

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS
FOR THE MINNESOTA DEPARTMENT OF HUMAN SERVICES

In the Matter of the Proposed
Adoption of Department of Human Service
Rules Relating to Medical Care Surcharge
on Health Care Providers, Minnesota Rules
JUDGE
Parts 9510.2000 to 9510.2050

REPORT OF THE
ADMINISTRATIVE LAW

The above-entitled matter came on for hearing before Administrative Law Judge Barbara L. Neilson on January 7, 1993, at 9:00 a.m. in the Fifth Floor Conference Room of the Veteran's Service Building in St. Paul, Minnesota.

This Report is part of a rulemaking proceeding held pursuant to Minn. Stat. 14.131 to 14.20 (1992) to hear public comment, determine whether the Minnesota Department of Human Services ("the Department") has fulfilled all relevant substantive and procedural requirements of law or rule applicable to the adoption of the rules, evaluate whether the proposed rules are needed and reasonable, and assess whether or not modifications to the rules proposed by the Department after initial publication are substantially different from those originally proposed.

Kim Buechel Mesun, Special Assistant Attorney General, Suite 500, 525 Park Street, St. Paul, Minnesota 55103, appeared on behalf of the Department at the hearing. The hearing panel consisted of Julie Elhard of the Department's Health Care Support Division and Jim Schmidt of the Department's Rules and Bulletins Division. Sixteen persons attended the hearing. Fourteen persons signed the hearing register. The Administrative Law Judge received five 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 January 27, 1993, twenty calendar days following the date of the hearing. Pursuant to Minn. Stat. 14.15, subd. 1 (1992), five business days were

allowed for the filing of responsive comments. At the close of business on February 3, 1993, the rulemaking record closed for all purposes. The Administrative Law Judge received five post-hearing written comments from interested persons. The Department submitted two written comments responding to matters discussed at the hearing and comments filed during the twenty-day period. At the hearing and in its written comments, the Department proposed further amendments to the rules.

The Department must wait at least five working days before taking any final action on the rules; during that period, this Report must be made available to all interested persons upon request.

Pursuant to the provisions of Minn. Stat. 14.15, subd. 3 and 4, this Report has been submitted to the Chief Administrative Law Judge for his approval. If the Chief Administrative law Judge approves the adverse findings of this Report, he will advise the Department of actions which will correct the defects and the Department may not adopt the rule until the Chief Administrative Law Judge determines that the defects have been corrected. However, in those instances where the Chief Administrative Law Judge identifies defects which relate to the issues of need or reasonableness, the Department may either adopt the Chief Administrative Law Judge's suggested actions to cure the defects or, in the alternative, if the Department does not elect to adopt the suggested actions, it must submit the proposed rule to the Legislative Commission to Review Administrative Rules for the Commission's advice and comment.

If the Department elects to adopt the suggested actions of the Chief Administrative Law Judge and makes no other changes and the Chief Administrative Law Judge determines that the defects have been corrected, then the Department may proceed to adopt the rule and submit it to the Revisor of Statutes for a review of the form. If the Department makes changes in the rule other than those suggested by the Administrative Law judge and the Chief Administrative Law Judge, then it shall submit the rule, with the complete record, to the Chief Administrative Law Judge for a review of the changes before adopting it and submitting it to the Revisor of Statutes.

When the Department files the rule with the Secretary of State, it shall give notice on the day of filing to all persons who requested that they be informed of the filing.

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

FINDINGS OF FACT

Procedural Requirements

1. On October 19, 1992, the Board 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) the proposed Notice of and Order for Hearing;
- (c) the Statement of Need and Reasonableness ("SONAR");
- (d) an estimate of the number of persons who were expected to attend the hearing;

- (e) an estimate of the length of the Department's presentation at the hearing;
- (f) a statement that the Department intended to provide discretionary additional public notice of the hearing; and
- (g) a fiscal note.

2. On November 18, 1992, 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. Department Ex. 4. On that date the Department also mailed additional discretionary notice to the 87 Minnesota County Human Service Agencies, the 25 advisory committee members, and 25 additional persons who requested that a public hearing be held. Department Ex. 4.

3. On November 23, 1992, the proposed rules and the Notice of Hearing were published in 17 State Register 1266. Department Ex. 4.

4. On December 11, 1992, 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 pages containing the Notice of Hearing and the proposed rules;
- (c) an affidavit stating that the Notice of Hearing was mailed on November 18, 1992, 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;
- (d) an affidavit stating that additional discretionary notice of the hearing was mailed on November 18, 1992, to the 87 Minnesota County Human Service Agencies, the 25 advisory committee members, and 25 additional persons who had requested that a public hearing be held regarding the proposed rules;
- (e) a copy of the Notice of Solicitation of Outside Information or Opinions published in 16 State Register 2987 on June 29, 1992, together with the materials received by the Department in response to the solicitations; and
- (f) the names of agency personnel who would represent the Department at the hearing, and a statement that no other witnesses had been solicited by the Department to appear on its behalf.

5. All documents were available for inspection and copying at the Office of Administrative Hearings from the date of filing to February 3, 1993,

the date the rulemaking record closed.

Nature of the Proposed Rules and Statutory Authority

6. Laws enacted by the Minnesota Legislature in 1991 and amended in 1992 established a medical care provider surcharge program effective July 1, 1991. As amended, the legislation generally requires that nursing homes, Minnesota hospitals (except facilities of the federal Indian Health Service and regional treatment centers), and health maintenance organizations pay certain surcharges to the Commissioner of Human Services. See Laws of Minnesota 1991, Chapter 292, Article 4, Sections 20, 21, 67 and 77, as amended by Laws of Minnesota 1992, Chapter 513, Article 7, sections 16-19 and 123-124, codified in pertinent part in Minn. Stat. 256.9657 and 256B.74 (1992). The surcharges are paid into the general fund of the State of Minnesota and are based upon the number of beds in nursing homes and revenues received by hospitals and health maintenance organizations (HMOs). The legislation specifies the percentages of revenue or amounts per licensed bed to be paid by the covered facilities.

The Legislature directed the Commissioner to implement the surcharge requirements on July 1, 1991, without complying with the rulemaking requirements of the Administrative Procedure Act. The law required the Commissioner to begin to adopt emergency rules to implement Laws 1991, chapter 292, article 4 (which includes the surcharge program) within 30 days and also authorized the Commissioner to adopt permanent rules. Minn. Stat. 256B.74, subd. 10 (1992). The Department adopted emergency rules to implement the surcharge program in December of 1991. 16 State Reg. 1557 (December 23, 1991). The emergency rules expired on December 6, 1992. The newly proposed rules are to take the place of the expired emergency rules.

The proposed permanent rules would define terms used in the rules; create mechanisms for payment, appeals, and enforcement of the surcharge requirements; and clarify the manner in which the surcharges will be applied to facilities that begin operations after October 1, 1992, or to those that close, change ownership, or enter into receivership. Because Minn. Stat.

256B.74, subd. 10 (1992), expressly authorizes the adoption of permanent rules to implement the medical care surcharge program, the Administrative Law

Judge concludes that the Commissioner has statutory authority to promulgate these rules.

Small Business Considerations in Rulemaking

7. Minn. Stat. 14.115, subd. 2 (1992), requires state agencies proposing rules which may affect small businesses to consider methods for reducing adverse impact on those businesses. In its Notice of Hearing and SONAR, the Department indicated that it believes that the small business statute does not apply to the proposed rules. The Department nevertheless did consider methods to reduce the impact of the proposed rules on small businesses when it formulated the proposed rules. The Department concluded that less stringent rules on small businesses would conflict with the statutorily established standards for operating the surcharge program.

The small business statute does not apply to "service businesses regulated by government bodies, for standards and costs, such as nursing homes, long-term care facilities, hospitals, providers of medical care, day

care centers, group homes, and residential care facilities." Minn. Stat. 14.115, subd. 7(3) (1992). The types of businesses affected by the proposed rules--nursing homes, hospitals and HMOs--thus are directly encompassed within the statutory exemption. The Administrative Law Judge thus finds that the Department is not required to consider the impact of the proposed rules on small businesses and that the requirements of Minn. Stat. 14.115, subd. 2 (1992), have been met in this rulemaking proceeding.

Fiscal Note

8. Minn. Stat. 14.11, subd. 1 (1992), 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 prepared a fiscal note which estimates the costs of the program to the State would be \$950,000 in fiscal 1992 and \$490,000 in fiscal 1993. The fiscal note indicated that no costs would be incurred by counties in fiscal 1992 and 1993.

The fiscal notice requirement is applicable only if the proposed rules will require "local public bodies" to expend the requisite public funds. The term "local public bodies" is defined in Minn. Stat. 14.11, subd. 1 (1992), as "officers and governing bodies of the political subdivisions of the state and other officers and bodies of less than statewide jurisdiction which have the authority to levy taxes." "Political subdivision" is defined in the Minnesota Statutes as "any agency or unit of this state which is now, or hereafter shall be, authorized to levy taxes or empowered to cause taxes to be levied." Minn. Stat. 471.49, subd. 3 (1990). The preparation of a fiscal note thus is not required when proposed rules require expenditures by entities which have statewide jurisdiction (such as the state Department of Human Services). No commentator argued that nursing homes, hospitals or HMOs are operated by political subdivisions or bodies of less than statewide jurisdiction. The Administrative Law Judge concludes that, because the proposed rules will not require the expenditure of public money by local public bodies in excess of \$100,000 per year during the next two years, the Department was not required to prepare a fiscal notice with respect to the rules.

Impact on Agricultural Land

9. Minn. Stat. 14.11, subd. 2 (1992), 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. 17.80 to 17.84 (1992). Because the proposed rules will not have an impact on agricultural land, these statutory provisions do not apply.

Outside Information Solicited

10. In formulating these proposed rules, the Department published a notice soliciting outside information and opinions in the State Register in June, 1992. Although the Department did not receive any materials in response to this notice, it did include in the rulemaking record written comments

submitted by Medica and the Minnesota Council of HMOs on previous drafts of the surcharge program rules. The written comments submitted by the Minnesota Council of HMOs indicates that Ms. Elhard and Mr. Schmidt attended a meeting in November 1992 of the HMO Council Regulatory Subcommittee Tax Issues Workgroup at which the proposed rules were discussed.

Substantive Provisions

11. 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 in its written post-hearing comments.

12. 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).

13. This Report is generally limited to the discussion of the portions of the proposed rules that received significant critical comment or otherwise need to be examined. Some sections of the proposed rules, such as rule parts 9519.2000 (setting forth the purpose and scope of the proposed rules) and 9510.2010 (setting forth definitions of terms used in the proposed rules), were not opposed and were adequately supported by the SONAR. A detailed discussion of each section of the proposed rules thus 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, that such provisions are specifically authorized by statute, and that there is no other problem preventing their adoption.

Proposed Rule Part 9510.2020 - Medical Care Surcharge

14. Proposed rule part 9510.2020 is composed of six subparts. Each will be discussed separately.

Subpart I - Nursing Homes

15. Subpart I of part 9510.2020 requires that non-state operated nursing homes must pay an annual medical care surcharge of \$535 for each nursing home bed licensed by the Minnesota Department of Health. The number of beds used to calculate the total surcharge due will be based upon the Department of Health's tally of the number of licensed beds on July 1 of each

year. The subpart also specifies that monthly installments are due on the fifteenth day of each month.

16. Care Providers of Minnesota ("Care Providers") objected to the rule's reliance on the Department of Health's tally of licensed beds. Care Providers asserted that the Department of Health makes errors which would then have an adverse impact on the particular nursing home involved by unjustly increasing its surcharge amount. Care Providers suggested that the proposed rules be revised to allow errors regarding the number of licensed beds to be corrected without having to go through the time-consuming appeal process set forth in proposed rule part 9510.2040. The Department asserted that, as the licensing agent for the State, the Department of Health is the most accurate source of information regarding the number of licensed beds. The Department indicated that errors made by the Department of Health which could be verified (such as typographical errors) will be corrected without resort to the appeal process, while alleged errors which are disputed and hinge on interpretations of applicable law will be handled through the appeal process. The Department of Human Services has shown that it is necessary and reasonable for it to rely upon the number of beds licensed by the Department of Health as the measure of a nursing home's surcharge liability, subject to the provider's appeal rights.

17. There are, however, several problems with the wording of the rule part. First, the proposed rule as presently drafted conveys the impression that the number of licensed beds as of July 1 is in all cases the number on which the surcharge is to be based. The governing statute, however, sets forth a potential exception to this requirement:

The surcharge shall be calculated as \$535 per bed licensed on the previous July 1, except that if the number of licensed beds is reduced after July 1 but prior to August 1, the surcharge shall be based on the number of remaining licensed beds. A nursing home entitled to a reduction in the number of beds subject to the surcharge under this provision must demonstrate to the satisfaction

of the commissioner by August 5 that the number of beds has been reduced,

Minn. Stat. 256.9657, subd. 1 (1992) (emphasis added). Because the proposed rule does not refer in any way to the possibility that the surcharge may be affected by a demonstrated reduction in the number of licensed beds between July 1 and August 1, it is contrary to the governing statute and is defective. The defect may be remedied by inserting the underlined language above in the proposed rule (see Finding 20 below).

18. Second, the proposed rule as presently drafted could be read to allow facilities to pay monthly installments of any amount, so long as the yearly total of installments equalled the total amount of the nursing home's surcharge. It is unlikely that the Department intended this result, particularly since the governing statute requires that "[t]he monthly payment must be equal to the annual surcharge divided by 12." Minn. Stat. 256.9657, subd. 4 (1992). While the language of the proposed rules is not defective in this regard, the Department may wish to clarify that the total surcharge amount is to be paid in equal monthly increments by modifying the language as suggested in Finding 20 below.

19. Finally, as currently drafted, the rule could be construed to mean that the surcharge will be calculated either (a) based upon the number of licensed beds in that facility; or (b) based on the number of licensed beds in the state as a whole. No commentators pointed out this ambiguity. It is clear that the Department and the regulated public understand that the proposed rules are intended to require the former interpretation rather than the latter, and it is unlikely that the latter interpretation would ever stand since it would be contrary to the clear intent of the governing statute. Although this portion of the rule is not defective as proposed, the Department may wish to consider modifying the language to remove the ambiguity concerning the calculation of the surcharge, as discussed in Finding 20 below.

20. The following language could be substituted in subpart 1 in order to correct the defect noted in Finding 17 and the potential ambiguities noted in Findings 18 and 19:

Effective October 1, 1992, and each July 1 after, an annual medical surcharge of \$535 is levied upon each nursing home bed licensed by the Minnesota Department of Health in non-state operated nursing homes. Each non-state operated nursing home must pay the surcharge for those beds licensed in its nursing home as of July 1 of each year, except that if the number of licensed beds is reduced after July 1 but prior to August 1, the surcharge shall be based on the number of remaining licensed beds. A nursing home entitled to a reduction in the number of beds subject to the surcharge under this provision must demonstrate to the satisfaction of the commissioner by August 5 that the number of beds has been reduced. Payments are due in equal monthly installments on the fifteenth day of each month beginning November 15, 1992. The monthly payment must be equal to the annual surcharge divided by 12. The November 15, 1992, payment shall be based on the number of licensed nursing home beds in the nursing home on July 1, 1992. Beginning July 1, 1993, the surcharge will be based on the number of licensed beds in the nursing home on July 1, 1993, and will change yearly on July 1, based on the then existing number of licensed nursing home beds in that nursing home.

Subpart 1, with the modifications suggested above, has been shown to be needed and reasonable to inform nursing homes of the surcharge requirements. The modifications proposed by the Administrative Law Judge would clarify the proposed rules, ensure that they are consistent with the governing statute, and accurately inform nursing homes of an available exception to the July 1 bench mark date. The modifications would not result in a rule which is substantially different from the rule as originally proposed.

Subpart a - Minnesota Hospitals

21. Subpart 2 requires that Minnesota hospitals pay a medical care surcharge of 1.4 percent of the net patient revenue, excluding net Medicare

revenues reported to the health care cost information system for the fiscal year two years prior to the fiscal year ending June 30. The rules further require that the surcharge be paid in monthly installments which are due on the 15th of each month, starting with October 15, 1992. Subpart 2 also defines four terms for use only in the subpart.

No comments were received in opposition to this rule part. The subpart is needed and reasonable as proposed. The wording of the subpart does, however, contain the same sort of potential ambiguities discussed in Findings 18 and 19 above with respect to subpart 1. In addition, while the intent is clear, the proposed rule does not expressly state that the Surcharge is annual in nature. If the Department wishes to clarify the rule, the first paragraph can be reworded as follows:

Effective October 1, 1992, each Minnesota hospital must pay an annual medical care surcharge equal to 1.4 percent of that hospital's net patient revenue, excluding that hospital's net Medicare revenues as reported to the health care cost information system for the fiscal year two years before the fiscal year ending June 30. This surcharge shall be paid in monthly installments due on the 15th of the month, beginning October 15, 1992. The monthly payment must be equal to the annual surcharge divided by 12,

The suggested modification is needed and reasonable to clarify the proposed rule. If adopted by the Department, the revision in the rule language would not constitute a substantial change.

Subpart 3 - Health Maintenance Organizations

22. Subpart 3 of the rules requires HMOs to pay a medical care surcharge equal to six-tenths of one percent (00.6%) of the "total premium revenues" as reported to the Commissioner of Health for the fiscal year two years before the fiscal year ending June 30. As with nursing homes and hospitals, the subpart requires the payment of monthly installments due on the 15th of every month, beginning October 15, 1992.

23. A major issue in this rulemaking proceeding concerns the proper meaning of the term "total premium revenues." As originally proposed and published in the State Register, the rules provided that premiums attributable to prepaid dental contracts were to be excluded from "total premium revenues" and that the term "total premium revenues" was to have the meaning given the term "Premium" in Minn. Rule pt. 4685.1930, subpart 3. That provision is part of a set of rules promulgated by the Department of Health which addresses the information and reports to be filed by HMOs each year with the Department of

Health. Rule part 4685.1930 requires that HMOs file NAIC Report #2 ("Report #2") and amends or clarifies the definitions, instructions, and information to be provided on that form. Part 4685.1930, subpart 3, provides as follows:

Premium. The definition of premium as used on line I of Report #2: STATEMENT OF REVENUES AND EXPENSES is amended in the GENERAL INFORMATION, DEFINITIONS, AND INSTRUCTIONS section to include only revenues from the health maintenance organization's Minnesota health maintenance contracts.

In its originally-filed SONAR with respect to the proposed rules, the Department indicated that "[i]t is reasonable to use the Department of Health's definition of premium since that is the definition used by health maintenance organizations in preparing their annual reports to the Department of Health." SONAR at 7.

24. Information concerning Report #2 was provided during the rulemaking hearing and in post-hearing comments. See, e.g., attachments to the discussion of the Department's proposed modifications provided at the rule hearing; Public Ex. 2; and comments filed by the Minnesota Council of HMOs. The relevant portion of Report #2 contains the following language:

PREVIOUS YEAR	CURRENT YEAR
2	3
Total	Total
REVENUES:	
1. Premium	
.....
2. Fee-For-Service	
.....	
3. Title XVIII--	
Medicare.....
4. Title XIX -	
Medicaid.....
5.	
Investment.....
6. Aggregate Write-ins for	
Other Revenues.....	
.....	
7. TOTAL REVENUES (Items I to	
6).....

HMOs completing Report #2 thus must provide information concerning their total amount of premium revenues during the current and previous years. Medicare and Medicaid payments are not included in "premiums" but rather are reported separately on lines 3 and 4 of Report #2. The instructions applicable to Report #2 explain that the reference to the term "premium" on line 1 includes "[r]evenue recognized on a prepaid basis from individuals and groups for provision of a specified range of health services over a defined period of time, normally one month" and "[p]remiums from Medicare Wrap-Around

subscribers for health benefits which supplement Medicare coverage." The Report #2 instructions further note that, "[i]f advance payments are made to the HMO for more than one reporting period, the portion of the payment that has not yet been earned must be treated as a liability." According to the instructions, lines 3 and 4 include revenue as a result of an arrangement between an HMO and the Health Care Financing Agency or a Medicaid State Agency for services to a Medicaid or Medicare beneficiary.

25. The Department decided prior to the hearing to modify subpart 3 by deleting the exclusion for premiums attributable to prepaid dental contracts and substituting a different definition of "total premium revenues." The

modifications were discussed at the rule hearing and at a November 2 meeting between Department representatives and members of the Minnesota Council of HMOs. As modified, subpart 3 of the proposed rules provides as follows:

Subp. 3. Health maintenance organizations. Health maintenance organizations must pay a medical care surcharge equal to six-tenths of one percent of the total premium revenues as reported to the commissioner of the Department of Health for the fiscal year two years before the fiscal year ending June 30. This surcharge shall be paid in monthly installments due the 15th day of the month, beginning October 15, 1992.

For the purposes of this subpart, "total premium revenues" mean:

- A. premium revenue recognized on a prepaid basis from individuals and groups for provision of a specified range of health services over a defined period of time, normally one month;
- B. premiums from Medicare Wrap-Around subscribers for health benefits which supplement Medicare coverage;
- C. Title XVIII Medicare revenue, as a result of an arrangement between an HMO and the Health Care Financing Administration, for services to a Medicare beneficiary; and
- D. Title XIX Medicaid revenue, as a result of an arrangement between an HMO and a Medicaid state agency, for services to a Medicaid beneficiary.

If advance payments are made under items A or B to the HMO for more than one reporting period, the portion of the payment that has not yet been earned must be treated as a liability.

Items A. and B. of the proposed modifications and the last paragraph of the subpart are identical to the instructions applicable to line I of Report #2, while items C. and D. are drawn from the instructions for lines 3 and 4 of Report #2.

26. The Department indicated at the hearing and in its post-hearing comments that the modification was necessary to be consistent with the statute and contended that the rules as originally proposed would have improperly limited the definition intended by the Legislature. The Department submitted a letter from the principal authors of the 1992 provider surcharge legislation, Senator Linda Berglin and Representative Lee Greenfield, in support of the modification. In the letter, Sen. Berglin and Rep. Greenfield indicate that data contained in an internal Department of Health memorandum

dated February 18, 1992, was used to develop a chart depicting estimated collections from the surcharge. The memorandum provided a summary of 1990 "HMO premium revenues by category" and included references to "commercial revenue," "Medicare revenue," "Medicaid revenue," "dental revenue," and "total premium revenue." Senator Berglin and Rep. Greenfield further stated that "[i]t is our understanding that premium revenues include Medicare and Medicaid revenues, and the estimate of collections from the surcharge is based on that understanding."

27. BluePlus, Group Health, Inc., MedCenters Health Plan, Central Minnesota Group Health Plan, Medica, and the Minnesota Council on HMOs objected to this new definition as being beyond the intent of the authorizing statute for the medical surcharge program. The Department asserted that it was necessary to amend the proposed rules in order to conform to the intent of the Legislature.

28. It is a well-established canon of statutory construction that, "[w]hen the words of a law in their application to an existing situation are clear and free from all ambiguity, the letter of the law shall not be disregarded under the pretext of pursuing the spirit." Minn. Stat. 645.16 (1992). The medical surcharge statute unfortunately does not contain a definition of "total premium revenues." The statute does, however, specify that the HMO surcharge shall be based on the "total premium revenues of the [HMO] as reported to the commissioner of health" Minn. Stat. 256.9657, subd. 3 (1992). The term "total premium revenues" is unambiguous and should be afforded its plain meaning. The word "premium" means "a sum paid, either all at once or periodically, for an insurance contract." New Webster's Dictionary and Thesaurus at 791 (1991). The plain language of the statute would not permit the inclusion of revenues which do not constitute premiums, such as payments received from governmental entities for services provided by an HMO to Medicare and Medicaid beneficiaries. The rules promulgated by the Department of Health which govern the manner in which HMOs report annual revenues to the Commission provide further support for this interpretation of the statutory language. Those rules require that HMOs file Report #2 in accordance with the instructions provided on the Report and as modified or clarified by various rule provisions. In the process of doing so, HMOs are required to segregate their total revenues from "premiums" from their total revenues from Medicare and Medicaid arrangements. While the instructions include premiums from Medicare Wrap-Around subscribers for health benefits which supplement Medicare coverage among the premiums to be reported on line 1, revenues received from governmental bodies for services provided to Medicare and Medicaid beneficiaries are clearly treated as non-premium

revenues.

29. The letter and charts submitted by the two principal sponsors of the medical surcharge legislation does not compel a different conclusion. Statements made regarding the intended purpose of legislation made by individual members after its enactment cannot be considered as conclusive evidence of legislative intent. The sponsors in the present instance have not provided any indication that the revenue estimates were discussed with other members of the Legislature or that the asserted definition of "total premium revenues" was relied upon by anyone else in the Legislature. It would be

inappropriate to use the sponsors' revenue projections as a basis for including Medicare and Medicaid payments within the definition of "total premium revenues" where, as here, the statute does not appear to be ambiguous on its face,

30. Accordingly, the Administrative Law Judge has concluded that the Department has exceeded its statutory authority by attempting to include Title XVIII Medicare revenue and Title XIX Medicaid revenue within the meaning of "total premium revenues." Items C. and D. of the proposed rules, as modified, thus are defective and may not be promulgated as part of this rulemaking proceeding. The remainder of the modifications proposed by the Department for the most part incorporate language from the instructions to Report #2 and result in clarifying the earlier draft of the proposed rules. The inclusion of dental premiums and Medicare Wrap-Around premiums within "total premium revenues" is consistent with the proposed definition of "premium" set forth in item A. The remainder of the modifications thus are found to be needed and reasonable.

31. Medica, BluePlus, and the Minnesota Council on HMOs asserted that the change proposed by the Department to the definition of total premium revenue is a substantial change. These commentators primarily were critical of the proposed inclusion of Medicare and Medicaid payments among "total premium revenues" and emphasized that the inclusion of such payment would have had a substantial impact on the amount of the surcharges assessed to HMOs. Medica Primary and Medica Choice expected to pay an additional \$1,100,000 per year in surcharge had the inclusion of Medicare and Medicaid payments been sustained, and Group Health, Inc. and MedCenters estimated that they would incur another \$769,089 in medical surcharges.

As discussed above, the Judge has concluded that the Department lacks statutory authority to expand the coverage of the proposed rules to encompass Medicare and Medicaid payments. The Judge finds that the remainder of the changes proposed by the Department to subpart 3 merely clarify the language of the rules as originally proposed. The modifications do not affect classes of persons who could not reasonably be expected to comment at the hearing, involve a new subject matter of significant substantive effect, make a major substantive change that was not raised by the Notice of Hearing so to invite reaction at the hearing, or result in a rule fundamentally different in effect from the rule as originally published. They thus do not constitute a substantial change within the meaning of Minn. Rules pt. 1400.1100, subp. 2 (1991).

32. Comments submitted on behalf of the Minnesota Council of HMOs,

MedCenters Health Plan, and Central Minnesota Group Health Plan asserted that HMO premiums received from the Federal Employees Health Benefit Program ("FEHBP") should be excluded from the total premium revenue; upon which the medical surcharge is calculated. The commentators introduced a letter received from Andrea S. Minniear, Assistant Director for Retirement and Insurance Policy, United States Office of Personnel Management, which stated that a federal law which took effect on January 1, 1991, precludes states from imposing any taxes or fees on payments made from the FEHBP fund. Public Law 101-86 & 8909(f). The commentators suggested that the rules be

changed to reflect the exempt status of such premiums. Because the state statute governing the surcharge program does not specify that premium payments made from the FEHB Fund are exempt, the Department responded that it lacked the statutory authority to make the requested modification to the rule. There is no requirement that the Department accept the legal opinion of the U.S. Office of Personnel Management regarding whether or not premiums made from the FEHB Fund premiums may properly be included in the calculation of the medical provider surcharge, particularly where the governing statute does not address the issue. The Department's decision to decline to modify the proposed rules under these circumstances does not render the proposed rules unreasonable or otherwise constitute a defect in the proposed rules.

33. The provisions of subpart 3 include the same potential ambiguities discussed in Findings 18 and 19 above. Although the proposed rules are not defective as written, the Department may wish to clarify the rules. The Department could consider the following modification to the first paragraph of subpart 3:

Health maintenance organizations must pay an annual medical care surcharge equal to six-tenths of one percent of the total premium revenues of that health maintenance organization as reported to the commissioner of the Department of Health for the fiscal year two years before the fiscal year ending June 30. This surcharge shall be paid in monthly installments due the 15th day of the month, beginning October 15, 1992. The monthly payment must be equal to the annual surcharge divided by 12.

The suggested modification is needed and reasonable, serves to clarify the proposed rule, and does not constitute a substantial change,

Subpart 3a - Installment Due Date, Acceptable Postmark

34. BluePlus and the Minnesota Council of HMOs expressed a concern that entities paying surcharges would suffer penalties for late payment if the payment was timely mailed but delayed in transit. The Department agreed to modify the language of the proposed rule to encompass such Situations. It added subpart 3a to the proposed rules, which would provide as follows:

Subp. 3a. Installment due date, acceptable postmark. An installment payment postmarked on or before the 12th of a month Satisfies the due date requirement for the 15th day of the month.

As a result of this modification, payments postmarked by the 12th day of the month will be deemed to satisfy the payment deadline of the 15th of the month. The Department noted in its comment supporting the change that three days are added to the prescribed notice period in many legal and administrative proceedings if the notice is mailed. The addition of subpart

3a has been shown to be needed and reasonable to avoid situations in which providers would be unfairly penalized for mail delivery delays beyond their control. The modification was suggested by a commentator, affects only the procedural aspects of the rule, and does not constitute a substantial change.

Subpart 5a - HM05 That Cease Operation

35. Subparts 4 and 5 of the proposed rules discuss the application of the surcharge program to hospitals and nursing homes that close, undergo a change in ownership, or enter into receivership. The Minnesota Council of HMOs pointed out that the proposed rules as originally drafted did not address the effect of closure or merger by an HMO. The Department acknowledged that the ceasing of operations by HMOs should also be discussed in the proposed rules. At the hearing, the Department proposed the addition of a new subpart 5a to accomplish this goal. As originally proposed, subpart 5a provided as follows:

Subp. 5a. HMOs that cease operation. HMOs that cease operation after October 1, 1992, are subject to the medical care surcharge until the first month after the HMO completely ceases operation. The medical care surcharge continues for HMOs that merge.

In their post-hearing comments, the Minnesota Council of HMOs and BluePlus pointed out that it is possible for two HMOs to merge and operate under only one certificate of authority. These commentators asserted that it would not be fair to continue to tax the entity which is no longer using its certificate of authority. The Department agreed and further modified the last sentence of subpart 5a to incorporate language suggested by the Council of HMOs. As finally proposed, the last sentence of the rule part would state, "The medical surcharge continues for HMOs that merge as long as each HMO's certificate of authority remains in force."

The Administrative Law Judge questions whether the proposed modification in fact accomplishes the result intended by the Department. While the proposed modification does ensure, by negative implication, that a partner to an HMO merger who is no longer using its certificate of authority would not continue in the surcharge program, it is silent concerning whether the merger partner who continues to use its certificate of authority would continue in the program. The rule is impermissibly vague in this regard and thus is defective. To cure this defect, the merger language should read as follows:

The medical surcharge continues for HMOs that merge as long as any of the certificates of authority of the merging HMOs remain in force. If the certificate of authority for a merging HMO no longer remains in force, the medical surcharge for that HMO will be discontinued.

The suggested rules modification cures the defect in the subpart, clarifies the surcharge participation status of HMOs which cease operations or merge, and is needed and reasonable. The modifications were originally suggested by commentators and do not constitute a substantial change from the rules as originally proposed.

Subpart 6 - Nursing Homes, Minnesota Hospitals, and HMOs That Begin Operations After October 1, 1992

36. As originally proposed, subpart 6 of the proposed rules specified that the medical care surcharge would apply to nursing homes that begin operation after October 1, 1992, effective on the July 1 following licensure and that the surcharge for hospitals and HMOs would begin the month immediately after the date when data has been reported to the health care cost information system for the fiscal year two years before the year of surcharge. No objections were raised to the provisions of this subpart pertaining to hospitals and nursing homes. With respect to HMOs, however, the Minnesota Council on HMOs pointed out that HMOs do not report to the health care cost information system. At the time of the hearing, the Department responded to this comment by deleting the reference to HMOs in item B and adding a new item C. Item C provides, "The surcharge for health maintenance organizations begins the month immediately after the date when data has been reported to the commissioner of health for the fiscal year two years before the year of surcharge." As modified, the rules would establish the same timetable for HMOs and hospitals without including an inappropriate reference to the health care cost information system. The new language is needed and reasonable to correct an error in the rules and provide guidance regarding the date on which new HMOs will begin to participate in the surcharge program. The modification does not result in a rule that is substantially different than that originally proposed.

Proposed Rule 9510.2030 - Notification of Surcharge Amount

37. As originally proposed, this rule part requires the Commissioner to give written notice to a nursing home, hospital, or HMO of the medical care surcharge owed at least 30 days before the date each payment is due. The rule thus echoes the requirement set forth in Minn. Stat. 256.9657, subd. 6 (1992). The Minnesota Council of HMOs suggested that this rule is potentially in conflict with other rule provisions that require payment by the 15th of each month and suggested that language be included in the rules which extends the due date past the 15th of the month if the Department fails to give 30 days notice. In its post-hearing comments, the Department decided that it would be appropriate to incorporate the suggested language. The Department suggested adding the following language to proposed rule part 9510.2020, subpart 3:

Notwithstanding the requirement that the monthly installments are due on the 15th day of the month, to the same extent written notice from the commissioner pursuant to part 9510.2030 is not received 30 days prior to the due date, that due date will be extended.

38. The suggested language suffers from awkward construction. The rule is vague and ambiguous concerning the length of the extension to be granted

when the Commissioner's notice is late. This lack of clarity is so severe as to constitute a defect in the proposed rules. Moreover, the Department's

inclusion of this language in rule part 9510.2020, subp. 3, has the effect of affording only HMOs (not hospitals or nursing homes) an extended date for payment. No rational explanation has been provided which justifies such a differential in treatment. Because of this potential inconsistency and unfairness, it would be advisable to instead add the new language to proposed rule part 9510.2030 (relating generally to notification of surcharge amount) or subparts 1, 2, and 3 of rule part 9510.2020.

39. If the Department chooses to alter Minn. Rules pt. 9510.2230 to remedy the defect, the following language could be included:

Notwithstanding the requirement that the monthly installments under Minnesota Rule 9510.2020, subparts 1, 2, and 3 are due on the 15th day of the month, if written notice from the commissioner under this part is not received 30 days prior to the 15th, the due date of the monthly installment will be extended to thirty days from the day the notice is actually received by the nursing home, hospital, or HMO.

If the Department wishes to add language to Minn. Rules pt, 9510.2020, subparts 1, 2, and 3, the language could be clarified as follows:

Notwithstanding the requirement that the monthly installments are due on the 15th day of the month, if written notice from the commissioner pursuant to part 9510.2030 is not received 30 days prior to the 15th, the due date of the monthly installment will be extended to thirty days from the day the notice is actually received by the [nursing home/hospital/HMO].

The Administrative Law Judge suggests that it would be preferable to modify Minn. Rules pt. 9510.2230 to accomplish the result sought by the Department and commentators. The new language eliminates a potential conflict within the rule. The modification suggested by the Administrative Law Judge cures a defect in the new language proposed by the Department by removing significant ambiguity. The suggested modifications do not constitute substantial changes.

Proposed Rule 9510.2040 - Surcharge Appeals

40. Part 9510.2040 of the proposed rules establishes the procedures by which providers may appeal the surcharge amounts assessed by the Department. The rule part is composed of six subparts which, inter alia, specify when appeals will be allowed, identify the criteria which must be satisfied for an appeal to be effective, provide for informal and formal steps to resolve appeals, and require that surcharge amounts be paid while appeals are pending. Subparts 5 and 6 were the only provisions that received significant comment.

41. Subpart 5 provides that the Commissioner shall "settle-up" with a successful appealing party after the exhaustion of the appeal process. The proposed rule proceeds to define "exhaustion of the appeal process" to mean within 45 days of the date of the final judicial decision or, if no judicial review is sought, within 45 days of the date of the final decision of the Commissioner. The Minnesota Council of HMOs and BluePlus suggested that the Department modify the rules to require that the Department pay interest on any amount due to the appealing party when the settle-up does not occur within 45 days. The Department declined to modify the proposed rules as suggested on the ground that the Legislature did not incorporate in the medical surcharge statute any sanctions or penalties to be imposed on the Department. The proposed rules are not rendered unreasonable by their failure to include a requirement that the Department pay interest charges if it fails to settle up within 45 days. The Department is not obligated to adopt such a provision.

42. Subpart 6 specifies that an appeal must be filed for each month that the amount of surcharge due is disputed. Medica, BluePlus, and the Minnesota Council of HMOs questioned the need for appeals to be filed each month where the surcharge amount at issue and the basis for appeal remain identical. Although the commentators agreed that the Department could reasonably request that these appeals be renewed or preserved at particular times, perhaps at one-year intervals, they viewed the monthly appeals contemplated by the proposed rules as administratively burdensome and unnecessary. The Department declined to modify the proposed rules. The Department indicated that it would accept a shortened version of the appeal letter for subsequent appeals and stated that it would be sufficient if the provider merely sent a statement reiterating its appeal of the surcharge tax as set out in the provider's initial appeal letter and referencing the date of its initial appeal. The proposed rules will avoid the potential confusion associated with the assertion of on-going objections and standing appeals by requiring a separate filing of some sort each month. The rules have been shown to be needed and reasonable to ensure that the Department receives adequate notice of a provider's continued objection to a particular surcharge amount. Because brief letter appeals may be filed following the initial appeal, the proposed rules should not be onerous.

43. Care Providers suggested that the rules be modified to incorporate a requirement that the Department respond to a written appeal within 30 days of receipt and that penalties be imposed for a failure to meet this time frame. The Department declined to make the suggested modifications and emphasized that it would not be possible to render a determination in 30 days in situations where a thorough investigation or involvement of legal counsel was necessary. The proposed rules are not rendered unreasonable by the

Department's failure to modify them in the manner suggested by Care Providers.

Based upon the foregoing Findings of Fact, the Administrative Law Judge makes the following:

CONCLUSIONS

1. The Minnesota Department of Human Services ("the Department") gave proper notice of this rulemaking hearing.

2. The Department has fulfilled the procedural requirements of Minn. Stat. 14.14, subs. 1, 1a, and 2 (1992), 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. 14.05, subd. 1, 14.15, subd. 3, and 14.50(i) and (ii) (1992), except as noted at Findings 17, 30, 35, and 38.

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. 14.14, subd. 2, and 14.50(iii) (1992).

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. 14.15, subd. 3 (1992), and Minn. Rules pts. 1400.1000, subp. 1 and 1400.1100 (1991).

6. The Administrative Law Judge has suggested action to correct the defects cited at Conclusion 3 as noted at Findings 20, 30, 35, and 38.

7. Due to Conclusions 3 and 6, this Report has been submitted to the Chief Administrative Law Judge for his approval pursuant to Minn. Stat. 14.15, subd. 3 (1992).

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

9. 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 except where specifically otherwise noted above.

Dated this 5th day of March, 1993.

BARBARA L. NEILSON
Administrative Law Judge

Reported: Tape Recorded; No Transcript.