1990). Section 62E.06 sets the annual out-of-pocket maximum for which enrollees are responsible at $3,000. MedCenters, Group Health, and Medica indicated that HMOs should be allowed to maintain a $3,000 limitation for out-of-pocket expenses for comprehensive HMO benefits and be allowed to maintain a separate $3,000 limitation for supplemental benefits. This approach would permit a total out-of-pocket expenditure limit of $6,000 with respect to both coverages. This situation presently exists in some arrangements where the HMO provides comprehensive plan services and supplemental benefits are underwritten by an insurance company.

Although the Department concedes that a $6,000 limitation on out-of Out-of-pocket expenses has been applied in such instances because no statute prohibits it, the Department contends that this is not a result intended by the Legislature. The Department interprets Minn. Stat. 62D.02, subd. 8 (1990), as clearly imposing the $3,000 maximum on an HMO contract encompassing both HMO and supplemental benefits. The Department's conclusion that the out-of-pocket expense limitation set by statute applies to both types of coverage when offered by one entity is reasonable. An HMO may choose to enter into an arrangement with an insurance company rather than underwriting the supplemental benefits itself and thereby apply the $6,000 out-of-pocket expense limitation. Proposed subpart 6 has been demonstrated to be needed and reasonable.

Proposed_Rule_4685.2200_-_Termination_of_Coverage

31. Proposed rule part 4685.2200 amends the existing rules relating to termination of coverage. The rules are intended to address two problems which have come to the attention of the Department. First, the individual members of groups have not received notice under certain circumstances that the group as a whole was being terminated for nonpayment of premiums. Second, enrollees of groups that were terminated when employers failed to pay the group premiums have been required to make significant payments in order to qualify for conversion to an individual plan. The proposed rule includes a new definitional section and a new subpart relating to notice of cancellation to group enrollees, and amends the provisions of the existing rules relating to justification for termination of coverage, notice, and termination of dependents. Only the portions of the rule which received significant comment will be discussed.

Subpart 1a, as amended, provides, inter alia, that an HMO may cancel the coverage of an enrollee upon 30 days advance notice

if the enrollee moves out of the HMO's geographic service area. The amendment specifies:

> Written notification of the change of address of an enrollee may be from any reliable source, such as the United States Postal Service or providers. If notification is received from a source other than the enrollee, the [HMO] must verify that the enrollee has moved out of the service area before sending notice of termination.

The proposed rules thus permit the HMO to receive notice of an enrollee's change of address from a source other than the enrollee, but require that the source be reliable and that, if the information was received from someone other than the enrollee, the HMO confirm that the enrollee has moved out of the service area before sending notice of termination. The Department indicated at the hearing that this amendment was prompted by a situation in which an HMO sent letters to 300 enrollees st

Several HMOs objected to the verification requirement. Medica suggested that the verification be made by sending the termination notice. This approach would clearly undermine the intent of the proposed rules in requiring verification. NWNL suggested that HMOs be allowed to rely on notification by the Postal Service or the employer and contended that verification is unnecessary because the 30-day advance notice period gives enrollees ample time to respond to the HMO and prevent termination. NWNL indicated that "[n]otice of termination for moving out of the service area could be required to contain a statement such as 'Your coverage will not be terminated if you notify the HMO within 30 days of the date of this letter that you reside within the HMO service area.'" The Department has not specified by rule how an HMO may meet the verification requirement. The Department indicated in its post-hearing comments that the method mentioned by NWNL for termination of coverage was acceptable, "provided there are records demonstrating that the HMO had valid notification that the enrollee moved out of the service area." Department's Post- Hearing Comments at 14.

The verification requirement is needed to prevent unnecessary anxiety among enrollees. The requirement is reasonable, since it requires an HMO to take some affirmative action to ensure that termination notices are directed to persons who are out of the coverage area. Although the rule is reasonable as proposed, the Department may wish to consider providing further guidance regarding the manner in which the verification requirement may be satisfied. Inclusion of such guidance in the proposed rules would not constitute a substantial change from the rule as originally proposed.

Blue Plus objected to the requirement in the proposed rules that persons who obtained HMO coverage through the provision of knowingly false information at the time of enrollment must be given 30 days advance notice prior to cancellation. Blue Plus pointed out that the proposed rule in essence would permit such an

enrollee an extended period of time to continue to take advantage of the coverage to which he or she is not legally entitled. The Department acknowledged in its post-hearing comments that an advance notice requirement would be inappropriate in such a situation and modified subpart 1a to not require advance notice with respect to termination for providing false information. The Department also included an express statement that the subpart does not impair the statutory appeal rights of the enrollee under Minn. Stat. Þ 62D.11. Subpart 1a, as modified, would provide as follows:

> Subpart 1a. Justification. In addition to those reasons specified in Minnesota Statutes, section 62D.12, subdivision 2, a health maintenance organization may, upon 30 days advance notice, cancel or fail to renew the coverage of an enrollee if such enrollee moves out of the geographic service area filed with the commissioner, provided such cancellation or nonrenewal is made within one year following the date the health maintenance organization was provided written notification of the address change. Written notification of the change of address of an enrollee may be from any reliable source, such as the U.S. Postal Service or providers. If the niotification is received from a source other than the enrollee, the HMO must verify that the enrollee has moved out of the service area before sending notice of termination.
>
> A health maintenance organization may cancel or fail to renew the coverage of an enrollee if such enrollee knowingly gives fale, material information at the time of enrollment relative to his health status, provided such cancellation or nonrenewal is made within six months of
> not prevent the enrollee from exercising the appeals rights provided by Minnesota Statutes 62D.11.

The altered subpart is needed and reasonable to limit the HMOs' coverage of persons who enrolled under false pretenses. The change was made in response to comments received in the rulemaking proceeding and does not constitute a substantial change from the rule as originally proposed.

32. HMO premiums are often paid by an employer for a group of enrollees. In some instances, employers do not make timely payments of the group premium or discontinue their payments entirely. This presents a dilemma for HMOs, since they generally give the employer several months to correct the problem and continue to provide services to enrollees during this time even though they are not receiving premium payments. Enrollees are dependent upon the HMO for health care and must cover the missed payments to maintain coverage. If payments are not received, HMOs give 30 days' notice to the employer, and coverage ends on the last day of the last month for which a premium was paid. In some instances, the retroactive termination date may be three or four months prior to the effective date of the notice. Employers

generally do not notify their employees that the group coverage will be terminated due to the employer's nonpayment of premiums. A further difficulty is presented when the group coverage payment is discontinued, because the individual enrollees must apply for individual coverage on their own or pay lump sum retroactive conversion premiums. Disruptions in coverage can have a catastrophic effect upon enrollees presently receiving treatment, since they are not likely to be insurable under the restrictions governing pre-existing conditions.

In subpart 2a of the proposed rules, the Department proposes to require HMOs to send all enrollees in a group plan 30-days' notice of termination where coverage is being cancelled for nonpayment. The notice of termination may specify an effective date which is not less than 30 days after the date the notice of termination was postmarked. The date the coverage ends may be no more than 60 days prior to the effective date of the notice. Thus, while advance notice is given of the cancellation, the actual cancellation date cannot be more than two months prior to the effective date which is stated in the notice. This process allows an HMO to grant a 30-day grace period to group payors and ensures that enrollees' exposure to past-due premium payments is limited to two months.

Group Health, Medica, MedCenters, and NWNL Health Network objected to this notification requirement. Several HMOs felt that the proposed rule improperly penalizes HMOs for the misconduct of employers, complained that the notice provisions will impose an enormous administrative burden upon HMOs, and stated that the Department should not be able to require HMOs to provide enrollees free coverage. Others were concerned that the notification would create panic among enrollees whenever a group payor was late in paying its premium. In addition, some HMOs believed that business relations between the HMOs and employers would suffer as a result of the proposed rule, since the HMO would not be able to exercise as much flexibility in structuring a payment schedule. The Department responded that HMOs are free to delay sending termination notices as long as they deem prudent. The proposed rule simply limits the extent to which HMOs can force enrollees to bear the costs associated with extending employers additional time to pay. The rule imposes the financial impact of delay on the HMO rather than the enrollees. In the proposed rules, the Department has balanced the need of the HMO for premium payments with the settled expectation of enrollees that the services are available, while remaining sensitive to the business relationship between the HMO and group payor. Subpart 2a has been shown to be needed and reasonable.

Based up

CONCLUSIONS

1. The Minnesota Department of Health gave proper notice of the hearing in this matter.

2. The Department has fulfilled the procedural requirements of Minn. Stat. ÞÞ 14.14, subds. 1, 1a, and 2 (1990), and all other procedural requirements of law or rule so as to allow it to adopt the proposed rules.

3. The Department has demonstrated its statutory authority to adopt the proposed rules, and has fulfilled all other substantive requirements of law or rule within the meaning of Minn. Stat. ÞÞ 14.05, subd. 1, 14.15, subd. 3, and 14.50 (i) and (ii) (1990).

4. The Department has demonstrated the need for and reasonableness of the proposed rules by an affirmative presentation of facts in the record within the meaning of Minn. Stat. ÞÞ 14.14, subd. 2 and 14.50 (iii) (1990).

5. The additions and amendments to the proposed rules which were suggested by the Department after publication of the proposed rules in the State Register do not result in rules which are substantially different from the proposed rules as published in the State Register within the meaning of Minn. Stat. Þ 14.15, subd. 3 (1990), and Minn. Rule pts. 1400.1000, subp. 1, and 1400.1100 (1991).

6. Any Findings which might properly be termed Conclusions and any Conclusions which might properly be termed Findings are hereby adopted as such.

7. A finding or conclusion of need and reasonableness in regard to any particular rule subsection does not preclude and should not discourage the Department from further modification of the proposed rules based upon an examination of the public comments, provided that no substantial change is made from the proposed rules as originally published, and provided that the rule finally adopted is based upon facts appearing in this rule hearing record.

Based upon the foregoing Conclusions, the Administrative Law Judge makes the following:

RECOMMENDATION

IT IS HEREBY RECOMMENDED that the proposed rules be adopted consistent with the Findings and Conclusions made above.

Dated this _____ day of March, 1992.

_____

_____

BARBARA L. NEILSON
Administrative Law Judge

Reported: Tape Recorded; No Transcript.