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GENERAL STATEMENT OF NEED AND REASONABLENESS - COPAYMENTS

The copayment rules currently in use delineate guidelines for a health maintenance organization's (HMO) use of enrollee copayments for health care services received through the HMO's system. The proposed rules provide clarification of some of the terms and procedures used in the existing rules.

In order to assure compliance with the proposed copayment rules, Minn. Rules 4685.3300 Periodic Filings has also been amended to cross-reference the copayment rule for the information which must be filed with the Department of Health to justify the level of copayments an HMO wishes to impose.

Copayments are payments made by HMO enrollees for covered medical services, on a per-use basis. Under the existing rules, they may be calculated either as a percentage of the provider's charges for the services actually received, or as a per-visit flat fee based on the average charge for similar services throughout the HMO network. The purpose of the proposed rules is to describe reasonable standards which address 1) the method of calculating flat fee copayments, 2) the method of calculating percentage copayments, 3) the method of disclosing copayments in the enrollee contract, and 4) the information to be reported to the Department of Health to show compliance with these rules.

As health care delivery systems, HMOs use a variety of strategies

to control costs. Studies have shown that reasonable enrollee copayments help to eliminate unnecessary health care utilization and therefore reduce the overall cost of health care (Shapiro, 1986; Leibowitz, 1985; Manning, 1987; Newhouse, 1981; Keeler, 1983). (A complete bibliography is included as attachment 1). In addition, the use of percentage copayments may involve the enrollee in the selection of cost effective health care providers by creating higher enrollee copayments for care received from higher cost providers.

Although they did not specifically examine the issue, the studies also suggest that when copayments become too high, enrollees may elect not to get some necessary treatment (Shapiro, 1986; Leibowitz, 1985; Starfield, 1985). If the lack of early treatment causes the condition to worsen the care eventually received may be extensive, which would lead to an increase in the overall cost of health care. This would be especially true if lack of early treatment leads to hospitalization that otherwise could have been avoided. Thus, for copayments to contribute to the containment of health care delivery costs, a balance must be struck which creates an incentive to avoid unnecessary care for minor complaints but does not discourage necessary early care of potentially serious conditions.

HMOs also want to offer products containing copayments because those products have lower monthly premiums than plans without

enrollee copayments. Products with copayments allow the HMOs to meet a market demand from employers who are looking for ways to reduce their monthly premiums without reducing the benefits they offer to their employees. In particular, some small businesses faced with rising health care costs say they may need to drop their coverage for employees unless they can transfer more of the cost to the employees (Minneapolis Star Tribune, October 2, 1989). Some larger employers are also using more employee copayments in order to keep the cost of health care coverage down. In a study of 227 major U.S. employers, the number of employers requiring copayments increased from 51% in 1984 to 70% in 1988 (DiBlase, 1989).

Questions and complaints regarding copayments have been received by the Department of Health from enrollees and providers regarding the fairness and reasonableness of copayments charged under the current rules. These fall generally into two categories: 1) percentage copayments appear to be a higher percentage of the cost of the service than stated in the enrollee's contract, and 2) flat fee copayments appear to exceed the maximum allowable percentage of the service received. The proposed rules attempt to address these questions and complaints as will be discussed in more detail in the part by part statement of need and reasonableness.

The HMOs in Minnesota vary widely in the types of provider arrangements and financial arrangements used. The rules should be flexible enough to allow each HMO, regardless of its provider and

financial arrangements, to comply with the copayment rules within their system.

Representatives of the Department of Health met with representatives of several HMOs to discuss the proposed rules changes. In addition, representatives of the Department met with the HMO Council, which consists of representatives from each HMO. Most of the issues of concern were similar for all HMOs, but their suggestions for resolving those issues varied for each HMO model. Many of the comments, suggestions, and concerns presented by the HMOs have been incorporated into these proposed rules. For example, provisions permitting the use of providers' fee schedules or billed charges, rather than "cost or charges" for calculating copayments, and allowing the HMOs to assess enrollees for failing to get prior authorization for supplemental benefit services were added as a result of the meeting with HMO Council.

A draft version of these proposed rules was distributed to interested parties for review and comment on April 19, 1991. The Department of Health has reviewed all comments submitted and made changes to the proposed rules where appropriate. Some comments have not been incorporated into the rules because they were deemed to be unnecessary or inconsistent with the purpose of the rules. For example, the Minnesota Department of Human Services (DHS) submitted several comments which expressed concern that state law and the proposed rules permit copayments in group contracts but

DHS does not permit HMOs to have copayments in medical assistance contracts. The proposed rules establish a minimum standard for establishing copayments. DHS, or any employer group, may negotiate particular terms with the HMOs for specific contracts.

PART BY PART STATEMENT OF NEED AND REASONABLENESS, COPAYMENTS 4685.0801

Subpart 1. Copayments On Specific Services.

Subpart 1 of the rule is amended to describe copayments in more detail. The existing rule establishes a maximum copayment of 25 percent of the "costs or charges" of a particular service. The Department of Health has received questions from the public and group purchasers asking how the 25 percent copayment is calculated and what "costs or charges" means.

The proposed rule establishes "provider's charge" as the basis for calculating percentage copayments. This is the amount a provider normally charges for that service, without regard to who is the payor. It may be different from the amount the HMO will actually pay for the service. The "cost", or the amount actually paid by the HMO for a service, may be difficult to calculate, especially in capitated or staff model HMOs which do not pay their providers based on specific services. In addition, at a May 23, 1991 meeting with representatives of the Department, representatives of the HMO Council expressed concern that if the rule required the copayment to be based on what they actually pay for a specific service, the amount of the copayment would reveal the HMOs' fee payment schedule as negotiated with their providers. All of the HMOs consider their fee schedule to be proprietary and confidential.

During the meeting with the Department, the HMO Council explained

that there are two fee schedules involved in determining payments to providers. The HMO has a fee schedule which is negotiated with the providers. This is the schedule used to determine what the provider will be paid for a specific service, if the provider is not an employee of the HMO. The providers also have a fee schedule which contains the fee that provider charges for services. This is the source of the provider's "billed charge." The copayment is calculated from the billed charge as set out in the provider's fee schedule. Based on discussions with the HMOs and the HMO Council, the Department's understanding is that to the extent any savings an HMO gains by negotiating lower fees to the providers will be passed on to the enrollees, it will be done through lower monthly premiums, not through lower copayments.

The proposed rules also acknowledge that HMOs do not all use the same standardized codes to describe the services they provide. The rules permit each HMO to determine which of the generally accepted standard codes it will use for determining the provider's charge when calculating copayments. The HMO council explained that the most commonly used standardized codes are Physicians' Current Procedural Terminology (CPT), published by the American Medical Association for use in describing physicians' charges, and diagnosis related groups (DRGs) used by the Health Care Financing Administration. DRGs are used primarily by hospitals and for reporting services to Medicare.

Subpart 2. Flat Fee Copayments

The existing rules do not specify a method for establishing copayments, provided they do not exceed 25 percent of the cost or charge for the affected service. The HMOs have developed copayment systems in existing contracts which include both service-specific copayments and flat fees based on categories of related services. Based on its meeting with the HMO council, the Department of Health has determined that both methods are useful in developing HMO products which meet the coverage demands of employers and enrollees.

Where copayments are required, flat fee copayments are appealing to both enrollees and providers. Enrollees can determine in advance what they will be expected to pay when they receive medical services by asking the provider's staff or by referring to their evidence of coverage. Since the provider does not need to compile billing information before calculating the flat fee copayment, it is easier to collect the copayment at the time of service, saving the cost of billing the enrollee.

Subpart 2 of the proposed rules specifically allows the use of flat fee copayments based on categories of similar services or goods. The method for establishing allowable categories is set out in subpart 3. When a flat fee copayment is used, the amount of the copayment may not exceed 25 percent of the average provider's charges for the services included in the category. The average

provider's charges must be calculated as set out in subpart 4.

Under the existing rules, prescription drug copayments are not subject to the maximum of 25 percent of provider's charges. At the time the rules were written in 1974, coverage for prescription drugs was typical in HMO contracts but not in health insurance contracts. In order to permit the HMOs to offer products which were priced competitively with insurance products, it was appropriate to allow more flexibility in drug copayments than the 25 percent maximum applied to copayments on other required services.

The current rules state: "copayments imposed upon prescription drug benefits shall be reasonable under the general provisions described in this part." Minn. Rules 4685.0800, Subp. 4. Prescription drugs are now included services for both HMOs and insurance products. Since the reason for treating drug copayments differently no longer exists, the proposed rules apply the same copayment rules to them as to other required services.

Some flat fee copayments on prescription drugs may have been approved as "reasonable" that will not meet the requirements of the proposed rule because they exceed 25 percent of the provider's fee. The proposed rules establish the date of publication of the proposed rules for hearing as a cut off date for approval of drug copayments under the old rule. Any copayment provisions approved

before that date will remain approved until the copayments are resubmitted for any reason. Copayment provisions submitted for approval after the date of publication, but before the proposed rules become effective, may be approved under the existing rules. However, they will need to be resubmitted for approval under the new rules within 30 days after the rules become effective. All copayments submitted for approval after the effective date of the proposed rules will be subject to those rules regardless of whether they are new copayments or amendments to existing copayments.

One HMO suggests that there be a 25% maximum copayment on "usual and customary" drugs but a 35-50% copayment on "medically elective drugs". The comment did not define "medically elective drugs" so the Department assumed it referred to drugs which are not medically necessary. For prescription drugs which are not medically necessary, the HMO can deny payment under Subpart 6.

The flat fee copayment is intended to reflect the average charge for the services included in the category. Subpart 4 of the proposed rules establishes the method for determining the average charge for services.

Premiums are established differently for Medicare, individual and group plans, and the mix and intensity of services may be different in each plan type. Because the members of Medicare, individual and group plans may required a different mix of services, the aggregate charges for the services included in a category may be different for each plan type. Consequently, in order to have a

copayment based on the utilization of people similarly situated, a flat fee based on a category of services must be established independently for Medicare, individual and group plans. For example, providers' charges data from group plans may be combined for calculating flat fee copayments for group contracts but group plan data cannot be used in calculating copayments for individual or Medicare plans. Information received during the meeting with the HMO council suggests that this method of calculating flat fee copayments could result in somewhat higher copayments for individual plan enrollees than for group plan enrollees when the same copayment percentage is used. This result is reasonable because the group plan enrollees' employer may choose a higher copayment plan in order to reduce its monthly premium. The group enrollee must take the plan selected by the employer or choose another HMO. Where an HMO provides a choice of plans offering higher monthly premiums or higher copayments, the individual plan enrollee is better able to choose between them, based on individual needs.

Comments from several HMOs suggest that calculating copayments separately for Medicare, group, and individual plans will adversely affect the copayments for Medicare eligible enrollees and would add to administrative costs. Other HMOs commented that this separation would have no immediate impact on their members. HMOs already separate this information for other reasons, such as reporting to Medicare and justifying copayments to the Department, and would not

experience a significant administrative impact. In order to have copayments which are related to the utilization of the portion of the population involved in the calculation, it is reasonable to require the separate calculation of Medicare, group, and individual copayments. This information will also be helpful in identifying trends in health care costs which would be useful in evaluating copayment requirements.

Subpart 3. Categories.

Subpart 3 of the proposed rules sets out the types of services or goods which may be included in categories for establishing flat fee copayments. This subpart is intended to provide guidance to the HMOs and is based on the experience of the Department of Health and the HMOs in establishing flat fees under the existing rules. Categories may be more specific than those set out as examples and HMOs may create other categories of related services. Services within a requested category must comply with the copayment rules and should be sufficiently similar to demonstrate a reasonable relationship between the services included in the category and the copayment requested.

Subpart 4. Determination Of Average Charge.

The use of the phrase "average provider's charges" has led to a considerable amount of confusion in calculating copayments and in determining whether they exceed the 25 percent maximum. It has been difficult for Department of Health personnel to evaluate the

calculations of the HMOs because the word "average" can be used to refer to median, mean or mode. The most commonly used use of "average" is to indicate the arithmetic mean. (Phillips, 1973).

Under the existing rule, most requests for approval of flat fee copayments are delayed while the Department requests additional information to justify the copayment. The Department has learned through experience with the existing rule what information it needs to apply the standards set out in the rules. That information, relating to population size, range of providers' charges, mean and median charges, quartiles, and standard deviations, is specifically required by the proposed rule and should eliminate the delay caused by requesting it separately.

Several HMOs already submit this information with their copayment requests because they have learned that it will be requested. The information relating to mean, quartiles and standard deviations will permit Department personnel to see the distribution of charges for related services which will be of help in validating the reliability of flat fee copayments and allow for comparison to similar copayment requests. This information will also be of help in understanding changes in copayment rates.

The issue of what information is necessary to justify a copayment was discussed with the HMO Council and with individual HMOs during

meetings held to discuss the proposed copayment rules, in order to determine the best method of eliminating confusion over reporting requirements. Rather than create new terminology which must be defined, it is preferable to set out the process which must be used in calculating copayments. The process, as set out in subpart 4, uses basic statistical terminology and concepts which should not require interpretation by HMO personnel.

The proposed rule describes the method for calculating the "average provider's charge" for services included in categories of similar services. In order to do this, the HMO must describe the services included in each category and/or cross-reference them to the applicable diagnostic or procedural codes used by the submitting HMO for those services. The calculation must be done according to the method set out in the rule and must include charges which cover at least one year. If the time range of the charges is less than one year, the HMO must explain how the time range used accounts for seasonal fluctuations in providers' charges and the types of services used by enrollees.

To justify a copayment for a given category based on "average providers' charges", an HMO must describe any relevant categories of services and identify the population, or sample of the population, to be used including the charges for services within the given category. The "average providers' charge" will be the median charge for the included services. This description will

include the following characteristics of the population or sample: range of charges, mean, median, quartiles, and standard deviations.

In determining a standard meaning for "average providers' charge" the Department considered the use of both the mean and median, and the lesser of the two after the calculations have been made. After considerable discussion with the HMOs individually and through the HMO Council, the Department believes that the median is the most relevant "average charge" within a category. The use of the median minimizes the effect of a few high cost services within a category. Such costs would affect the mean more than the median and could raise copayments for more of the lower cost services in the category above the 25 percent level.

The purpose of the required calculations is to provide sufficient information to assure that enrollees are not charged copayments which exceed the allowable amounts and to eliminate the need to request additional information for each copayment submitted, by standardizing the supporting information required .

When calculating the average providers' charge for a service or good, an HMO may use all of the relevant charges or a sample of the charges. If a sample is used, it must be random and large enough to be statistically reliable. According to the definitions in the proposed rules, a sample is statistically reliable if any

other sample drawn in the same manner would produce essentially the same results.

The medical care component of the consumer price index, or similar national or regional index, is established in the proposed rule as the basis for any acceptable flat fee cost adjustment based on inflation. The HMOs have requested the use of a variety of other factors in calculating inflation including regional trends, nurses strikes, new technology, and out of the ordinary occurrences in the past year. The Department has considered these requests and has discussed them with the HMOs. The HMOs have not submitted data to indicate what specific factors they would include or how those factors would affect the median. In addition, the use of such factors would allow the HMOs to make their own inflation calculations rather than using an independently produced index.

Nurses strikes and other out of the ordinary occurrences should not be included in inflation calculations because they are situational, one-time events. It is unclear to what extent new technology, new drugs, and changes in utilization patterns would affect the median. Since there is insufficient data to evaluate the significance of the additional inflation factors the HMOs want to use, a standard index is the best indicator of inflation.

Subpart 5. Required Disclosure.

The existing rules require that copayment provisions must be

clearly stated pursuant to Minnesota Statutes section 62D.07, Subdivision 3(b)(2), which requires a "clear, concise and complete statement" of any copayment features in the evidence of coverage. Evidences of coverage explain that copayments are a percentage of the charges associated with the service received. Enrollee complaints received by the Department of Health indicate that when enrollees learn what their HMO actually pays their provider for a particular service and attempt to calculate the copayment associated with that service, they find the percentage is higher than they expected.

The reason enrollees cannot calculate the copayments based on what the HMO actually pays is that the HMO pays the provider based on the HMO's fee schedule. The copayment is calculated based on the provider's fee schedule.

The Department of Health discussed this issue during its meetings with the HMOs and the HMO Council. The HMOs claim their fee schedules are confidential and want to protect them from disclosure to the public. To do that, they need to calculate the copayment based on the provider's fee schedule for the relevant service, not necessarily what the HMO will actually pay according to the HMO's fee schedule, as established by contract with the providers.

The proposed rule requires the HMOs to clearly inform their

enrollees that the copayment is calculated from the amount the provider typically charges for the service, what is commonly referred to as a "provider's fee schedule" or "billed charges". This information will eliminate confusion for the enrollees in regard to the basis for the percentage copayment calculation. In addition, it will encourage enrollees to exercise some control over the amount of their copayments by selecting providers who charge lower fees. If the enrollees mistakenly believe the copayment is based on the amount their HMO pays for the service, they believe that their choice of participating provider will have no impact on what they must pay in the form of a copayment.

In addition, if an HMO uses flat fee copayments based on a category of services, the proposed rule requires the HMO to describe in the evidence of coverage, master group contract, or individual contract what services are included in each category.

Subpart 6. Exclusions.

Subpart 6 of the proposed rules takes the language permitting exclusions from the existing rule and places it in a separate subpart. The only change in the language is to replace the phase "cost or charge" with the phrase "provider's charge". The existing rules permit any amount of copayment on services which are not required to be covered by the health plan, provided they do not exceed the "cost or charge" for the service. This proposed change

is needed to clarify the method for setting copayments on otherwise excludable services.

Subpart 7. Out-of-plan Services.

The proposed rules also place out-of-plan services in a separate subpart for easier reference. The substance of the out-of-plan rule has not been changed. The minimum annual aggregate out-of-plan coverage amount has been changed from $25,000 to $90,000. This change is not intended as an increase in required HMO coverage but rather is intended as an inflation adjustment to the existing rule which was enacted in 1974. The Department applied an inflation adjustment taken from the Consumer Price Index for medical services from 1976 to 1991 to arrive at the $90,000 annual aggregate amount.

Language relating to services other than emergencies and the annual aggregate coverage requirement has been removed from this subpart by the proposed rules. This language was originally included in an effort to provide guidance to the HMOs in determining copayments. Through experience with the existing rule, the Department of Health has learned that this language was more confusing than helpful. If out-of-plan services other than emergencies are covered by a plan, they will be covered under a supplemental benefit pursuant to Minn. Stat. 62D.05, Subd. 6 and proposed Rules 4685.1955.

Subpart 8. Preventive Health Care Services.

This subpart states that there may be no copayments on preventive health services as defined in these rules. Language in the existing rule which permitted copayments on some maternity services has been removed to eliminate possible confusion regarding copayments on prenatal care. Pursuant to Minn. Stat. 62A.047, prenatal care and child health supervision are primarily preventive and cannot be subject to a copayment. Minn. Stat. 62A.047 defines child health supervision as periodic services for children up to 6 years old. Periodic health screening applies to children over 6 years old.

Other provisions of the existing rules have been removed from this portion of the proposed rule and moved to other subparts to better organize the copayment rules.

4685.3300 Periodic Filings.

Subpart 3. Filing of contracts.

The current rule regarding the filing of contracts containing flat fee copayment provisions requires "sufficient evidence on cost of services on which copayments are being imposed to allow the commissioner of health to determine the impact and reasonableness of the copayment provision." Minn. Rules 4685.3300, subp. 3.

The information submitted in response to the existing rule has often been inadequate for consistent interpretation by Department

of Health personnel who must determine whether flat fee copayments comply with the rules. In discussions with the HMOs the Department has learned that although HMOs have attempted to comply with this filing requirement, there is insufficient guidance in the existing rule to determine what constitutes "sufficient evidence" for calculating flat fee copayments. This proposed rule refers to Minn. Rules 4685.0800, Subp. 4 for a listing of the information which must be filed in support of a copayment.

GENERAL STATEMENT OF NEED AND REASONABLENESS - SUPPLEMENTAL BENEFITS

During its 1989 session, the Minnesota Legislature amended Minn. Stat. 62D.05, subd. 6 to permit health maintenance organizations (HMOs) to offer supplemental benefits which are underwritten by the HMO. Prior to that amendment, HMOs could offer supplemental benefits only through a contract with a licensed insurance company.

The amendment directs the Department of Health to promulgate rules for supplemental benefits and to give consideration to the Department of Commerce rules which govern supplemental benefits provided by insurance companies.

The intent of these proposed rules is to allow HMOs the flexibility of offering supplemental benefits without the need to contract with an insurance company if they can provide the financial reserves required. The rules establish both the standards for the benefits themselves and the financial reporting requirements for the HMOs to provide their own supplemental benefits. An HMO may still provide these benefits by contract with an insurance company, as regulated by the Department of Commerce.

PART BY PART STATEMENT OF NEED AND REASONABLENESS - SUPPLEMENTAL BENEFITS.

Minnesota Rules Part 4685.1910, Uniform Reporting.

This rule is amended to include a reference to Minn. Rules Part 4685.1955 relating to supplemental benefits. This change will alert the HMO preparing its annual report to the reporting requirements contained in the supplemental benefits rule, if applicable to that HMO. The specific reporting requirements are contained in the supplemental benefits rules.

Minnesota Rules Part 4685.1940, NAIC Blank For Health Maintenance Organizations, Report #2: Statement Of Revenue And Expenses.

Subpart 1. A new item, E, is added which requires an HMO to submit a separate Statement Of Revenue And Expenses, including a separate schedule H, for its supplemental benefits operations. A schedule H form, specific to supplemental benefits, is available from the Department of Health. (A copy is attached as attachment 2). This separate reporting is needed in order to insure that appropriate financial reserves, in compliance with Minnesota Statutes 62D.05, Subdivision 6(a)(2), are in place for HMOs which choose to finance their own supplemental benefits. The information required is similar to that required for the HMO operations generally, but must be set out independently for supplemental benefits. The financial requirements for supplemental benefits will be reported completely separately from the HMO operations as a whole.

Minnesota Rules part 4685.1955, Supplemental Benefits.

Subpart 1. Definitions.

Subpart 1 sets out the definitions of supplemental benefits generally and defines the two basic types of supplemental benefits: Comprehensive Supplemental Benefits and Limited Supplemental Benefits.

In order to allow maximum flexibility in the supplemental benefits products offered, HMOs may provide a comprehensive supplemental benefit which offers coverage for all of the health services available through the comprehensive health maintenance services, except emergency services, or a limited supplemental benefit which permits an HMO to offer only selected services. Emergency services are not a part of the supplemental benefits because out-of-area emergency services must be covered by the comprehensive health maintenance services. Therefore, a supplemental emergency benefit would not add any coverage to what is already available through standard HMO coverage.

The minimum 80% coverage level required for a qualified plan applies only to a comprehensive supplemental benefit. In a limited supplemental benefit the HMOs are free to negotiate the level of coverage and the services provided for each contract. Either type of supplemental benefit may impose a deductible on covered services, but any deductible in a comprehensive supplemental

benefit is governed by the requirements of a qualified plan, Minn. Stat. 62E.06 Subd. 1.

Some HMOs submitted comments to the proposed rules which objected to the inclusion of the term "self-referral" in the definition of a supplemental benefit. They requested that the rules allow them to require an enrollee to get a general referral for the type of service desired before they could use their supplemental benefit. The legislative intent of permitting HMOs to underwrite supplemental benefits was to allow benefits similar to insurance benefits, which are obtained without referral. One HMO submitted comments which stated that enrollees want supplemental benefits that do not require a referral from their HMO. This issue will be addressed in more detail in the discussion of subpart 2.

Subpart 2. General Requirements On Provisions Of Coverage.
The requirements section of this rule establish that supplemental benefits may not be used by an HMO as a substitute for the comprehensive health maintenance services required for HMO coverage. This requirement is established by the Legislature in Minnesota Statutes 62D.05, Subdivision 6(b).

The Department of Health has received complaints from some health care providers that HMOs are no longer covering their services, as they did when supplemental benefits were provided through insurance companies. HMOs have justified this change by explaining that

coverage for the services of certain providers was required by the insurance statutes, Minnesota Statutes Chapter 62A, but were not required by the HMO statutes, Chapter 62D. Since supplemental benefits provided directly by the HMO are not subject to the provisions of Chapter 62A, the HMO was free to exclude certain classes of providers from coverage under supplemental benefits, such as chiropractors, osteopaths, and nurse practitioners.

The 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. Minn. Stat. 62D.05 Subdivision 6(b) states: "[t]he commissioner, in adopting rules, shall give consideration to existing laws and rules administered and enforced by the Department of Commerce relating to health insurance plans". The Department reviewed Commerce and other rules and laws relating to coverage of services by classes of providers. The proposed rules require that, unless a classification of practitioners are specifically excluded from coverage in the evidence of coverage, supplemental benefits must provide coverage for services provided by any practitioner credentialed under Minnesota Statute Chapter 214 who provides the covered services. Chapter 214 sets out the requirements and procedures for the licensing or registering of all health care professionals in Minnesota.

This subpart includes the provisions from Chapter 62A prohibiting the exclusion of certain types of practitioners from coverage under the supplemental benefits. This will require HMOs to provide coverage for the same classes of providers whether the supplemental benefit is provided by the HMO or by an insurance company.

Supplemental benefits may not be denied solely for failure to obtain prior authorization from the HMO. This policy is consistent with Minn. Stat. 62D.11, Subd. 4 regarding prior authorization for comprehensive health maintenance services. However, after discussions with HMOs, the Department has determined that when an enrollee uses supplemental benefits the HMO loses some of its ability to manage that enrollee's care because the provider of that service is not a part of the HMO network. The quality of care received may then be diminished if the HMO does not have the opportunity to provide a second opinion before surgery or suggest alternative treatment methods. In response to this concern by the HMOs, the proposed rule permits an HMO to impose a limited assessment on coverage of up to 20 percent of the usual and customary fee for the service received if the enrollee does not get prior authorization for the service from the HMO, but does not permit the HMO to deny coverage altogether. This limitation will give the enrollee an incentive to discuss the proposed treatment with the HMO in advance but will not exclude coverage of the service if prior authorization is not requested.

Comments received from HMOs suggest that they be permitted to require a referral for supplemental benefits, as discussed above, or to permit an assessment of up to 25% for failure to obtain prior approval.

There is no financial data available to indicate what percentage of assessment would be optimal to encourage enrollees to cooperate with the HMOs' prior approval requirements for supplemental benefits. None of the HMOs which requested a higher level of assessment submitted any financial data to support their request. The Department of Health has discussed the level of assessment with the Department of Commerce to determine the applicable rules for insurance coverage. Insurance companies are permitted to assess up to 25 percent for failure to obtain prior approval for services. However, insurance companies and HMO supplemental benefits provided through insurance are required to provide at least 80 percent coverage for services. Under the proposed rules, an HMO may provide a lower level of coverage for a limited supplemental benefit. In consideration of the differences in required coverage levels between HMOs and insurance companies and without data to support a specific percentage of assessment, 20 percent is a reasonable incentive without becoming a penalty for failure to get prior approval.

Subpart 3. Disclosure Of Comprehensive Supplemental Benefits.

All contracts for comprehensive supplemental benefits must contain

a detailed description of the coverage available including the level of coverage, all out-of-pocket expenses, and claims filing procedures. The claims filing procedures must be in accordance with Minnesota Statutes 72A.201. This requirement is established by the Legislature in Minnesota Statutes 62D.05, Subdivision 6(a)(3). It is important for the HMO to fully explain the claims processing procedures in the supplemental benefits section of the contract because enrollees are not accustomed to filing claims under the comprehensive health maintenance services contract. Claims under the HMO side of their coverage are filed by the providers directly with the HMO and the enrollee is not involved. Since supplemental benefits cover services delivered to the enrollee by providers who are not a part of the HMO network, the providers will bill the enrollee who must know how to process the bills for payment. This may be the first instance in which some enrollees are required to file claims.

Subpart 4. Disclosure Of Limited Supplemental Benefits. Contracts for limited supplemental benefits must contain the same basic information as the contract for comprehensive supplemental benefits with the exception that the limited supplemental benefits contract must include a concise description of the benefits covered by the contract. Benefits must be listed separately with specific descriptions of any limitations, copayments or deductibles set out for each benefit. Since the purpose of allowing HMOs to provide their own supplemental benefits was to increase the flexibility

available in benefits packages, it is important that each enrollee or group clearly understand what benefits are offered as supplemental benefits. A plan could offer a single benefit or a nearly comprehensive package. The enrollee cannot fully utilize benefits without a clear understanding of what coverage is available.

Subpart 5. Consumer Information.

The proposed rule requires a statement of consumer rights for supplemental benefits, similar to the consumer information requirements for comprehensive health maintenance services. These rights must be set out separately from the general statement of consumer rights because there may be necessary differences when applied to supplemental benefits.

The proposed rule sets out the form in which these rights must be presented and provides recommended language for both comprehensive and limited supplemental benefits. The proposed rule also establishes where the consumer information must appear in the contract, depending on the layout of the contract. This is necessary because consumers need to know their rights as they apply specifically to the supplemental benefits, not just their rights generally. This information needs to be physically close to the other supplemental benefits information so that the consumer can adequately evaluate all relevant information in choosing to use supplemental benefits, which may have different rights,

limitations, and obligations from the comprehensive health maintenance services described in the other sections of the contract.

In its comments about the proposed rules, one HMO suggests that this requirement will unduly lengthen the certificate of coverage and would restrict its flexibility in product design. It suggests that the listed consumer information be removed from the rule (and therefore the certificate of coverage) and be used by the Department as a check list to determine whether the necessary information is contained somewhere in the certificate of coverage. This change would require both the enrollees and the Department to determine what consumer information is contained in the certificate of coverage in a piecemeal manner. The information could be scattered throughout the contract. Enrollees should find all of the important consumer information in a single place and stated in a clear and concise manner. The benefits of listing the consumers' rights outweigh potential problems in the flexibility of product design.

Subpart 6. Out-Of-Pocket Expenditures.

An enrollee's out-of-pocket expenses associated with supplemental benefits have raised several questions regarding the maximum out-of-pocket expenses allowed by an HMO. When HMOs could only offer supplemental benefits through a separate contract with an insurance company the contract could impose deductibles and copayments which

applied to the supplemental benefits, subject to a maximum out-of-pocket limit for that contract. Several HMOs have indicated in their comments that they should be permitted to have a separate out-of-pocket limit for a supplemental benefit provided by an HMO. This would increase the total amount an enrollee would need to pay out-of-pocket for HMO coverage that included supplemental benefits.

HMOs may continue to offer supplemental benefits through separate insurance contracts. However, if they choose to offer them as a part of the HMO contract, those benefits are subject to Minn. Stat. 62D.02, subd. 8 which prohibits out-of-pocket expenditures in excess of those permitted for a number three qualified policy under Minn. Stat. 62E.06. Section 62E.06 sets the annual out-of-pocket maximum at $3,000. This limit applies to the HMO contract as a whole which includes supplemental benefits provided by the HMO.

If an HMO wants to limit the use of supplemental benefits by imposing higher out-of-pocket expenses limits, it may do that by allocating the $3,000 maximum between the supplemental benefits and the comprehensive health maintenance services. This will permit the enrollee to weigh the cost to the enrollee of receiving services through supplemental benefits against the cost of services through the comprehensive health maintenance services contract. It will also encourage the enrollee to stay within the comprehensive health maintenance services as much as possible without creating additional cost restrictions.

Subpart 7. Annual Reports.

Minnesota Statutes 62D.05, Subdivision 6 establishes the option for HMOs to provide supplemental benefits without contracting with a licensed insurance company. Subdivision 6(a)(2) establishes the amount of additional surplus an HMO must have if it offers supplemental benefits pursuant to 62D.05. The additional surplus amount depends on the number of years the HMO has offered the supplemental benefit. Subpart 7 of the proposed rule requires the HMOs to provide a schedule analyzing the previous year's estimation of incurred but not reported supplemental benefits claims and a schedule detailing claim development. This information is reasonably required in order to determine whether the appropriate statutorily required surplus is in place.

Subpart 8. **Estimation of incurred but not reported claims.**

Subpart 8 of the proposed rules sets out the method of estimating incurred but not reported claims which is required by subpart 7. The estimate must be done in accordance with generally accepted actuarial methods. The reserves required in connection with the estimated liability will be tested for adequacy and reasonableness by reviewing the HMO's claim runoff schedules in accordance with generally accepted accounting principles. The reserves, along with the runoff schedules, will be reported annually in the schedule required under subpart 7 A of the proposed rules.

Subpart 9. Accrued supplemental benefits claims.

The most reasonable method of requiring supplemental benefits claims data reporting is to require the same standardized forms currently used for reporting comprehensive health maintenance services claims data. NAIC BLANK FOR HEALTH MAINTENANCE ORGANIZATIONS, REPORT #1-B has been modified for supplemental benefits use by adding a line for accrued supplemental benefits claims. Subpart 9 requires HMOs to submit a separate REPORT #1-B for supplemental benefits as part of their annual report, along with a separate schedule detailing direct claims adjusted or in the process of being adjusted. These reporting requirements will permit the HMOs to report their supplemental benefits data using reports that are essentially the same as the reports they currently submit for their comprehensive health maintenance services claims, and will provide the necessary information for the Department of Health to verify that the appropriate surplus is in place for supplemental benefits.

GENERAL STATEMENT OF NEED AND REASONABLENESS - TERMINATION OF COVERAGE

The proposed changes to the rules for termination of coverage address two problems which became evident through the experience of the Department of Health and HMOs working with the existing rules. First, under certain circumstances, the individual members of groups were not receiving any notice that the group as a whole was being terminated for nonpayment of premiums. Both state and federal laws encourage giving enrollees sufficient notice of termination to afford them sufficient time to arrange for other coverage.

Second, enrollees of groups which were terminated for nonpayment of group premiums have been required to make significant conversion premium payments in order to qualify for conversion to an individual plan, even though it was the employer who failed to make the group premium payments. The proposed rule changes establish 60 days as the maximum period of retroactive conversion premiums an enrollee must pay to qualify for conversion. The 60 day period corresponds to a 30 day grace period to pay late premiums plus 30 days notice of cancellation.

PART BY PART STATEMENT OF NEED AND REASONABLENESS - TERMINATION OF COVERAGE

Minnesota Rules Part 4685.2200, Termination Of Coverage.

Subpart 1. Definitions.

Subpart 1 was added to the termination rules in order to provide definitions for the terms used in the proposed rules. The proposed rules use three dates, each of which has a distinct meaning and impact on the rules. By providing the definitions of these dates the proposed rules eliminate confusion or possible misinterpretation of their meaning.

Subpart 1a. Justification.

This subpart, and all subsequent subparts, have been renumbered to accommodate the addition of the definitions as Subpart 1. Part A of this Subpart was changed by inserting the word "within" before the phase "six months of the date of enrollment" in the last sentence. This word was inadvertently omitted from the original rule.

Part B was changed to permit the HMOs to receive notice of the change of address of an enrollee from a source other than the enrollee. This change is in response to HMO comments stating that enrollees often do not notify their HMO when they move. The HMO does, however, sometimes learn of an enrollee's change of address from other sources.

The source must be reliable and the HMO must confirm that the enrollee has moved out of the service area before it sends the enrollee a notice of termination. If a notice of termination is sent without confirmation of the enrollee's new address, the HMO has no reasonable expectation that the notice was received by the enrollee.

The Department has also learned through experience that enrollees may be unnecessarily upset if the HMO uses the notice of termination as a means of confirming whether the enrollee has moved out of the service area and the enrollee has, in fact, not moved.

Subpart 2. Notice. The Department of Health has received complaints from the public indicating that group coverages have been cancelled without the prior knowledge of the enrollees in the group. When such complaints were investigated, the Department learned that the HMOs had given the required notice pursuant to Minn. Rules 4685.2200 subp. 2 which states:

> In any situation where 30 days notice of cancellation or nonrenewal of the coverage of a specified group plan or of the coverage of any individual therein is required, notice given by a health maintenance organization to an authorized representative of any such group shall be deemed to be notice to all affected enrollees in any such group and satisfy the notice requirement of the act.

In situations where a group may be terminated because the employer has not made timely payments of the group premium, the HMOs generally give the employer several months to correct the situation. When payments are not received the HMOs then give 30

days notice to the employer that coverage will be terminated. The termination is effective retroactively, that is, coverage ends on the last day of the last month for which a premium was paid. In some situations, this can be as much as, or more than, three or four months prior to the effective date of the notice.

In such a situation, employers generally do not voluntarily tell their employees that the group coverage will be terminated as a result of the employer's failure to comply with its agreement to pay the monthly premiums. Therefore, the notice given by the HMO to the employer may never reach the individual enrollees.

The paragraph in Subpart 2 which permits notice of a group termination to be sent to the authorized representative of the group has been changed to include an exception for the provisions of a new Subpart 2a which controls the notice requirements for termination of a group for nonpayment.

A new paragraph added to Subpart 2 states that when a group notifies the HMO of its voluntary cancellation of coverage, the HMO is not required to send notice of termination to the group. Since the group has notified the HMO there is no benefit to sending a notice of termination to the group simply as a formality.

In addition, a paragraph which relieved the HMO of any obligation to provide health care services after the last date for which payment could reasonably be expected was deleted. The changes to that paragraph were incorporated into the new Subpart 2a.

Subpart 2a. Notice Of Cancellation To Group Enrollees.

Subpart 2a is a new addition to this rule. It requires an HMO to send notice of termination of a group for nonpayment directly to the enrollees in that group. Minn. Stat. 62D.12, Subd. 2a requires HMOs to provide 30 days notice of cancelation to all enrollees. The existing rule permits HMOs to send notice to the authorized representative of the group in order to satisfy the notice requirement. The proposed rule requires that each enrollee be notified. This change is necessary to insure that each enrollee knows in advance that coverage is being terminated.

The notice must include a statement of the enrollees' rights under Minn. Stat. 62E.16, which requires HMOs to offer conversion to an individual plan, without underwriting restrictions, to every enrollee of a terminated group.

HMOs have expressed concern that they do not have accurate records of all group enrollees. This information is supplied to them by the employer as stated in Minn. Stat. 62E.16, which also requires the HMO to provide notice of termination to the enrollees. The notice requirement in the proposed rules should not increase the

burden of getting an accurate enrollee list because it is already needed in order to send the conversion notices required under existing law.

In order to qualify for conversion, enrollees must have had continuous coverage under the group plan. This means that the enrollee currently must pay a significant lump sum, representing retroactive conversion premiums, to qualify for conversion. HMOs sometimes permit employers several months in which to pay past due amounts before giving them notice of termination, and in some cases, agree by contract to permit the employer several months to pay for coverage. The HMOs, through their representatives to the Department's meeting with the HMO Council, indicate that this time is needed, especially by large employers, to process their payments. If the payment is not made at that time, 30 days notice of termination is sent to the employer by the HMO. For example, by contract, a group is given 90 days to pay. If it does not pay at that time, the HMO sends the employer 30 days notice of termination. The cancellation date is the last day of the last month for which the group premium was paid. Any enrollees of that group who want to convert to an individual plan without underwriting restrictions, must pay four months conversion premiums, even if they are told of the termination in a timely manner. If they are not aware of the situation for some time, the lump sum conversion premium will be even higher. To make the situation worse on the enrollee, in some cases, a portion of the

group premium has already been paid to the employer by the enrollee.

Enrollees who choose not to convert and instead apply for individual coverage on their own, must pay for any health services received after the cancellation date. They must also pass any underwriting restrictions and preexisting conditions exclusions which apply to an individual plan.

It is not reasonable to place the entire burden of unpaid health care coverage on the enrollee who has been unaware that the group premiums were not paid on a timely basis and, in fact, may have paid a portion of the group premium. Subpart 2a prohibits the HMO from billing an enrollee for more than 60 days of retroactive conversion premiums or for services received prior to the cancellation date. If, for business reasons, an HMO wishes to permit an employer to take more than 60 days to pay monthly premiums, it may do so but it cannot place the risk of nonpayment entirely on the enrollees.

The 60 day period is reasonable when the enrollees have notice that their coverage will be terminated retroactively. This gives them an opportunity to explore available options regarding other coverage and alerts them that they will be liable for any health care services they receive after the cancellation date, unless they

pay the conversion premiums. Since the payment of the retroactive conversion premiums will provide them with continuous coverage, they do get value for their payment. The HMOs should not be required to provide their products without receiving payment, but they should also not be permitted to extend additional time for payment to the employers without assuming some of the risk inherent in that practice.

Some HMOs commented that there should be a statutory change, similar to Minn. Stat. 62A.17, which places the burden of past due premiums on the employer. Minn. Stat. 62A.17 states in relevant part:

> Subd. 4. Responsibility of employer. After timely receipt of the monthly payment from a covered employee, if the employer... fails to make the payment to the... health maintenance organization, with the result that the employee's coverage is terminated, the employer... shall become liable for the employee's coverage to the same extent as the... health maintenance organization would be if the coverage were still in effect.

Minn. Stat. 62A.16 already specifically applies Minn. Stat. 62A.17 to HMOs. The problem with this statute is that the enrollees' employment must be terminated in order for liability to fall on the employer. The employee who is still at work and paying a portion of the HMO premium to the employer through a payroll deduction is not protected by Minn. Stat. 62A.17 if the employer fails to make the monthly premium payments.

In addition, the employee must sue the employer for recovery of the premium paid by the enrollee or the value of the coverage. In

situations where the employer is bankrupt, there is no practical value to placing liability on the employer. Another difficulty with 62A.17 as a remedy is that if the employer has agreed to pay the entire monthly premium, the enrollee has made no timely monthly payment and no liability arises.

Subpart 2a specifies that the enrollee may be charged for no more than 60 days retroactive conversion premiums. The HMO may extend the payment period beyond 60 days but if it terminates the group for nonpayment after that time it must recover the difference from the employer or absorb the cost itself.

The provisions of Subpart 2a may influence the HMOs to terminate groups sooner. It is in the best interest of the enrollees to know as soon as possible when there is a problem with their coverage. They must also be fully aware of the situation in order to make informed decisions about their health coverage. In order for that to happen, they must receive direct notice of termination in situations where the employer has stopped cooperating with the HMO.

It is reasonable to require the HMOs to share some risk of extending more time to the employer to pay premiums. If they are unwilling to bear some risk of such an agreement, they should not be permitted to transfer that risk to enrollees who cannot influence the decision to extend the time to pay.

Subpart 3. Termination of dependents at limiting age.

The substance of Subpart 3 has not been changed. The language and sentence structure have been changed to make the subpart more clear but no requirements have been added or changed.

STATE OF MINNESOTA
DEPARTMENT OF HEALTH

Date 11/22/91

Marlene E. Marschall
Commissioner