STATE OF MINNESOTA
DEPARTMENT OF HEALTH

In The Matter Of The Proposed Rules Of The Department Of Health Governing Aggregate Data From Group Purchasers - Chapter 4652

STATEMENT OF NEED AND REASONABLENESS

Statutory Authority

The Commissioner's statutory authority for collecting health care data from group purchasers and for adopting these rules is found in Minnesota Statutes, section 62J.35, subdivisions 1 and 5, which state:

> **"62J.35 DATA COLLECTION.**
>
> Subdivision 1. **Data collection by commissioner.** For purposes of forecasting rates of growth in health care spending and setting limits under section 62J.04, subdivisions 1 and 1a, the commissioner may collect from health care providers data on patient revenues and health care spending received during a time period specified by the commissioner. The commissioner may also collect data on health care revenues and spending from group purchasers of health care. Health care providers and group purchasers doing business in the state shall provide the data requested by the commissioner at the times and in the form specified by the commissioner. Professional licensing boards and state agencies responsible for licensing, registering, or regulating providers shall cooperate fully with the commissioner in achieving compliance with the reporting requirements.
>
> Subd. 5. **Rules.** The commissioner shall adopt permanent rules and may adopt emergency rules to implement the data collection and reporting requirements in this chapter. The commissioner may combine all data reporting and collection requirements into a unified process so as to minimize duplication and administrative costs." (Subdivisions 1 and 5 were not changed by 1994 Minnesota Laws, chapter 625.)

Statutory authority for requiring group purchasers to collect and provide financial and statistical data to the Commissioner is found in Minnesota Statutes, section 62J.38, which states:

> **"62J.38 DATA FROM GROUP PURCHASERS.**
>
> (a) The commissioner shall require group purchasers to submit detailed data on total health care spending for calendar years 1990, 1991, and 1992, and for calendar year 1993 and successive calendar years. Group purchasers shall submit data for the 1993 calendar year by April 1, 1994, and each April 1 thereafter shall submit data for the preceding calendar year.
>
> (b) The commissioner shall require each group purchaser to submit data on revenue, expenses, and member months, as applicable. Revenue data must

distinguish between premium revenue and revenue from other sources and must also include information on the amount of revenue in reserves and changes in reserves. Expenditure data, including raw data from claims, must be provided separately for the following categories: physician services, dental services, other professional services, inpatient hospital services, outpatient hospital services, emergency and out-of-area care, pharmacy services and prescription drugs, mental health services, chemical dependency services, other expenditures, subscriber liability, and administrative costs.

(c) State agencies and all other group purchasers shall provide the required data using a uniform format and uniform definitions, as prescribed by the commissioner." (Includes updates from 1994 Minnesota Laws, chapter 625.)

Additional statutory authority for requiring group purchasers to collect and provide financial and statistical data to the Commissioner is found in Minnesota Statutes, section 62P.04, subdivisions 3 and 4, which state:

"**62P.04 INTERIM HEALTH PLAN COMPANY EXPENDITURE LIMITS.**

Subd. 3. **Determination of expenditures.** Health plan companies shall submit to the commissioner of health, by April 1, 1994, for calendar year 1993; April 1, 1995, for calendar year 1994; April 1, 1996, for calendar year 1995; April 1, 1997, for calendar year 1996; and April 1, 1998, for calendar year 1997 all information the commissioner determines to be necessary to implement and enforce this section. The information must be submitted in the form specified by the commissioner. The information must include, but is not limited to, expenditures per member per month or cost per employee per month, and detailed information on revenues and reserves. The commissioner, to the extent possible, shall coordinate the submittal of the information required under this section with the submittal of the financial data required under chapter 62J, to minimize the administrative burden on health plan companies. The commissioner may adjust final expenditure figures for demographic changes, risk selection, changes in basic benefits, and legislative initiatives that materially change health care costs . . . .

Subd. 4. **Monitoring of reserves.** (a) The commissioners of health and commerce shall monitor health plan company reserves and net worth as established under chapters 60A, 62C, 62D, 62H, and 64B, with respect to the health plan companies that each commissioner respectively regulates to ensure that savings resulting from the establishment of expenditure limits are passed on to consumers in the form of lower premium rates." (Includes updates from 1994 Minnesota Laws, chapter 625.)

Specific references to other statutory authority and statutory directives will be given as appropriate in the General Statement and the Rule-By-Rule Analysis sections of this Statement Of Need And Reasonableness.

General Statement Of Need And Reasonableness

The proposed rules set out the reporting requirements for group purchaser financial and statistical data. The proposed rules state who is required to report the data and list the data

elements which must be annually reported. The proposed rules specifically define the data elements to ensure that uniform and accurate data are reported. The proposed rules also include provisions for reporting dates, extensions, and review of reports.

Legislative History - Health Care Reform - MinnesotaCare Act - Data Collection Objectives

Minnesota's health care reform initiative encompasses a wide range of activities. The primary goal is to provide universal coverage for health care while maintaining the quality of the care and reducing the rate of growth in current health care expenditures. Cost containment was clearly a part of the 1992 HealthRight Act and is the vehicle to achieve savings that could be used to expand coverage to the currently uninsured. The 1992 legislation provided a framework for the overall approach to cost containment; the rate of growth in health care spending must be reduced by 10 percent each year beginning in 1993 and the Commissioner of Health was required to establish enforceable statewide and regional limits on the rate of growth of health care spending for Minnesota residents. The 1992 legislation established a 25-member commission (The Minnesota Health Care Commission) of providers, payers, and consumers to develop a cost containment strategy and report back to the Legislature in 1993. The Minnesota Health Care Commission met bimonthly for a period of six months to develop and report its cost containment strategy to the Legislature. The Commission's basic proposal, with some modification of the details, was passed by the Legislature as part of the 1993 health reform legislation.

The three key components of Minnesota's cost containment strategy include the following: 1) Integrated Service Networks (ISNs) that agree to provide a defined set of benefits for a fixed price; 2) the Regulated All-Payer Option (RAPO) that sets standardized payment rates for payers and providers who do not participate in ISNs; and 3) overall limits of the rate of growth for health care expenditures for the State.

The framework underlying the strategy of expenditure limits chosen by the state of Minnesota requires that one be able to quantify state health care expenditures and monitor the expenditures and their trends over time. There is currently limited data available on health care spending at the state level. The federal Health Care Financing Administration (HCFA) publishes estimates on health care spending by state; once in 1982 and just recently in 1993. However, the method used by HCFA actuaries does not provide the detailed information needed to effectively implement and enforce spending limits at the state level. In addition, much of the work done in estimating state-level spending is developed by manually pulling together a diverse set of information from various data sources and this time-consuming compilation of disparate data sources must be re-enacted every year to keep the numbers up to date.

Minnesota's objective was to develop its own method and state infrastructure for collecting information on health care spending for the purposes of quantifying and monitoring health care expenditures and enforcing the limits on the rate of growth of that spending. State-level data would be more accurate, more timely, and could be tied to individual payers and provider groups for accountability purposes. In addition the data could be used to inform policy makers on the impact of health care reform.

The Health Care Commission recommended using a two stage strategy for data collection that included: (1) a short-term initiative to provide immediate information from payers on a significant, but not complete, picture of health care spending that will be used to establish a growth trend for 1991; and (2) a more comprehensive data collection plan to provide more detailed data based on aggregate surveys of providers and payers and encounter-level data that can be used to monitor spending and growth patterns over time. The framework for defining the elements to include in health care spending is based on the framework used by HCFA National Health Expenditure accounts to estimate national expenditures.

The short-term data collection strategy used to establish the 1991 baseline of health care expenditures clearly did not capture all health care expenditures of interest. The data do not represent all payers nor all types of health care expenditures. Other expenditures of interest that were not reviewed as part of the short-term strategy include out-of-pocket expenditures, charity care and bad debt, technology, research and education, and capital expenses. Several provider groups felt strongly that by relying on payer-level data to set expenditure limits, the Department would miss several important components, namely bad debt, charity care and out-of-pocket costs. In response, a physician-clinic survey was developed to supplement hospital financial information as part of the long-term data collection strategy.

The goal of the long-term data collection strategy was to collect aggregate data on health care revenues and expenditures by payer type and service category for all public and private payers. The state has several data sources that while not all-inclusive are helpful in building the process for data collection for other payers and providers. Minnesota has long-standing data collection requirements for aggregate financial data from hospitals and HMOs and detailed information on its public programs. The largest gaps include the lack of information on physician services and other providers.

The data collection strategy involves collecting: 1) aggregate data on health care revenues and expenditures by payer type and service category for both public and private programs, and 2) disaggregated claims paid and encounter level data provided by payers. This data will be used to track total health care expenditures and revenues in the State of Minnesota. Attention will be given to the data collection and aggregation process to avoid any double counting. The two levels of data will be used to document revenues and expenditures and to cross check the data provided through each method. More detailed information will be needed for both the provider and payer groups including but not limited to the identification of Minnesota and non-Minnesota residents and the county of residence to be able to establish regional spending and growth targets.

Aggregate data from HMOs (and eventually ISNs) and hospitals will be based on modified versions of existing annual financial reporting forms. New surveys were developed for commercial insurers, Blue Cross/Blue Shield, self-insured plans, and physician clinics.

In order to estimate and monitor health care spending in the State of Minnesota for the purposes of establishing spending limits more precise state-level data is needed. A primary objective has been to collect uniform and consistent state-level data in a routine and efficient manner on an ongoing basis. The Health Care Commission's report to the Legislature

outlined the key assumptions for data collection. These include the following: 1) Health care revenue and spending data will be routinely collected from both payers and providers of health care services. 2) Data will be collected annually based on consistent guidelines and data definitions. 3) The data set will include as a base, expenditures and revenues for health care services contained in the set of basic benefits generally included in health coverage programs. 4) The expenditure data base will be limited in the initial years but will evolve as additional sources of data are developed and submitted. 5) Data definitions and data collection techniques will be refined over time to ensure the collection of uniform and accurate data on health care spending and to assess the balance between the need for accurate data and the costs associated with collecting the data.

Other Statutory Sections Relating To Group Purchaser Data Requirements

Under Minnesota Statutes, section 62J.04, subdivision 1a, paragraph (a), the Commissioner of Health is required to "report to the legislature by February 15 of each year on differences between the projected increase in health care expenditures, the actual expenditures based on data collected, and the impact and validity of growth limits within the overall health care reform strategy." (Includes updates from the 1994 MinnesotaCare Law.) To do the report required under this section, it is necessary for the Commissioner to collect data from group purchasers on actual expenditures.

Under Minnesota Statutes, section 62J.04, subdivision 1a, paragraph (f), the Commissioner of Health is required to "report to the legislative commission on health care access by December 1, 1994, on trends in aggregate spending and premium revenue for health plan companies. The commissioner shall use data submitted under section 62P.04 and other available data to complete this report." (Paragraph (f) was added to section 62J.04 by the 1994 MinnesotaCare Law.) Admittedly, paragraph (f) will not use the data collected under the permanent rules because the report is due before the permanent rules collect data. However, the Department should use the permanent rules to collect data on aggregate spending and premium revenue because it is likely that the Legislature will want reports on these matters in the future.

Minnesota Statutes, section 62J.35, subdivision 3, states: "All data received under this section or under section 62J.04, 62J.37, 62J.38, 62J.41, or 62J.42 is private or nonpublic, except to the extent that it is given a different classification elsewhere in this chapter. The commissioner shall establish procedures and safeguards to ensure that data released by the commissioner is in a form that does not identify specific patients, providers, employers, purchasers, or other specific individuals and organizations, except with the permission of the affected individual or organization, or as permitted elsewhere in this chapter." (Includes updates from the 1994 MinnesotaCare Law.)

Uses For Group Purchaser Data

The group purchaser data collected pursuant to these rules will assist analysts with public policy decisions and will also assist group purchasers in comparing their expenditures to aggregated data from all group purchasers. Ultimately the data collection should provide the information needed to monitor cost savings in the health care system. The financial and statistical data collected by the Department will serve the following purposes:

1) The aggregate group purchaser data will be used to form a total picture of the baseline levels of health care expenditures and to monitor trends in how expenditures are changing over time.

Currently there are only rough estimates on all aspects of health care expenditures. Analysts are unable to quantify billing and collection costs, out-of-pocket costs, research and education costs, and other cost categories. Policy makers need accurate numbers to develop a total picture of health care spending as a basis to make informed public policy decisions. Once a complete picture of health care spending is developed, trends in spending can be monitored over time.

2) The aggregate group purchaser data will be used to monitor and enforce compliance with statutory growth limits. The data will also be used to help refine growth limit methodology and enforcement policy.

The Commissioner is directed by Minnesota Statutes, section 62P.04, subdivision 3, to monitor and enforce compliance with growth limits. The Commissioner is specifically directed to coordinate the collection of data for this purpose with the collection of data under Minnesota Statutes, chapter 62J. The data used for this purpose would include expenditures per member per month or cost per employee per month, and detailed information on revenues and reserves. The experience gained by the Department in monitoring and enforcing compliance with growth limits will be valuable in refining growth limit methodology and enforcement policy.

3) The aggregate group purchaser data will be used to study the impact of health care reform and to evaluate the success of reform in controlling health care spending. The data will also be used by policy makers to set the future direction of health care reform.

What effect will MinnesotaCare reforms have on expenditures? Which costs are increasing or decreasing or remaining the same? Researchers will use the information to monitor the trends in health care expenditures and evaluate the impact of health care reform on health care costs as reported in the survey. The data will also be monitored to identify areas where health care spending is of particular interest.

4) The aggregate group purchaser data will be used to monitor revenues and reserves and consumer cost sharing to ensure that savings resulting from growth limits are passed on to consumers in the form of lower premiums.

The Commissioner is directed by Minnesota Statutes, section 62P.04, subdivision 4, to ensure that health plan companies' savings achieved due to complying with the state mandated growth limits are passed on to consumers in the form of lower premium rates. The data provided on trends in consumer cost-sharing including copayments and deductibles will also be monitored to ensure savings are passed on to consumers and that limits aren't met by shifting costs to consumers.

5) The aggregate group purchaser data will be used to measure and track spending associated with major administrative functions.

Minnesota Laws 1993, chapter 345, article 3, section 17, mandated that the Department "study costs and requirements incurred by health carriers, group purchasers, and health care providers that are related to the collection and submission of information to the state and federal government, insurers, and other third parties." The Department was also required to "evaluate and make recommendations related to cost-savings and efficiencies that may be achieved through streamlining and consolidating health care administrative, payment, and data collection systems." The Data Collection Advisory Committee recommended that administrative costs data be collected in functional categories. Aggregate administrative costs data will be collected from group purchasers by functional areas where administrative dollars are spent. This will help identify areas where expenses are increasing or decreasing, and where opportunities exist for administrative savings.

6) The aggregate group purchaser data can be used in certain ways by group purchasers to enhance their business and the industry.

Note first that an individual group purchaser's data is considered private data and will not be available to other group purchasers or the public, except when aggregated with other group purchaser data. Individual group purchasers can use their own data to track their own costs over time. Individual group purchasers can also compare their own costs to aggregate costs for all group purchasers, and after taking into consideration its own unique characteristics, the group purchaser can identify areas where opportunities exist for savings. Group purchasers might even use the aggregate group purchaser data to identify areas where they might advocate for improvements to the health care system.

<u>Four Data Collection Initiatives - Emergency Rules - Input Into The Development Of The Permanent Rules</u>

In response to the data collection and analysis requirements in the 1993 MinnesotaCare Law, the Department embarked on the development of four sets of related data collection rules: 1) aggregate data from hospitals; 2) aggregate data from health care providers; 3) aggregate data from group purchasers; and 4) encounter level (or claims) data from group purchasers.

In January 1993, based on a directive in the 1992 health reform legislation, the Commissioner convened a special work group of the Data Collection Advisory Committee to advise the Department on issues related to the collection of administrative costs data. The Department also communicated with affected parties and received input regarding data collection issues and procedures. Based on the statutory directives and the input from affected parties, the Department developed draft data collection instruments. In June 1993, the Department informed affected parties of what the new reporting requirements would likely be.

The Department proposed four sets of emergency rules on October 4, 1993. The emergency rules were adopted on November 19, 1993, were approved by the Attorney General on December 7, 1993, and became effective December 14, 1993. The emergency rules are effective through December 8, 1994. The emergency rules governed the 1994 data collection survey of 1993 data. The proposed permanent rules will replace the emergency rules and will govern data collection surveys beginning in 1995. The first survey under the permanent rules will cover 1994 data.

Immediately after the adoption and approval of the emergency rules, the Department began work on the development of the permanent rules. It was the Department's plan to have four work groups to advise the Department on the development of the permanent rules, one for each set of rules. The Department then approached the Minnesota Health Data Institute for input regarding the role the Institute wanted in advising on the development of the rules. (The Minnesota Health Data Institute is created under Minnesota Statutes, section 62J.45, and is a public-private partnership between the Commissioner of Health and a Board of Directors representing health carriers and other group purchasers, health care providers, and consumers.) Based on the suggestions of the Data Institute, the Department formed an advisory task force in addition to the four advisory work groups. The task force oversaw the work on all four sets of rules and coordinated the work on issues common to more than one set of rules. The task force consisted of 12 members, half from the Data Institute and half appointed by the Department. The work groups were to be made up of persons technically qualified to advise on data collection issues. The Department's goal was to accommodate all persons who wanted to participate on the work groups.

On January 18, 1994, the Department published in the State Register a Notice Of Solicitation Of Outside Information Or Opinions notifying the public of the Department's plans to develop rules and to form a task force and four work groups to advise on the development of the rules. The Solicitation invited all interested persons to contact the Department. The Solicitation was also mailed to persons on the Department's rulemaking mailing list, to persons who had commented on the proposed emergency rules, and to other persons identified by the Department as likely to be interested in the permanent rules.

The first meeting of the task force and work groups was on March 3, 1994. The group purchaser work group met nine times from March through June 1994. The task force met four times.

The work group did not endorse the concept of a survey, but, given the requirement, felt the survey under the permanent rules would be a good survey and an improvement from the survey under the emergency rules.

Persons who participated in one or more group purchaser work group meetings were:

Mark Bjornson, Prudential
Kevin Brandt, HealthPartners
Steve Bunde, HealthPartners
Judy Busse, Blue Cross and Blue Shield of Minnesota
Dick DiFalco, Delta Dental

Michelle Hegarty, Medica
Michele Hostager, Prudential
Joan Johnson, Northwestern National Life
Nancy Krogstad, Fortis
Norma Porter, Delta Dental
Bob Power, HealthPartners
Susan Quint, Blue Cross and Blue Shield of Minnesota
Dan Rydel, Blue Cross and Blue Shield of Minnesota
Carrie Schulz, Mid-America Mutual
Anne Marie Seward, Metropolitan Health Plan
Patti Warden, Medica
Sandy Abrams, Minnesota Department of Health
Michelle Barnes Lewis, Minnesota Department of Health
Jim Golden, Minnesota Department of Health
Dave Orren, Minnesota Department of Health
JoMarie Williamson, Minnesota Department of Health

Small Business Considerations

Minnesota Statutes, section 14.115, requires the Department of Health to consider the effect on small businesses when it adopts rules. For purposes of this section, "small business" means a business entity, including farming and other agricultural operations and its affiliates, that (a) is independently owned and operated; (b) is not dominant in its field; and (c) employs fewer than 50 full-time employees or has gross annual sales of less than $4,000,000. For purposes of a specific rule, an agency may define small business to include more employees if necessary to adapt the rule to the needs and problems of small businesses.

The rules will have a direct effect on small businesses that meet the definition of group purchaser in part 4652.0100, subpart 12. These businesses are engaged in purchasing health care services on behalf of an identified group of persons. A list of the specific types of organizations that fit this definition is given in subpart 12.

Section 14.115, subdivision 2, states in part:

"When an agency proposes a new rule, or an amendment to an existing rule, which may affect small businesses ..., the agency shall consider each of the following methods for reducing the impact of the rule on small businesses:

(a) the establishment of less stringent compliance or reporting requirements for small businesses;

(b) the establishment of less stringent schedules or deadlines for compliance or reporting requirements for small businesses;

(c) the consolidation or simplification of compliance or reporting requirements for small businesses;

(d) the establishment of performance standards for small businesses to replace design or operational standards required in the rule; and

(e) the exemption of small businesses from any or all requirements of the rule."

Specific methods for reducing the impact of the rules on small businesses have been considered. In general, the rules are drafted to impose as small a burden as possible on all businesses, including small businesses. The impact of the rules on small businesses has been reduced as follows:

a. Less stringent requirements. The work group process was designed to get input from the health care industry in an effort to make these rules more workable for the industry and to get the data needed by the Department without undue burden.

b. Less stringent schedules. The rules include extensions of the filing deadline for reasonable cause. Also, the rules include the ability to correct a submission found to be incomplete, without this affecting the original filing date.

c. Consolidation or simplification of requirements. The work group process achieved significant clarification of definitions. This will simplify the process of completing the survey.

d. Performance standards. This is not applicable because there are no design or operational standards.

e. Exemption. Group purchasers with a small amount of business in Minnesota are exempted from completing the full survey. Instead, they just have to submit basic information on their Minnesota business.

Departmental Charges Imposed By The Rules

Minnesota Statutes, section 16A.1285, does not apply because the rules do not establish or adjust charges for goods and services, licenses, or regulation.

Fiscal Impact On Local Public Bodies

Minnesota Statutes, section 14.11, subdivision 1, does not apply because adoption of these rules will not result in additional spending by local public bodies in excess of $100,000 per year for the first two years following adoption of the rules.

Agricultural Land Impact

Minnesota Statutes, section 14.11, subdivision 2, does not apply because adoption of these rules will not have an impact on agricultural land.

Other Specific Statutory Requirements

Minnesota Statutes, section 62J.07, subdivision 3, requires the commissioners of health, commerce, and human services to provide periodic reports to the legislative commission on health care access on the progress of rulemaking that is authorized or required under the MinnesotaCare Law and to notify members of the commission when a draft of proposed rules has been completed and scheduled for publication in the State Register. This will be done concurrently with submitting the rules and the Notice of Intent to Adopt to the State Register for publication.

Other Statutory Requirements

Minnesota Statutes, sections 115.43, subdivision 1, and 116.07, subdivision 6, regarding pollution control and Minnesota Statutes, section 144A.29, subdivision 4, regarding nursing homes are not applicable to these rules.

Witnesses

If these rules go to a public hearing, the witnesses listed below may testify on behalf of the Department in support of the need for and reasonableness of the rules. The witnesses will be available to answer questions about the development and the content of the rules.

- Barbara Nerness, Assistant Commissioner of Health.
- Mary Kennedy, Director, Health Care Delivery Systems Policy Division, Minnesota Department of Health.
- Lynn Blewett, Director, Health Economics Program, Health Care Delivery Systems Policy Division, Minnesota Department of Health.
- JoMarie Williamson, Research Analysis Specialist, Health Care Delivery Systems Policy Division, Minnesota Department of Health.
- Dave Orren, Rulewriter, Health Care Delivery Systems Policy Division, Minnesota Department of Health.
- Michelle Barnes Lewis, Analyst, Occupational and Systems Compliance Division, Minnesota Department of Health.
- Any other employee of the Minnesota Department of Health.

Rule-By-Rule Analysis

4652.0010 INCORPORATIONS BY REFERENCE.

The rules incorporate by reference ICD-9 diagnostic codes and CPT codes. Part 4652.0010 sets out the source documents for these codes and states where these source documents are available, as required by Minnesota Statutes, section 14.07, subdivision 4.

4652.0100 DEFINITIONS.

Definitions for Indirect Health Care Expenses Categories. These definitions are discussed as a group because a single process was used to develop all of these definitions and because this process ensures the reasonableness of these definitions. Note that indirect health care expenses categories themselves and the process used to determine these categories are described in this SONAR under part 4652.0120, item E. These categories are defined in the following subparts:

Subpart 2. Billing and enrollment expenses.
Subpart 3. Charitable contributions expenses.
Subpart 5. Claim processing expenses.
Subpart 7. Customer service expenses.
Subpart 11. General administration expenses.

Subpart 20. MinnesotaCare tax expenses.
Subpart 23. Other taxes and assessments expenses.
Subpart 27. Product management and marketing expenses.
Subpart 28. Provider relations and contracting expenses.
Subpart 29. Quality assurance and utilization management expenses.
Subpart 30. Regulatory compliance and government relations expenses.
Subpart 31. Research and product development expenses.
Subpart 35. Wellness and health education expenses.

Definitions for these terms are needed because the terms are used in part 4652.0120, item E, and the terms are not defined elsewhere nor subject to commonly understood or shared definitions.

As stated earlier, the process used to develop the definitions ensures that the definitions are reasonable. This process relied heavily on the input from the work group. The work group was representative of many parts of the industry, from HMOs to indemnity insurers. The submission of data under the emergency rules was done during the same time period as the development of the permanent rules definitions. Work group members were involved in preparing their companies' submissions under the emergency rules, so they were immediately and intimately aware of problems with emergency rules definitions.

As part of the process, each work group member was asked to list the functions attributed to or allocated in part to each category. The work group members responses were compiled and the work group then resolved any differences in the definitions for each category. Draft definitions were then developed based on these lists. The draft definitions went through several iterations so they were reviewed and refined by the work group to make sure they made sense and were understandable. It was the consensus of the work group that the definitions were a significant improvement over the emergency rules definitions.

The definitions are reasonable because they were developed by people with hands-on experience in capturing and submitting this type of data. The Department will consider further refinements to these definitions based on comments received during the 30-day comment period, especially those comments based on experience in preparing the submission under the emergency rules.

Definitions for Service Categories of Total Expenses. Similar to the discussion for indirect health care expenses definitions, the definitions for service categories of total expenses are discussed as a group because a single process was used to develop all of these definitions. This process ensures the reasonableness of these definitions. Note that the service categories themselves are described in this SONAR under part 4652.0120, item C. These categories are defined in the following subparts:

Subpart 4. Chemical dependency services expenses.
Subpart 8. Dental services expenses.
Subpart 9. Durable medical goods expenses.
Subpart 10. Emergency services expenses.

Subpart 13. Home health care expenses.
Subpart 14. Inpatient hospital services expenses.
Subpart 19. Mental health services expenses.
Subpart 22. Other health professional services expenses.
Subpart 24. Outpatient services expenses.
Subpart 25. Pharmacy and other nondurable medical goods expenses.
Subpart 26. Physician services expenses.
Subpart 32. Skilled nursing facilities expenses.

Definitions for these terms are needed because the terms are used in part 4652.0120, item C, and the terms are not defined elsewhere nor subject to commonly understood or shared definitions.

As stated earlier, the process used to develop the definitions ensures that the definitions are reasonable. This process relied heavily on the input from the work group. The work group was representative of many parts of the industry, from HMOs to indemnity insurers. The submission of data under the emergency rules was done during the same time period as the development of the permanent rules definitions. Work group members were involved in preparing their companies' submissions under the emergency rules, so they were immediately and intimately aware of problems with emergency rules definitions.

Draft definitions were developed based on the definitions in the emergency rules. The draft definitions went through several iterations so they were reviewed and refined by the work group to make sure they made sense and were understandable. It was the consensus of the work group that the definitions were a significant improvement over the emergency rules definitions.

The definitions are reasonable because they were developed by people with hands-on experience in capturing and submitting this type of data. The Department is willing to consider further refinements to these definitions based on comments received during the 30-day comment period, especially those comments based on experience in preparing the submission under the emergency rules.

Subpart 1. Scope. The definitions in this part apply to chapter 4652.
Subpart 6. Commissioner. This subpart states that the term "Commissioner" refers to the Commissioner of the Department of Health and duly authorized agents. This is needed because the rules refer to the Commissioner many times. The reference to duly authorized agents reflects how the Department conducts its business through its employees.
Subpart 12. Group purchaser. Subpart 12 adopts the definition of group purchaser from Minnesota Statutes, section 62J.03, subdivision 6. This definition is used because it defines the term "group purchaser" as it is used in section 62J.38, which is the statutory section used as the authority for this set of rules to collect data from group purchasers. There has been some confusion as to the meaning of group purchaser because the term is not adequately descriptive of all of the entities within the definition. For this reason, we will use the full text of the statutory definition as the language for the rules definition, rather than merely a reference to the statutory cite. The drawback to quoting rather than citing a statutory

definition is that when the statute is amended, it becomes necessary to amend the rules definition. The advantage of avoiding the confusion that occurred in implementing the emergency rules outweighs this drawback.

Subpart 15. Insurance company. Subpart 15 adopts a definition of insurance company that covers group purchasers other than HMOs. These group purchasers are carved out because those that have only a small amount of health care business in Minnesota ($3,000,000 or less in annual health premiums) will have the option to submit a shorter and less burdensome report.

Subpart 16. Member. This definition is needed because the term "member" is used in the rules and is not defined elsewhere. This term is reasonable because some (although not all) group purchasers commonly use this term. Using this term will give a measure of consistency to the data collected under the rules.

Subpart 17. Member liability. This definition is needed because the term "member liability" is used in the rules and is not defined elsewhere. This term is reasonable because some (although not all) group purchasers commonly use this term. Using this term will give a measure of consistency to the data collected under the rules.

Subpart 18. Member month. This definition is needed because the term "member month" is used in the rules and is not defined elsewhere. This term is reasonable because some (although not all) group purchasers commonly use this term. Using this term will give a measure of consistency to the data collected under the rules.

Subpart 21. Minnesota resident. In its most simple conceptual form, this term would be defined as a person residing in Minnesota. The definition takes into account several practical realities centered around the fact that group purchasers will have to base their submissions on the directory data available to them in their enrollment files. For the most part, this will match closely with the member's residence. However, there is some possibility for over and under reporting because, for example, dependent's addresses are often listed as the same as the subscriber, even when the dependent is living in a different state than the subscriber. We expect the over and under reporting that will result from this definition will not be significant and that the over reporting will approximately cancel out the under reporting.

Subpart 33. Subscriber. This definition is needed because the term "subscriber" is used in the rules and is not defined elsewhere. This definition is reasonable because it is consistent with the common use of the term by group purchasers

Subpart 34. Total premium revenue. This definition is needed because the term "total premium revenue" is used in the rules and is not defined elsewhere. This term is reasonable because some (although not all) group purchasers commonly use this term. Using this term will give a measure of consistency to the data collected under the rules.

4652.0110 GROUP PURCHASER REPORTING.

Subpart 1. Group purchasers must report; exceptions. Minnesota Statutes, section 62J.38, tells the Commissioner to require all group purchasers to submit data. It is important to further define and limit the scope of the statute for the reasons discussed under each item.

Item A. Insurance company with less than $3,000,000 in total health premiums. A threshold of $3,000,000 in total health premiums gives the Department 95% to 98% of all premium dollars, based on 1992 Minnesota Comprehensive Health Association assessment

figures. This will provide an adequate sample size and is sufficient for the general purpose of development of total expenditure estimates under Minnesota Statutes, sections 62J.04 and 62J.38. This sample size will allow for adequate enforcement of the growth limits under Minnesota Statutes, section 62P.05. This threshold is in recognition that (based on work group comments) the report costs from $10,000 to $20,000 to develop. Such a cost would be an excessive burden on those with a small presence in Minnesota. Minnesota Statutes, section 14.115, gives direction to reduce the burden of rules on small businesses and gives the Department discretion to expand the definition of small businesses, which the Department has done here by considering all businesses, especially those with only a small amount of business in Minnesota. Those companies exempted will file a short report which states that they are under the threshold amount and which includes the total number of members or subscribers covered. This will help us monitor the portion of health care that the aggregated data does and does not include and will be useful for reviewing the appropriateness of this threshold amount.

Item B. State agency that reports under section 62J.40. Other state agencies report data to the Department of Health under 62J.40. There is no need for them to report the data twice. Item B recognizes this and makes the exception explicit.

Item C. Self-insured employers. Employee health plans offered by self-insured employers or by employee organizations are encouraged to comply. The federal Employee Retirement Income Security Act (ERISA) has a federal preemption provision which exempts such employee health plans from complying with state regulation, including these rules. Item C explicitly acknowledges this. People covered under employee health plans make up a significant portion of Minnesotans. 1991 estimates indicate approximately 30% of Minnesota population is self insured. Data on the health care expenditures related to these people would be valuable to understanding the complete picture of health care spending in Minnesota. For this reason, these employee health plans are encouraged to comply with these rules.

Subpart 2. Date for filing; reporting period. Subpart 2 restates the requirements of Minnesota Statutes, section 62J.38, paragraph (a), which states in pertinent part: "Group purchasers shall submit data for the 1993 calendar year by April 1, 1994, and each April 1 thereafter shall submit data for the preceding calendar year." Subpart 2 repeats the statutory requirement in the rules for the convenience of the reader so that all of the requirements regarding the submission of the report are in one place.

Subpart 3. Organizations operating more than one group purchaser. According to this subpart, several group purchasers who are operated by one corporation or organization may submit the survey information in aggregate for all their affiliated group purchasers as long as they elect to meet the expenditure limits as a single entity. As outlined in Minnesota Statutes, section 62P.04, subdivision 2, health plan companies with affiliates may elect to meet a combined growth limit, for all affiliates, if they notify the Department of Health. No notification is required if they elect to use separate growth limit calculations for each affiliate. In order to effectively and efficiently enforce growth limits as well as reduce the reporting burden on group purchasers, the survey data submitted should be formatted consistently with how the growth limits will be monitored. Because the data from group

purchasers is aggregated to a state-wide level for purposes other than growth limits, submitting a single report for affiliated group purchasers does not adversely impact the Department of Health's use of the data.

Subpart 4. Extensions. Subpart 4 recognizes the reality that some group purchasers may be unable to submit the report by the required date because it would be unreasonably costly to comply or because of unforeseen circumstances. This is consistent with Minnesota Statutes, section 14.115, subdivision 2, paragraph (b), which encourages agencies, when developing rules, to consider less stringent schedules or deadlines for compliance. This will reduce the burden of the rules on group purchasers.

4652.0120 CONTENTS OF REPORT. The introductory paragraph to part 4652.0120, states that information in the report must pertain to health and medical related coverages, excluding accidental death and dismemberment coverages, short-term disability coverages, long-term disability coverages, long-term care coverages, workers compensation coverages, and personal accident coverages. This paragraph clearly sets out the scope of the data that the report must contain. It is important that group purchasers be consistent in the data submitted. The data is limited to the main body of health care spending.

Item A. Total premium and other revenues. Minnesota Statutes, section 62J.38, paragraph (b), states in pertinent part: "The commissioner shall require each group purchaser to submit data on revenue . . . . Revenue data must distinguish between premium revenue and revenue from other sources and must also include information on the amount of revenue in reserves and changes in reserves. . . ."

Item A repeats the requirement from section 62J.38, paragraph (b), that a group purchaser submit information on premium revenues and other revenues. Note that item A does not require the submission of reserves information even though section 62J.38, paragraph (b), requires this. We are not requiring reserves information in the survey because we will get this information from the Commerce Department and from the Health Department's HMO section. This is in line with the statutory directive to not duplicate data collection efforts.

Item B. Total expenses incurred by type of policy. Must be broken down by type of policy. Must include insured business, self-insured business, medicare, medical assistance and general assistance.

This part requires that data be broken down by type of policy. This breakdown is necessary to monitor spending and growth limits within the public and private sectors of the market as required in Minnesota Statutes, section 62J.04, subdivision 1. Tracking public and private spending separately will assist in answering the following policy questions:

- How do types of spending differ between the public and private sectors?
- Is overall spending rising faster in one sector?
- What types of public and private spending are increasing faster than the norm?
- How have health care reform initiatives impacted spending in each sector?

Government programs are broken into several categories to provide more detailed information regarding spending trends in specific programs. These expenses are typically segregated by group purchasers to facilitate other reporting to government agencies. Therefore, splitting them out in this report will not be a significant burden.

Self-insured business refers to employee health plans offered by self-insured employers or by employee organizations. Self-insured business is broken out because this portion of a group purchaser's business is not subject to the growth limits, given ERISA limitations. However, self-insured products represent approximately 30% of all health care spending in Minnesota. Therefore, collecting data regarding this portion of the market is essential to determining total health care spending and monitoring spending trends. In light of the ERISA preemption provision, any plan to collect self-insured data would involve voluntary compliance by the ERISA plan.

Developing a data collection plan for self-insured data was a challenge for the Department. One possibility was to send a survey to all employers offering self-insured products. To approach this, the Department met with members of the Business Health Care Action Group, a local consortium of large, self-insured employers. They suggested that the Department survey group purchasers to collect expenditure data from self-insured plans. If self-insured employers were identified and could be surveyed individually, most would merely ask the health plan company they contract with to provide the data. Going directly to group purchasers for self-insured data was a means to streamline the data collection process.

Item C. Total expenses incurred by service category. Expense categories include: physician services, other health professional services, inpatient hospital services, outpatient services, skilled nursing facilities, home health care, emergency services, pharmacy and other nondurable medical goods, durable medical goods, chemical dependency services and mental health services, dental services, and total indirect health care expenses.

This break out is consistent with Minnesota Statutes, section 62J.38, paragraph (b), which states: "The commissioner shall require each group purchaser to submit data on . . . expenses . . . . Expenditure data, including raw data from claims, must be provided separately for the following categories: physician services, dental services, other professional services, inpatient hospital services, outpatient hospital services, emergency and out-of-area care, pharmacy services and prescription drugs, mental health services, chemical dependency services, other expenditures, subscriber liability, and administrative costs."

The break out of expenses by service categories in section 62J.38, paragraph (b), was done because the legislature and the Health Care Commission expressed interest in detailed information regarding health care spending in Minnesota. To develop these service categories, a model developed by the federal Health Care Finance Administration (HCFA) was used as the baseline. This model breaks down personal health care spending into the following categories:

Hospital care	Physician services
Dental services	Other professional services

Home health care
Nursing home care
Other personal health care
Vision products/other medical durables
Drugs and/other medical non-durables

During discussions with the legislature and the Health Care Commission, categories for mental health, chemical dependency, and emergency services were added to the model. These were added because they are perceived as areas of significant impact on health care spending in Minnesota where detailed information is needed to make informed policy decisions.

The Department added categories for skilled nursing facilities and home health care during the development of the permanent rules. There are also some small differences between the rules categories and the statutory categories. Further, the Department combined the chemical dependency and mental health categories because it would be difficult for group purchasers to split these categories. The addition of skilled nursing facilities was discussed with the work group members who said this could be split off, but they expressed a concern about the cost of adding any further categories. These changes are based on an evolving understanding of the ways to analyze data in relation to health care reform. Some of the input in this has come from the 1994 survey of 1993 data under the emergency rules and from work group discussions.

Tracking these categories will provide useful information to policy makers on the trends in health care spending. This information will help address policy questions such as:

- How much is spent within each category of health care service?
- How fast are these expenditures growing each year?
- What types of health care expenditures are growing faster than the norm?
- How do spending trends in Minnesota vary from national trends?
- Where should future health care reform initiatives be targeted?

Item D. Total member liability. Or its actuarial estimate, for all covered persons.

Minnesota Statutes, section 62D.04, subdivision 7, paragraph (c), deals with enforcement of the growth limits and states in part: "Health plan companies are prohibited from meeting spending obligations by increasing subscriber liability, including copayments and deductibles and amounts in excess of benefit plan maximums." (Includes updates from 1994 Minnesota Laws, chapter 625.)

It is important for the Department to collect data on subscriber liability in order to monitor compliance with the requirement that companies not meet the growth limits by shifting costs to consumers.

Item E. Total indirect health care expenses. Expense categories are: billing and enrollment; claim processing; customer service; product management and marketing; regulatory compliance and government relations; provider relations and contracting; quality assurance and utilization management; wellness and health education; research and product

development; charitable contributions; general administration; MinnesotaCare taxes; and all other taxes and assessments.

The Department recognizes that expenses for these categories will have to be allocated because these categories do not match traditional accounting categories. For this reason, item E contains the language: "The information required for this report may be estimated from existing accounting methods with allocation to specific categories."

Minnesota Statutes, section 62J.38, paragraph (b), states in pertinent part: "Expenditure data . . . must be provided separately for . . . administrative costs."

Additionally, the 1993 MinnesotaCare Act required the Commissioner of Health to study administrative costs in the health care system in the interest of identifying and recommending cost savings and efficiencies related to administrative costs. Minnesota Laws 1993, chapter 345, article 3, section 17, titled "Study Of Administrative Costs" states:

> "The data analysis unit shall study costs and requirements incurred by health carriers, group purchasers, and health care providers that are related to the collection and submission of information to the state and federal government, insurers, and other third parties. The data analysis unit shall also evaluate and make recommendations related to cost-savings and efficiencies that may be achieved through streamlining and consolidating health care administrative, payment, and data collection systems. The unit shall recommend to the commissioner of health and the Minnesota health care commission by January 1, 1994, any reforms that may produce cost-savings and efficiencies without compromising the purposes for which the information is collected."

Item E asks for administrative costs data, but uses the term "indirect health care expenses" in place of the term "administrative costs."

There has been continuing and intense interest in administrative costs generally by persons interested in health care reform and specifically by the Legislature. Because of this, the Department decided to include administrative cost data as part of its annual aggregate data collection effort. The starting point for the survey under the permanent rules was the survey under the emergency rules. To understand the development of and rationale for the permanent rules survey, it would be instructive to look at the development of and rationale for the emergency rules survey.

In developing the original survey and emergency rules, the Department worked with a work group formed from the Data Collection Advisory Committee. In their preliminary research, the group and the Department found that estimates of administrative costs vary based on operational definitions, data sources, measurement techniques, and theoretical assumptions. Cost accounting is a complex exercise, the principles of which vary among the various components of the health care system. It should also be noted that the definition, identification, measurement, and analysis of administrative costs is likely to become even

more difficult with a further integration of the various components of the health care delivery system. Managed care and capitation further challenge traditional accounting procedures and cost-finding. Thus the concept of administrative costs will become more ambiguous, less precise, increasingly controversial and, consequently, of little analytic value, unless a consistent conceptual framework and uniform accounting procedures are applied.

Despite the inherent difficulties with the issue of administrative costs, the Department felt that measuring these costs as well as costs directly related to patient care was important to provide a total picture of health care spending. It will be important to collect and maintain data to chart the trend in all sectors of health care spending in order to make informed policy decisions and to adequately assess the impact of health care reform legislation. However, in order to meaningfully and accurately measure these costs, the Department needed to develop a framework to consistently identify these costs. For the emergency rules survey, the Department, in conjunction with the Data Collection Advisory Committee (DCAC), looked to Kenneth Thorpe's framework for identifying administrative costs as a model.

Thorpe's model for categorizing and analyzing administrative costs was presented in the Summer 1992 volume of Health Affairs. Thorpe begins by explaining that administrative costs should be identified as "inputs" into the "function" of health care providers and payers. He notes that "investments in administrative spending produce or support several outputs, including patient care, clinical and health services research, and education," (Thorpe, 1992). Importantly, Thorpe's conceptualization of administrative costs includes a framework which may help distinguish which costs "are amenable to change and those where reductions could increase total (health care) spending." There are administrative functions that, if eliminated would increase health care spending. For example, a study of industry data reveals that every dollar spent on utilization management reduces claim costs from one to nine dollars, (Sheils, et al., 1992). In addition, Thorpe's research and article clearly acknowledge the difficulty in comparing administrative costs across payers and providers.

In his paper, Thorpe groups administrative costs by function into four categories: 1) transaction-related, 2) benefits management, 3) selling and marketing, and 4) regulatory/compliance. Within these functions are various administrative activities or inputs. The administrative costs work group of the DCAC began with the Thorpe system for categorizing administrative costs. The work group expanded some of the expense categories described by Thorpe. These were the categories used in the 1993 survey of 1994 data.

After the group purchasers completed the 1994 survey of 1993 data it was clear that one of the difficulties in using the Thorpe model of administrative cost functions, is that the cost data required for the survey categories are different from the cost data contained in the typical financial statement or easily accessible within the financial statement. Thorpe's methodology for determining functional costs does not follow traditional general ledger accounting. A typical financial statement does not reflect the cost of the functions defined by Thorpe and used in the original survey. Many group purchasers expressed problems in completing the survey because they did not know what expenses to include in the categories. The original survey and emergency rules did not adequately define what costs to include and how to calculate these costs from typical clinic financial data.

In order to transform standard financial data into the Thorpe functional categories, the survey respondent needed to allocate costs from traditional categories from the chart of accounts. For example, the Thorpe-defined transaction-related function includes billing and enrollment costs. Billing and enrollment costs are not a unique item in a typical chart of accounts. However, items such as postage, wages, and space, which contribute to the process of billing and enrollment as well as many other functions are included within the chart of accounts. In order to determine the billing and enrollment functional cost, the survey respondent had to allocate and sum up the costs of the various inputs that comprise billing and enrollment costs.

It is necessary for the proposed rules survey instrument to include a statement which instructs the survey respondent in the method for making expense allocations. The proposed rules do not prescribe one precise method for making expense allocations. It was determined, with the work group's recommendation, that it was important to state clearly that a group purchaser could use estimates and allocations to complete the report and to have a flexible approach for making allocations. Based upon this, the expense allocations will be made in a generally similar manner. Because of the variety of administrative and organizational schemes, one rigid approach for allocating expenses would be unworkable.

The work group members who completed the 1994 survey of 1993 data also voiced their concerns and problems with the labeling of particular functional cost categories in the original survey. Work group members said that some of the categories did not reflect the nature of their business. They indicated that many of the classifications or labels were unnatural. Finally, there were concerns about labeling costs as "administrative" which may be potentially interpreted as "unnecessary paper shuffling" or potentially perceived as "bad costs" by some policy makers. Therefore, the work group recommended that a less controversial term be used. "Indirect Health Care Expenses" was chosen.

The work group recommended combining some of the categories, expanding some of the categories, and deleting some of the categories in an effort to present a more rational and understandable means of reporting group purchaser expenses. In addition, each definition was extensively rewritten in language familiar to those who will complete the survey.

The original survey expense categories and the work group's proposed expense categories are as follows:

Previous Categories	Proposed Categories
Billing and Data Processing	Billing and Enrollment
Quality Assurance	Claim Processing
Regulatory and Compliance Reporting	Customer Service
Selling and Promotion	Product Management and Marketing
General Administration	Regulatory Compliance/ Government Relations
Government Relations	Provider Relations/Contracting
Research Program Expenses and Education Program Expenses	Quality Assurance/Utilization Management
Fees	Wellness and Health Education
Taxes and Assessments	Research and Product Development
	Charitable Contributions
	General Administration
	MinnesotaCare Taxes
	Other Taxes and Assessments

The administrative costs categories under the emergency rules were the starting point for the development of the indirect health care expenses categories for the permanent rules. The work group was asked to recommend categories that would provide meaningful information for policy makers, while at the same time being workable for the group purchasers that had to supply the data. The proposed categories resulted from this process.

As stated earlier, the work group was representative of many parts of the industry, from HMOs to indemnity insurers. Many work group members were directly involved in their companies' submission of data under the emergency rules. The input from the work group provides the underlying reasonableness of the categories. Additional reasons for the categories are as follows:

Billing and Enrollment. There was discussion as to whether to combine the Billing and Enrollment and Customer Service Categories. For some group purchasers, this is only an artificial split because the functions are integrated. Many in the work group felt it was important to highlight the expenses related to customer services as this is a value added service. Therefore, these categories will remain distinct.

Claim Processing. Electronic data interchange (EDI) costs currently pertain mainly to claim processing, but this may change in the future.

Customer Service. See the discussion under Billing and Enrollment.

Product Management and Marketing. The work group started with the category of Marketing/Selling/Product Management. They discussed whether product development should be in this category? After some discussion, the group agreed that new product

development should be combined with Research in a new category. In most companies, new product development is done by task force so allocation will be made regardless of where the expense is included. Concern was expressed about the difference between product management and product development. The group agreed that product development would apply to products not currently available. Expense resulting from modifications to existing products belongs in the Product Management category. The group also recommended to rename this category Product Management and Marketing to accurately reflect the range of expenses included in it.

Regulatory Compliance/ Government Relations. Early in the discussion, this category was Regulatory Compliance. The work group considered whether this category should be combined with the Cost of Government programs? The group agreed it made sense to lump these costs together into one category. The definition should include language indicating that licensing and filing fees should be included. Membership fees, such as those to GHAA belong under General Administration.

Provider Relations/Contracting. The work group recommended that this category also include language about monitoring compliance with provider contracts.

Quality Assurance/Utilization Management. There was some discussion at the work group about whether to keep Quality Assurance/Utilization Management and the Wellness and Health Education categories separate. There may not be many dollars in these categories and there may not in the long run be a good reason for keeping these separate, but the work group thought that for now it would be good to keep them separate because they may grow and, if so, the separate functions are things that would provide interesting and useful information. This was a close question. It was recommended to keep them separate for now because they could always be put together later if experience dictates, whereas, if these categories were combined now, it would be difficult to separate them later and compare with earlier years' combined data.

Wellness and Health Education. See the discussion under Quality Assurance/Utilization Management.

Research and Product Development. As noted above, this category now includes product development. The definition should include language regarding integrated service network (ISN) development. The language should also indicate that product development applies to products not currently functional.

Charitable Contributions. The work group wanted to emphasize the level of charitable contributions.

General Administration. As noted above, GHAA membership fees are included here. This should be the category where anything not outlined above is included. It will incorporate many allocations.

MinnesotaCare Taxes. The work group members recommended this as a separate category to highlight this particular expense.

Other Taxes and Assessments. This category will show the amount of the burden on group purchasers from this cost.

Item F. Total number of members and subscribers and member months. Number of members must be broken down by type of policy. Group purchasers that do not maintain member information may submit actuarial estimates of total number of members covered under all health policies.

(Note: A subscriber is the person who obtains a policy of coverage. The subscriber may have dependents who are covered under the policy. The subscriber and all covered dependents are called members.)

This part outlines specific demographic information required in statute. Minnesota Statutes, section 62J.38, requires that members and member months be reported annually. These figures are important in tracking the number of Minnesotans included in the survey as well as to provide one base from which to estimate uninsured populations.

Based on feedback received during the emergency rules comment period, language was added indicating that estimates may be made for those group purchasers who track subscribers, but who do not routinely track members. Group purchasers in some segments of the market do not need to track individual members. It would be a significant burden to require them to begin tracking this information for aggregate reporting purposes. Therefore, an actuarial estimate will meet the Department's needs at the aggregate data level.

The number of subscribers was included in the emergency rules based on feedback from indemnity insurers who do not routinely track members. They wished to include the more accurate figure of subscribers along with their estimated membership figures. This will provide useful information to the Department, so the element was added to the survey.

The number of individuals and families is included in the survey to provide additional information regarding the type of contract under which people are covered. Tracking this information over time will allow the Department to monitor the changes in individual and family coverages and assess the impact health care reform may have on these coverages.

Item G. Reconciliation with audited financial statements. Item G requires a statement that revenues and expense amounts under items A and B reconcile to audited financial statements. This will ensure accuracy of the report for amounts that can reasonably be derived from financial statements. This is based on the recommendation of DeLoitte and Touche, the Department's consultant. The work group discussed the consultant's recommendation and in turn recommended that the rules use "reconcile" rather than "tie to" because "reconcile" will be sufficient to ensure accuracy but may not be as burdensome or costly as "tie to." Item G does not apply to items C to F because it is not necessary for ensuring the accuracy of the report and, in the case of item E on indirect health care

expenses, because the information in the categories will have to be estimated from amounts that are not directly captured into the categories.

Item G sets out two separate ways for complying, based on the portion of the group purchasers business in Minnesota. Both methods recognize the difficulty of separating Minnesota data from non-Minnesota data and allow the group purchasers to comply in a workable fashion.

4652.0130 REVIEW OF REPORTS.

Subpart 1. Record complete. It is necessary to set a standard for how the Commissioner will determine whether a group purchaser has met its requirement to file a report. It is reasonable that the report meet the requirements of this rules chapter.

Subpart 2. Review by commissioner. This gives the Commissioner 60 days to complete the review. This was increased from 30 days under the emergency rules based upon our experience in the time it took to review the reports submitted under the emergency rules. It is important to limit the amount of time during which a group purchaser's report can be reviewed for completeness. The longer the amount of time, the more difficult it would be for a group purchaser to reconstruct the data needed to amend an incomplete report.

Subpart 3. Incomplete report. It is necessary to require a group purchaser to amend an incomplete report. This subpart allows the group purchaser 30 days (increased from 14 days under the emergency rules) to submit the amended report. It is reasonable to allow the report to be deemed filed as of the original filing date because it will encourage cooperation by the group purchaser in addressing any problems with a report.

Subpart 4. Amending reports. and Subpart 5. **Error in reports.** These subparts deal with errors discovered in a report after it has been determined to be complete. It is reasonable to make clear that the sanctions for not filing a report do not apply to this situation. It is also reasonable to require the group purchaser to amend the report to correct the error.

Conclusion

Based on the foregoing, the Department's proposed rules are both necessary and reasonable.

8/2/94
Date

Mary Jo O'Brien, Commissioner
Department of Health

Appendix

Items in the Appendix are included as part of the official rulemaking record. Copies of Appendix items are available upon request from JoMarie Williamson, Minnesota Department of Health, Health Care Delivery Systems Policy Division, P.O. Box 64975, 171 East Seventh Place, Suite 400, St. Paul, Minnesota 55164-0975, 612/282-6351. TDD users may call the Minnesota Department of Health at 612/623-5522.

A. Emergency rules chapter 4652, effective from 12/14/93 through 12/9/94.

B. 1994 data collection survey of 1993 data under emergency rules chapter 4652.

C. Minutes of work group meetings. Note that minutes are included for the purpose of documenting the work group's input, and do not necessarily represent the Department's position.

Appendix A

Minutes for the Work Group on Chapter 4652
Aggregate Data from Commercial Insurers and HMOs
March 3, 1994

Persons attending the meeting included:

Mark Bjornson, Prudential Insurance
Dick DiFalco, Delta Dental
Michele Hostager, Prudential Insurance
Susan Quint, BlueCross Blue Shield
Dan Rydel, BlueCross Blue Shield
Patti Warden, Medica
JoMarie Williamson, Minnesota Department of Health

This meeting was for organizational purposes and preliminary discussion and identification of issues. The work group didn't get into too much detail because there will be several new members by the next work group meeting. We plan to discuss scope as our first issue at the next meeting. We talked through some general issues regarding how the surveys work, some initial questions on data elements, etc.

Our meeting schedule was set as follows:
March 11 - 9:00 at Delta Dental
March 25 - 9:00 at Medica
April 8 - at Blue Cross

Minnesota Department Of Health
Minutes for the Work Group on Chapter 4652
Aggregate Data from Commercial Insurers and HMOs
March 11, 1994, 9:00 - 11:00 a.m.
Delta Dental
Bloomington, Minnesota
Working Notes

Persons attending the meeting included:

Michelle Barnes Lewis Minnesota Department of Health
Mark Bjornson, Prudential Insurance
Dick DiFalco, Delta Dental
Jim Golden, Minnesota Department of Health
Michelle Hegarty, Medica, attended for Patti Warden
Michele Hostager, Prudential Insurance
Joan Johnson, Northwestern National Life
Nancy Krogstad, Fortis
Dave Orren, Minnesota Department of Health
Norma Porter, Delta Dental
Susan Quint, BlueCross Blue Shield
Dan Rydel, BlueCross Blue Shield
Carrie Schulz, Mid-America Mutual

The meeting began with the work group members going around the table and introducing themselves and giving a brief overview of their background.

The first item of discussion was the scope of the rules. The emergency rules apply to all insurance companies that reported $10,000 or more in total premiums to the Department of Commerce in 1991. Should there be a similar cut off for reporting in the permanent rules and, if so, what should the dollar amount of the cut off be? The following includes my notes on the discussion that ensued.

- A list titled "Minnesota Comprehensive Health Association" from the Department of Commerce was distributed to WG members. This list specified insurers and HMOs by 1991 premium dollars.
- For the sake of discussion it was suggested we consider $500,000 as the threshold, so that an insurer or HMO with less than $500,000 in total premiums would not have to submit data. These insurers and HMOs collect only about 1% of the total premiums.
- It was stated by a group member that for very low premium dollars, there is no real importance to the numbers that would be submitted. The data submitted by these companies with low total premiums would be unreliable and statistically insignificant in relation to the total picture.
- The Department wants a total picture, not just a sampling of the data.
- Work group members reported that the burden for reporting is substantial. It includes these general categories:
    - System resources, including new systems in some cases and system modifications;

- Personnel hours; and
- Opportunity costs of devoting personnel to matters other than business.

- The Department asked that the burden for reporting be quantified, rather than just described in the above general categories. Work group members were asked to do a ball-park estimate of the costs of complying with the data collection requirements of the emergency rules. **Please bring your estimates to the next work group meeting on March 25. It will be helpful to have some break down of the costs, but please don't spend a great deal of time on this.**
- Will the costs for submitting 1994 data in 1995 be reduced because much of the system design and redesign work was done for submitting 1993 data in 1994? Work group members said that some of the system redesign will not have to be done again, but that there would be significant costs for the analysis that goes into monitoring trends, which will only be done for the first time when 1994 data is given in 1995.
- This topic of scope will be revisited when we can look at the data produced by the work group members on the burden of compliance and the information on the percent of the total picture that would be missing related to the different possible thresholds for submitting data.

Year-to-year consistency by the Legislature in what is required would make it easier to comply. However, this was just an observation since it is something not within the control of the work group or the Department.

Can the date for reporting be changed? Yes, but it would have to be done legislatively because the date is set in statute. The work group could consider this aspect of data collection and make a recommendation to the Department. This would be in addition to the recommendation the work group will make regarding the permanent rules.

We also discussed who else should be around the table. We need HealthPartners and representatives of self-insured employers. The Department has been in contact with HealthPartners and organizations representing large and small employers and hopes that representatives of these organizations will be represented on the work group.

Where will the request come from for voluntary compliance by self-insured employers and who will the request go to? Requests will go to the Business Health Care Action Group and to commercial insurance companies, including HMOs and third party administrators.

The work group then moved on to discuss definitional issues.

- The work group wants to see the wording of statutory definitions that are adopted by reference in the emergency rules. The Department will assemble and distribute this.
- Definition of Minnesota resident. One of the work group members was going to use zip code of insured. The rules need to address this issue. How do we include Minnesota residents who get care outside of the state and out-of-state residents who get care in Minnesota? There will need to be a reasonable basis for how you determine residency. What word is/should be used (subscriber, insured, policy holder) in statute/rules? Where does it say that data has to apply to Minnesota residents? Is it in statutes? Where? Section 62P.01. Should this be in rules?

- Skilled nursing - Is it under in-patient or out-patient? One of the work group members uses in-patient. It was suggested that we look at the box for type of claim on Box 4 of UB82. **Work group members who have access to UB82 forms please look up this question.**
- Is it the intent to capture workers compensation data in this survey. The Department will clarify at the next meeting and we will decide whether this should be noted in the permanent rules.

The next meeting is on Friday, March 25, from 9:00 to 11:00 a.m. It will be at Medica at 5601 Smetana Drive. **Dress is casual for this meeting.**

Minutes for the Work Group on Chapter 4652
Aggregate Data from Commercial Insurers and HMOs
March 25, 1994, 9:00 - 11:00 a.m.
at Medica in Minnetonka, Minnesota

Persons attending the meeting included:

Sandy Abrams, Minnesota Department of Health
Michelle Barnes Lewis, Minnesota Department of Health
Dick DiFalco, Delta Dental
Jim Golden, Minnesota Department of Health
Michelle Hegarty, Medica
Michele Hostager, Prudential Insurance
Joan Johnson, Northwestern National Life
Dave Orren, Minnesota Department of Health
Norma Porter, Delta Dental
Bob Power, HealthPartners
Dan Rydel, Blue Cross Blue Shield
Patti Warden, Medica
JoMarie Williamson, Minnesota Department of Health

Review of minutes from 3/25 meeting - corrections/additions

There were no changes or additions to last meeting's notes.

Cost of compliance

The group was asked to estimate the cost for compliance with the survey data for 1993 data. Medica estimated that the cost was relatively minimal because report structures were already in place. Delta Dental indicated that the cost was also minimal - for 1993 under $5,000. NWNL indicated that their costs for the HMO were a bit higher because they had to program additional reports. The cost for the HMO was approximately $15,000. They also indicated that the data will be useful for purposes beyond reporting to the Department. Prudential indicated their costs were estimated in the same range as NWNL, if not a little higher. In future years, Prudential and NWNL expect costs to be lower as long as the reports do not change significantly. Blue Cross & Blue Shield indicated their costs for pulling out the data were not significant, but when looking at costs, we should also consider the cost of analyzing the data. Members of the group agreed that the costs are most likely higher for smaller companies.

The Department then asked for feedback regarding what we can do to reduce the cost of compliance. The first area indicated by the group was consistency. Report costs in future years should decrease significantly if new programming is not required. Several members of the group also indicated that April is not a good time of the year to request this data. Also,

if the data were provided later in the year, actual incurred claims rather than IBNR estimates could be reported. However, if the dates were to change, then some may wish to modify their adjustment methodologies.

Scope

Discussion then turned to the dollar threshold listed in the scope. The Department provided updated MCHA premium figures from the Department of Commerce. HMO premium was over half the total included in MCHA's report. The Department will receive data on the HMOs primarily through their annual filing, so the group looked at the non-HMO portion of premium. After excluding HMOs, total premium reported was $1,224,834,067. In recommending a premium figure to use in the scope, the group was asked to balance capturing a reasonable percentage of the market from which to monitor compliance with growth limits and determine total expenditures in the Minnesota economy, against the burden of preparing reports to the state.

The current threshold of $10,000 accounts for 99.98% of the total premium. Using $2,000,000 as a threshold would account for 96% of the total premium. Using $3,000,000 as a threshold accounts for approximately 95% of the total premium. Combined with HMO premium, a $3,000,000 threshold accounts for approximately 97.8% of total MCHA premium. The group felt this would provide the Department with a reasonable sampling of data to determine total Minnesota expenditures and eliminate many smaller carriers from the survey, for whom reporting is a greater burden. One group member estimated that if we assumed slightly higher costs for a smaller company (assume $20,000) - preparing these reports would load costs by approximately 2% for a company reporting 1,000,000 of premium - a significant burden.

The work group was also asked to consider what the Department may be missing by not including some of the smaller carriers. Specifically, are there important niches of the market not represented? Are we missing certain geographic areas? The group did not feel that this would be a problem. With the $3,000,000 threshold, we will capture enough of the market to estimate total expenditures.

The group's final recommendation is a $3,000,000 threshold. Department of Health personnel will draft the rule and a statement of need and reasonableness regarding the scope for the group's review.

Definitions

The group spent the rest of the meeting identifying the best way to review the definitions. For instance, we could begin by identifying the conceptual framework used to develop this year's report as a framework for the discussion. As an example, one group used site of service first, then ICD-9 code, then provider type - could we work with that? Another idea was to build on the work done by the UDDC group. One group member expressed concern that this would require specially programmed ad hoc reports in order to complete these reports.

One group member wanted to know how the detailed data in report 3 (or report 1 for the HMOs) would be used. The legislature expressed a desire to not only quantify total health care expenditures, but to know how those dollars were spent. Therefore, the final MinnesotaCare legislation included language directing the department to collect, at minimum, certain broad categories of expenditures. This will provide general information regarding how and where health care dollars are spent. Trends in these categories may then be monitored over time. This will be useful to identify areas of concentrated study. It is hoped that when the encounter level claim data is collected, this portion of the survey may be eliminated, however, that is well down the road.

An example of the type of issues involved in clarifying the definitions regards emergency room expenses. Medica identified expenses by site of service. NWNL used ICD-9 codes to identify emergencies as opposed to pulling all charges from the emergency room. Where to include urgent care is another issue to resolve. We also need to address capitation and how to split costs into these expense types when they may be combined under a capitated arrangement. This will be more and more of an issue as the market moves toward increased use of capitated arrangements.

The Department's goal is to capture meaningful data where everyone uses the same definitions in order to monitor trends in the general categories over time. The role of the work group is to identify areas of concern and suggest language to clarify the definitions to work toward consistency in the data from all companies. Before the next meeting, each work group member will discuss issues regarding report 3 (or 1) with knowledgeable members of their organization. We will spend most of next meeting walking through each item in the report, identifying concerns and discussing possible resolutions. Other representatives are welcome to join in the discussion. Please let JoMarie know if you plan to bring anyone else along.

Other items

The Administrative Costs Joint Task Force will meet on April 6 from 8:30 to 11:30 in the Chesley Room at the Department of Health Building at 717 Delaware Street in Minneapolis. The Department strongly encourages your attendance to provide feedback on this issue. A meeting notice and additional background information outlining the present method of collecting administrative cost data will be sent in a separate package.

Schedule for future meetings

The consensus was to maintain the present schedule of every other Friday from 9:00 to 11:00. Blue Cross Blue Shield will host the next meeting. At that meeting, please be prepared to volunteer if your company can host one of the meetings. Dates are as follows: April 22; May 6; May 20.

One group member asked for a general overview of what will be discussed in future meetings. After working through the definitions, the group will draft the statement of need and reasonableness needed to accompany the final set of permanent rules. Department

members will prepare drafts for the group to edit. The Department would also like to hear the group's thoughts regarding ways to pursue data on the self insured. The Department would also like to discuss the possibility of maintaining the work group after the SONAR is drafted to continue refining the data collection process and provide ongoing feedback to the Department.

TO Dos for next meeting:

What	Who
1. Draft rule and SONAR for scope	MDH staff
2. Identify issues for each data element in Report 3	Work Group members
3. Volunteer to host future meetings	Work Group members

Minutes for the Work Group on Chapter 4652
Aggregate Data from Commercial Insurers and HMOs
April 8, 1994, 9:00 - 11:00 a.m.
at BlueCross BlueShield in Eagan, Minnesota

Persons attending the meeting included:

Michelle Barnes Lewis, Minnesota Department of Health
Steve Bunde, HealthPartners
Judy Busse, BlueCross BlueShield
Jim Golden, Minnesota Department of Health
Michelle Hegarty, Medica
Michele Hostager, Prudential Insurance
Nancy Krogstad, Fortis
Dave Orren, Minnesota Department of Health
Norma Porter, Delta Dental
Carrie Schulz, Mid-America Mutual
Patti Warden, Medica
JoMarie Williamson, Minnesota Department of Health

The meeting began with a discussion about administrative costs based on the 4/6/94 meeting of the Task Force. The Task Force asked each work group to review the present structure of administrative costs and rework it to meet the needs of each work group's constituency. Each work group will then report to the Task Force on May 6 regarding their proposed formset and definitions. While each group will use the current formset as the starting point, it is not imperative that the categories or definitions remain the same.

Several work group members expressed concern regarding how the information will be used and why detailed information was needed. One member also asked for a "quality assurance" statement to be included on the form assuring that the data will be kept non-public (except in aggregate) and that comparisons between plans will be not made to the public or the legislature. The collecting of this data is a sensitive issue and the work group thought that a statement on the form regarding how the data will (or won't) be used may encourage more accurate reporting.

The Department also asked for feedback on including a question on the form asking for how long it took to complete the survey. The intent of this would be to provide feedback to the Department regarding the burden of reporting and how it could be minimized. It is not intended to be used as a comparative number between companies. Some group members suggested that the intent be outlined clearly to encourage people to accurately report their time without fear of punitive action against them.

The group also recommended that these expenses be renamed "indirect health care expenses". This more accurately reflects all the spending included in this category and does not have the same negative connotations as the term "administrative costs".

The Work Group began the modification of report 4 (Indirect health care expenses) by itemizing the types of expenses that could be included in each of the present categories. The list of expenses within each category is included as an attachment to the minutes. This discussion was not completed in the time allotted so a meeting on Wednesday, April 13, at Fortis was scheduled to complete this discussion.

The Work Group discussed Report 3 (or 1 for HMOs) for the final hour of the meeting. Discussion focussed on areas of confusion or missing pieces from the present categories. The group was also given copies of the HCFA spending chart and an article containing definitions they use. JoMarie indicated that while we are striving for consistency in this report, we will not be able to resolve all issues in this work group. The Department would like to keep this work group going after the rules are drafted to provide ongoing feedback regarding these data collection forms. The detailed notes for this discussion are attached to these minutes. This discussion will continue at future meetings.

Jim Golden then addressed the group. The Department is interested in expanding the report card beyond HMOs. Jim is working with the Report Card Committee (of the Data Institute) on this issue. The Committee has not made a recommendation regarding expanding the scope of the Report Card, however, the Department is still considering this as a possibility. At this point, the Department asks that work group members identify people within their organization who may be able to work with us on this issue. Jim will keep the group up to date on this issue.

Indirect Health Care Expenses

Notes from brainstorming session - Friday, April 8

Working from the current functional categories, the group identified costs that could be grouped into each category.

Billing and Data Processing

1. Billing and enrollment
2. Claims processing
3. Customer Services
4. Member Services
5. Ad hoc programming
6. Allocations from data processing (this item could apply to all categories)

Product Management and Design

1. Product development (very few companies probably have a separate division for this - it is more often done by committee/task force)
2. Outside consulting fees
3. Underwriting
4. Allocations from: Legal
   Finance
   Marketing
   Information Systems
5. Allocation from actuarial

Quality Assurance

1. Managed Care (including nurse reviewers)
2. All physician services
3. Provider Relations: Contracting
   QA/Feedback
4. Benefit appeals

Regulatory and Compliance Reporting

1. Contracts and Compliance
2. Legal area
3. Allocations: legal
   finance
   executives
   data processing
4. Actuarial
5. Regulatory fees
6. Large account reporting

Selling and Promotion

1. Marketing
2. Broker Fees
3. Commissions
4. Marketing Brochures/materials
5. Public Relations
6. Actuarial and Rating
7. Underwriting
8. Allocations from Information Systems

Additional issues:

- Where to put marketing costs for medicare?
- Where to put costs for research projects?
- Where to put one time development costs?

After list is finished:

- How many categories should we have?
- What should we call each category?
- Which expenditure types fit into each category?
- Is anything missing from the list?
- Should the form change?
- Who will volunteer to present this to the Task Force?

Report 3 (Report 1 for HMOs)

Physician Services

- Includes MDs
- Includes DOs
- Includes Ophthalmologists
- Chiropractic charges are in Other Health Professional Services

Other Health Professional Services

- Allied health providers - optometrists
- Social Workers
- Nurse Practitioners
- Medical Dental Services
- Physical, Speech, Occupational Therapy

Social workers may appear under mental health depending upon what they are treating.

Hospital - inpatient

- Under capitated deals plans can't always allocate mental health and chemical dependency costs back to hospital (or split into in and out patient)

- We need to clarify treatment of long term care - is it omitted from the survey?

- Skilled Nursing - majority of work group members include in inpatient for internal reporting.

Hospital - Outpatient

- One day surgery stays - is considered outpatient if there is not a room and board charge. If there is a room and board charge, the cost falls into inpatient.

- Home health care - most plans report this separately.

Notes from: 4/13/94 Meeting regarding Indirect Health Care Spending

Attending:

Michelle Barnes Lewis, Minnesota Department of Health
Steve Bunde, HealthPartners
Judy Busse, BlueCross BlueShield
Michelle Hegarty, Medica
Nancy Krogstad, Fortis
Dave Orren, Minnesota Department of Health
Norma Porter, Delta Dental
Anne Marie Seward, Metropolitan Health Plan
Patti Warden, Medica
JoMarie Williamson, Minnesota Department of Health

The meeting began with a brief discussion of the process thus far. Dave Orren was interested in why this group seemed able to progress faster on this issue than other work groups. Also, the definition of what constitutes administrative type costs seems more straightforward for this group. Group members explained that they routinely identify administrative type expenses to their customers. The HMOs also already report this type of information to the state. It could be that the other groups (providers and hospitals) are not as used to segregating and reporting these expenses.

The group then completed the list began at the last meeting (see attached). They then had an outline of where different types of expenses could fall in the presently defined categories. The group was then asked to identify the categories they believe make sense to report to the Department. As part of deciding this issue, the group considered issues such as:

- The way expenses are grouped within organizations currently
- Identifying categories that will provide meaningful information to the Department
- The relative size of expenses

Attached to these minutes is a list of the categories identified by the group as those to measure. Other expenses on the list may fall into several categories as allocations.

HOMEWORK FOR THE APRIL 22 MEETING:

Each Work Group member should go through the list of categories and list bullet items to be included in each category. Please bring at least 15 copies of your list to distribute. Also, feel free to share with other people within your organization for their input. At the meeting on the 22nd, we will go through each person's list and discuss/resolve differences. The Department will then use these to draft definitions.

Notes from 4/13/94 meeting:

Continued discussion from previous meeting - Working from the current functional categories, the group identified costs that could be grouped into each category.

Government Relations

- Lobbying
- Membership fees in trade organizations
- Political donations
- Charitable contributions

General Administration

- Accounting
- Legal
- Human Resources
- Communications
- Underwriting
- Executive costs/Board costs
- Outside consulting services
- Communications/Public relations
- miscellaneous - catch all
- Allocation from information systems

Research Program Expenses

- Development of report card
- Wellness programs
- Allocation from medical director
- Studies
  - Outcome studies
- System development
- Education
  - Employee
  - Patient

Taxes - where to put Minnesota Care tax?

Category Headings:

1. **Billing and enrollment**

2. **Claim Processing**

3. **Customer Service**
   (both member and group)

4. **Charitable Contributions**

5. **Selling/Marketing/Product Management**

6. **Regulatory Compliance**
   Contracting
   Rate filing
   Audit

7. **Provider Relations/Contracting**

8. **Quality Assurance/Utilization Management**

9. **Wellness/Health Education**
   Outreach

10. **Research**
    Development
    Design

11. **General Administration**
    Human Resources
    General Accounting

12. **Direct expenses from government programs**
    HCFA audit
    Reports
    Legal Costs
    Rate Filings

Minutes for the Work Group on Chapter 4652
Aggregate Data from Commercial Insurers and HMOs
April 22, 1994, 9:00 - 11:00 a.m.
at Prudential Insurance in Golden Valley, Minnesota

Persons attending the meeting included:

Kevin Brandt, HealthPartners
Judy Busse, Blue Cross Blue Shield
Dick DiFalco, Delta Dental
Michelle Hegarty, Medica
Michele Hostager, Prudential Insurance
Joan Johnson, NWNL Health Network
Dave Orren, Minnesota Department of Health
Norma Porter, Delta Dental
Dan Rydel, Blue Cross Blue Shield
Carrie Schulz, Mid-America Mutual
Anne Marie Seward, Metropolitan Health Plan
Patti Warden, Medica
JoMarie Williamson, Minnesota Department of Health

The meeting began with a review of each work group member's bullet points regarding indirect health care expenditures. The group then discussed differences and key points to include in the definitions. JoMarie will then use these bullet points to develop draft definitions. These definitions will be presented to the Task Force as part of the May 4 meeting regarding administrative costs. The group will have an opportunity to fine tune the definitions in the next meeting.

Indirect Health Care Expenditure Discussion

The following includes the main points made during the discussion of each category:

Billing and Enrollment - should we continue to split this from customer service costs? For some groups, this is only an artificial split because the functions are integrated. Many in the work group felt it was important to highlight the expenses related to customer services as this is a value added service. Therefore, they will remain distinct categories.

Claim Processing - add language about fraud investigation. Capitation should move to general administration. EDI costs currently pertain mainly to claim processing, but this may change in the future. Note in the definition that EDI services should be split by function if possible.

Customer Services and **Charitable Contributions** did not need further discussion.

Marketing/Selling/Product Management - should product development be in this category? After some discussion, the group agreed that new product development should be combined

with Research in a new category. In most companies, new product development is done by task force so allocation will be made regardless of where the expense is included. Concern was expressed about the difference between product management and product development. The group agreed that product development would apply to products not currently available. Expense resulting from modifications to existing products belongs in the Product Management category. The group also decided to rename this category Product Management and Marketing to accurately reflect the range of expenses included in it.

Regulatory Compliance - can this category be combined with the Cost of Government programs? The group agreed it made sense to lump these costs together into one category. The definition should include language indicating that licensing and filing fees should be included. Membership fees, such as those to GHAA belong under General Administration.

Provider Relations/Contracting - this category should also include language about monitoring compliance with provider contracts.

Quality Assurance/Utilization Management - Should wellness be a separate category? There may not be many dollars in the wellness category, however, it will be easy to combine in future years if a separate category doesn't appear useful. Consensus was that both are value added services which should be highlighted separately.

Research - as noted above, this category now includes product development. The definition should include language regarding ISN development. The language should also indicate that product development applies to products not currently functional.

General Administration. - as noted above, GHAA membership fees are included here. This should be the category where anything not outlined above is included. It will incorporate many allocations.

Note: MDH should also include space for explanation of unusual expenses or expenses that are difficult to classify. This will provide additional clarification to MDH about the information they have received.

Direct Expenses From Government Programs - has been combined with Regulatory Compliance - see above.

Please see the attached list for the draft definitions.

After the definitions were completed, the group considered who could present this to the Task Force. Dave Orren asked that it not be him, JoMarie or Judy Busse (a member of the Task Force). Dave and JoMarie will be at the meeting and will be available for questions or comments and to support the presenter. Patty Warden was nominated and graciously accepted. JoMarie will fax copies of the definitions to the group for review prior to the May 4 meeting.

The group then had several questions regarding the tax section of the form. Where should MinnesotaCare taxes be reported? What about income taxes? Several group members mentioned an interest in putting MinnesotaCare tax in a separate category. One group member also asked for confirmation that the data in reports 1 and 2 for HMOs does not need to tie directly to other parts of the annual statement. This is correct.

Minutes from last meeting:

There was one comment regarding last meeting's minutes. In the second paragraph, the second sentence should read: One member also asked for a "quality assurance" statement to be included on the form assuring that the data will be kept non-public (except in aggregate) and that comparisons between plans will not be made to the public or the legislature.

Next meeting:

Future meetings will be three hours long as agreed upon in the 4/8 meeting. The next meeting will be at Medica from 9:00 - 12:00. Directions were provided previously. If anyone is in need of a new map, please contact JoMarie.

Draft Definitions - Indirect Health Care Costs

1. Billing and Enrollment

This category includes all costs associated with group and/or individual billing, member enrollment and premium collection and reconciliation functions. This may include costs for the collection and reconciliation of cash, group and membership set-up and maintenance, contract, identification card and directory preparation and issuance, and enrollment materials. This may include allocations from finance, information services, programming and ad hoc reporting.

2. Claim Processing

This category includes all costs associated with the adjudication and adjustment of claims, coordination of benefits processing, maintenance of the claim system, printing of claim forms, claim quality assurance, electronic data interchange (EDI) expenses as pertains to claim processing, and fraud investigation. This may include allocations from information services, programming and ad hoc reporting, mail room, and legal.

3. Customer Service

This category includes all costs associated with individual, group or provider support relating to membership, open enrollment, grievance resolution, claim problems, and specialized phone services and equipment. This may include allocations from information services, programming and ad hoc reporting, finance, and sales and marketing.

4. Charitable Contributions

This category includes all costs related to contributions to external agencies.

5. Product Management and Marketing

This category includes all costs associated with the management and marketing of current products. This may include costs relating to product promotion and advertising, public relations, sales, pricing, broker fees and commissions, internal commissions and commissions processing, marketing materials, large account reporting, changes/additions to current products, and enrollee education. This may include allocations from information systems, programming and ad hoc reporting, underwriting, legal, executives, finance, actuarial and network management.

6. Regulatory Compliance and Government Relations

This category includes all costs associated with federal and state reporting, rate filing, state and federal audits, tax accounting and lobbying, licensing and filing fees, and costs associated with the preparation and filing of all financial, utilization, statistical and quality reports, and summary plan descriptions for government programs. This may include

allocations from information systems, ad hoc reporting and programming, finance, actuarial, sales and marketing, underwriting, contract, legal, quality assurance, compliance, and executives.

7. Provider Relations and Contracting

This category includes all costs associated with contract negotiation and preparation, **credentialing**, monitoring of provider compliance, field training with providers, provider communication materials and bulletins, and determination of provider settlements.. This may include allocations from finance, legal, mail room, accounting, information systems, ad hoc reporting and programming, and dental.

8. Quality Assurance and Utilization Management

This category includes all costs associated with quality assurance, practice protocol development, utilization review, peer review, **credentialing**, outcomes analysis, and other medical care evaluation activities. This may include allocations from information systems, ad hoc reporting and programming, executives, and legal.

9. Wellness and Health Education

This category includes all costs associated with wellness and health promotion, disease prevention, member education and materials, provider education and outreach services. This may include allocations from marketing, medical services, and printing,

10. Research and Product Development

This category includes all costs associated with outcomes research, medical research programs, product design and development for products not currently offered, major systems development and integrated service network development. This may include allocations from actuarial, information services, ad hoc reporting and programming, marketing, finance, underwriting, and wellness programs.

11. General Administration

This category includes all costs not outlined or allocated above, including human resources, facility maintenance, payroll, general accounting, capitation, finance, executives, internal audit, treasury, actuarial, finance, information systems, public relations, office management, general office supplies and equipment, legal, board, outside consulting services, membership fees in trade organizations, and mail room.

Minutes for the Work Group on Chapter 4652
Aggregate Data from Commercial Insurers and HMOs
May 6, 1994, 9:00 - 12:00

Persons attending the meeting included:

Michelle Barnes Lewis, Department of Health
Steve Bunde, HealthPartners
Judy Busse, Blue Cross Blue Shield
Dick DiFalco, Delta Dental
Jim Golden, Department of Health
Michelle Hegarty, Medica
Michele Hostager, Prudential Insurance
Dave Orren, Department of Health
Dan Rydel, Blue Cross Blue Shield
Anne Marie Seward, Metropolitan Health Plan
Patti Warden, Medica
JoMarie Williamson, Department of Health

The meeting began with a review of minutes from the last meeting. There were no changes. Dave Orren then provided a summary of the Task Force meeting on Wednesday. This work group and the providers work group both had largely completed their work on proposed categories for the survey. Both work groups also made much progress on the definitions. The hospital work group had begun identification of its proposed categories and had not yet drafted definitions. The Task Force approved of the general direction taken by this work group and complimented them on good progress regarding this issue.

The discussion then moved to the draft definitions of indirect health care expenditure categories. These drafts were developed based on the bulleted items provided by each work group member at the last meeting. Based on comments by the work group at the last meeting, MDH also looked at the tax section. MDH suggests that the section be streamlined to include only two items: MinnesotaCare and All Other Taxes. However, if members of the work group felt that it would be useful to provide a breakout, MDH is open to the suggestion. The group indicated that they did not feel it was necessary to include more detail regarding the types of taxes.

JoMarie also asked the group to comment on research and whether or not it should be split between medical research and other types of research. For ISN's, medical research will be exempted from the growth limits and there may be value in splitting those costs out now. The group agreed that at this point, there was very little that would likely be classified as pure medical research. This is something the group should consider later along with a clearer definition from MDH of medical research.

The suggested changes to the draft definitions were as follows:

1. Billing and Enrollment

This category includes all costs associated with group and/or individual billing, member enrollment and premium collection and reconciliation functions. This may include costs for the collection and reconciliation of cash, group and membership set-up and maintenance, contract, identification card and directory preparation and issuance, electronic data interchange (EDI) expenses as pertains to billing and enrollment, and enrollment materials. This may include allocations from finance, and information services, ~~programming and ad hoc reporting~~.

2. Claim Processing

This category includes all costs associated with the adjudication and adjustment of claims, coordination of benefits processing, maintenance of the claim system, printing of claim forms, claim quality assurance, electronic data interchange (EDI) expenses as pertains to claim processing, and fraud investigation. This may include allocations from information services, ~~programming and ad hoc reporting, mail room~~, and legal.

3. Customer Service

This category includes all costs associated with individual, group or provider support relating to membership, open enrollment, grievance resolution, claim problems, and specialized phone services and equipment. This may include allocations from information services, ~~programming and ad hoc reporting, finance,~~ legal, and sales and marketing.

4. Charitable Contributions

This category includes all costs related to contributions ~~to external agencies~~ made for charitable purposes.

5. Product Management and Marketing

This category includes all costs associated with the management and marketing of current products. This may include costs relating to product promotion and advertising, ~~public relations,~~ sales, pricing, broker fees and commissions, internal commissions and commissions processing, marketing materials, ~~large~~ account reporting, changes/additions to current products, and enrollee education regarding coverage. This may include allocations from information systems, ~~programming and ad hoc reporting,~~ underwriting, legal, ~~executives,~~ finance, actuarial, public relations, and network management.

6. Regulatory Compliance and Government Relations

This category includes all costs associated with federal and state reporting, rate filing, state and federal audits, tax accounting and lobbying, licensing and filing fees, and costs

associated with the preparation and filing of all financial, utilization, statistical and quality reports, and ~~summary plan descriptions of~~ administration of government programs. This may include allocations from information systems, ~~ad hoc reporting and programming,~~ finance, actuarial, sales and marketing, underwriting, contract, legal, utilization management, quality assurance, and compliance~~, and executives~~.

7. Provider Relations and Contracting

This category includes all costs associated with contract negotiation and preparation, ~~credentialing,~~ monitoring of provider compliance, field training with providers, provider communication materials and bulletins, and ~~determination~~ administration of provider capitations and settlements. This may include allocations from finance, legal, ~~mail room,~~ accounting, actuarial, and information systems. ~~ad hoc reporting and programming, and dental.~~

8. Quality Assurance and Utilization Management

This category includes all costs associated with quality assurance, practice protocol development, utilization review, peer review, credentialing, outcomes analysis related to existing products, and other medical care evaluation activities. This may include allocations from information systems, actuarial ~~ad hoc reporting and programming, executives,~~ and legal.

9. Wellness and Health Education

This category includes all costs associated with wellness and health promotion, disease prevention, member education and materials, provider education and outreach services. This may include allocations from marketing, medical services, and printing.

10. Research and Product Development

This category includes all costs associated with outcomes research, medical research programs, product design and development for products and programs not currently offered, major systems development and integrated service network development. This may include allocations from actuarial, information services, ~~ad hoc reporting and programming,~~ marketing, finance, underwriting, and wellness programs.

11. General Administration

This category includes all other costs not outlined or allocated above, including human resources, facility maintenance, payroll, general accounting, ~~capitation,~~ finance, executives, internal audit, treasury, actuarial, finance, information systems, ~~public relations,~~ office management and occupancy costs, general office supplies and equipment, legal, board, outside consulting services, membership fees in trade organizations, public relations and mail room.

We also discussed reordering the definitions. Charitable contributions will be moved toward the bottom of the form. MDH will also include language in the instructions noting that the items listed within each definition do not include a comprehensive list, but should give a feel for the types of costs included within each functional category.

Please see the attached list for revised draft definitions.

Report 3 (or 1 for HMOs)
Dental

The discussion of Report 3 began with the dental category. The work group recommends that MDH indicate that the dental costs included in this category should be those from dental contracts. Therefore, certain types of oral surgery and TMJ, for instance, may be included in the medical categories if paid as medical claims. As indicated in previous discussions, medical dental expenses will be included in definition for other health professional costs. Following the contract or rider allows us to have a dental member months figure that is consistent with the reported dental expenses. Also, it matches the way most work group members currently split out their expenses. Other health professional costs will then contain a few comprehensive policies that include preventative dental for children. There are very few of these policies, however.

The group also suggested that we make the definitions more parallel to the medical definitions. For instance, the current definition refers to dentists only, we may wish to make the definition broader to include other types of dental providers. Also, there was concern about including services that are experimental, cosmetic or voluntary. The medical definitions do not include similar language. These expenses are often not covered benefits so it may be more appropriate to include non-covered amounts as subscriber liability (see discussion of subscriber liability below).

Emergency Room

Emergency costs are not broken out in the HCFA model. These expenses were broken out in the current survey based on interest by the Health Care Commission in proper and improper usage of the emergency room. It would be useful to track the trend in these expenditures as health care reform progresses. However, the current definition refers only to "true" medical emergencies, not all costs from the emergency room. Most work group members indicated that they provided data based on site of service, not only "true" emergencies. In addition, emergency room physician costs will be reported based on how the provider bills. If the physician bills separately, the cost would be in physician costs. It would be very difficult to match up these charges with ER visits.

JoMarie asked if it would be possible to provide data on both site of service and "true" emergencies so that the trends in each could be monitored over time. Most work group members indicated that this would be very difficult and require extensive additional programming. One member suggested that we pursue other ways to address this policy

question. Most plans are probably working on this issue and it may be possible for the Department to work with their data.

Non-durable medical goods

This category should be renamed "Pharmacy and other non-durable medical goods". The definition should also note that this will include outpatient RX only. Inpatient RX costs will be in the inpatient hospital category.

Vision products and other medical durables

The group suggested we use the HCFA definition for this category. It more clearly outlines the types of expenses to include.

Mental Health and Chemical Dependency

The group recommends that MDH consider the UDDC definitions for these expenses.

Member months

We should remove the reference to "prepaid basis" since this does not apply to indemnity coverage. We should also include an example in the instructions.

Subscriber liability

It may be more consistent to refer to this as "member liability". The work group also noted that we will have difficulty getting to total liability. The intent of tracking these costs is to arrive at total expenditures and to monitor them as part of growth limits legislation. Legislation states that plans may not meet the growth limits by cutting back on benefits provided. Tracking the change in subscriber liability is a way to monitor that piece of legislation. However, work group members expressed concern with quantifying this accurately.

Total denied or disallowed claims may include many items, some of which fall into the types of expenses MDH wishes to monitor and others that do not. For most plans, it would be very difficult to separate claims disallowed because, for instance, the claimant was beyond the plan maximum from claims denied because the person was not eligible. Deductibles, coinsurance and copayments, however are easier to identify and report. This is another area that will require additional discussion with the work group.

Medicare

MDH should also be careful when combining the data because there is a potential for double counting between medicare and medicare supplement policies. For instance, medicare payers will report subscriber liability. A portion of those costs will be picked up under medicare supp. plans who will also report subscriber liability. Also, it may be that this survey is the

only way to collect data regarding pharmacy costs under medicare supp. policies. MDH will continue to discuss medicare reporting issues with work group members in future meetings.

Next meeting:

The next meeting will be at **Minnesota Department of Health** (Metro Square Building in St. Paul) on Friday, May 20 from 9:00 - 12:00. A map is attached to these minutes. We will finalize definitions for indirect health care expenditures, discuss premium and reserve definitions, and review draft definitions for report 3.

Draft Definitions - Indirect Health Care Costs 5/9/94

1. Billing and Enrollment

This category includes all costs associated with group and/or individual billing, member enrollment and premium collection and reconciliation functions. This may include costs for the collection and reconciliation of cash, group and membership set-up and maintenance, contract, identification card and directory preparation and issuance, electronic data interchange (EDI) expenses as pertains to billing and enrollment, and enrollment materials. This may include allocations from finance, and, information services.

2. Claim Processing

This category includes all costs associated with the adjudication and adjustment of claims, coordination of benefits processing, maintenance of the claim system, printing of claim forms, claim quality assurance, electronic data interchange (EDI) expenses as pertains to claim processing, and fraud investigation. This may include allocations from information services, and, legal.

3. Customer Service

This category includes all costs associated with individual, group or provider support relating to membership, open enrollment, grievance resolution, claim problems, and specialized phone services and equipment. This may include allocations from information services, finance, legal, and, sales and marketing.

4. Product Management and Marketing

This category includes all costs associated with the management and marketing of current products. This may include costs relating to product promotion and advertising, sales, pricing, broker fees and commissions, internal commissions and commissions processing, marketing materials, account reporting, changes/additions to current products, and enrollee education regarding coverage. This may include allocations from information systems, underwriting, legal, finance, actuarial, public relations, and, network management.

5. Regulatory Compliance and Government Relations

This category includes all costs associated with federal and state reporting, rate filing, state and federal audits, tax accounting, lobbying, licensing and filing fees, and costs associated with the preparation and filing of all financial, utilization, statistical and quality reports, and administration of government programs. This may include allocations from information systems, finance, actuarial, sales and marketing, underwriting, contract, legal, utilization management, quality assurance, and, compliance.

6. Provider Relations and Contracting

This category includes all costs associated with contract negotiation and preparation, monitoring of provider compliance, field training with providers, provider communication materials and bulletins, and administration of provider capitations and settlements. This may include allocations from finance, legal, accounting, actuarial, and, information systems.

7. Quality Assurance and Utilization Management

This category includes all costs associated with quality assurance, practice protocol development, utilization review, peer review, credentialing, outcomes analysis related to exiting products, and other medical care evaluation activities. This may include allocations from information systems, and, legal.

8. Wellness and Health Education

This category includes all costs associated with wellness and health promotion, disease prevention, member education and materials, provider education and outreach services. This may include allocations from marketing, medical services, and, printing.

9. Research and Product Development

This category includes all costs associated with outcomes research, medical research programs, product design and development for products and programs not currently offered, major systems development and integrated service network development. This may include allocations from actuarial, information services, marketing, finance, underwriting, and,, wellness programs.

10. Charitable Contributions

This category includes all costs related to contributions made for charitable purposes.

11. General Administration

This category includes all other costs not outlined or allocated above, including human resources, facility maintenance, payroll, general accounting, finance, executives, internal audit, treasury, actuarial, finance, information systems, office management and occupancy costs, general office supplies and equipment, legal, board, outside consulting services, membership fees in trade organizations, public relations, and, mail room.

Report 3 Definitions

Chemical dependency services means all costs related to inpatient and outpatient chemical dependency services as defined by the following ICD-9 diagnosis code ranges: 303.00 - 305.92 and DRG codes 433-437 and the following CPT codes: 90801, 90841, 90843, 90844, 90844.22, 90846, 90847, 90847.22, 90849, 90853, 98900, 98902, 98910, 98912.

Dental services means all costs, professional and other, provided under dental services contracts or riders.

Durable medical goods means all costs for such items as eye glasses, hearing aids, surgical appliances and supplies, bulk and cylinder oxygen and equipment rental.

Emergency services *means all costs for medical care provided in the emergency room of a hospital.* **Lynn, do we want to include urgent care here?**

Inpatient hospital services means costs for those services furnished by a hospital for inpatient services. The costs reported under this item should exclude mental health services as defined in ???? and chemical dependency services as defined in ????.

Home health care means all costs for medical care services delivered in the home under the direction of a physician.

Mental health services means all costs related to inpatient and outpatient mental health services as defined by the following ICD-9 diagnosis code ranges: 290-302.9 and DRG codes 424-432 and the following CPT codes: 90801, 90841, 90843, 90844, 90844.22, 90846, 90847, 90847.22, 90849, 90853, 98900, 98902, 98910, 98912.

Pharmacy and other nondurable medical goods means costs for pharmaceuticals and nonreusable supplies or pieces of equipment that are used to treat a health condition.

Outpatient services means costs for those services offered by a hospital which are furnished to ambulatory patients not requiring emergency care and for which there is not a room and board charge. The costs reported under this item should exclude mental health services as defined in ???? and chemical dependency services as defined in ????.

Other health professional services means costs for all services provided by health professionals other than physicians and dentists including chiropractors, therapists, social workers, nurse practitioners, and medical dental services. Services for mental health services as defined in ???? and chemical dependency services as defined in ???? should be excluded from this item.

Physician services means costs for all services provided by or under the supervision of licensed medical doctors, doctors of osteopathy and ophthalmologists. Services for mental health services as defined in ???? and chemical dependency services as defined in ???? should be excluded from this item.

Member means a person who has been enrolled as a subscriber or an eligible dependent of a subscriber and for whom the insurer has accepted the responsibility for the provision of basic health services as may be contracted for.

Medical member month means the equivalent to one member for whom the insurer has recognized premium revenue for one month under a medical contract. Member months should be totaled for the calendar year of the report.

Dental member month means the equivalent to one member for whom the insurer has recognized premium revenue for one month under a dental contract. Member months should be totaled for the calendar year of the report.

Member liability means the total amount payable by the member for health care services. This may include deductibles, coinsurance, copayments, amounts beyond plan maximums and **non-covered benefits**. If data regarding this item is not available, an actuarily justified estimate is permissible.

Loss reserves. "Loss reserves" has the meaning given in Minnesota Statutes, section 60A.12, subdivision 5.

Earned premium. "Earned premium" has the meaning given in Minnesota Statutes, section 60A.02, subdivision 10.

Unearned premium. "Unearned premium" has the meaning given in Minnesota Statutes, section 60A.02, subdivision 11.

Unearned premium reserve. "Unearned premium reserve" has the meaning given in Minnesota Statutes, section 60A.12, subdivision 4.

Minutes for the Work Group on Chapter 4652
Aggregate Data from Commercial Insurers and HMOs
May 20, 1994, 9:00 - 12:00
Minnesota Department of Health

Persons attending the meeting included:

Michelle Barnes Lewis, Department of Health
Steve Bunde, HealthPartners
Michelle Hegarty, Medica
Michele Hostager, Prudential Insurance
Joan Johnson, NWNL Health Network
Nancy Krogstad, Fortis
Dave Orren, Department of Health
Norma Porter, Delta Dental
Bob Power, HealthPartners
Dan Rydel, Blue Cross Blue Shield
Carrie Schulz, Mid-America Mutual
Anne Marie Seward, Metropolitan Health Plan
JoMarie Williamson, Department of Health

Changes to 5/6/95 Minutes

There were no changes to the minutes from the May 6th Work Group meeting. A question was raised whether taxes should be removed from Report 1 and Report 2 of the HMO filings. Taxes are not included in either page of the filing. This should be made clearer for next year.

Interim growth limits questions

The group had several questions about member liability as it relates to interim growth limits. JoMarie explained that the interim limits are monitored on expenditure data which includes incurred claims and administrative costs. Member liability is not required as part of the limits, but it must be reported. MDH is required to monitor the change in member liability and carriers may not increase member liability as a means of meeting the limits. Some companies have elected to include member liability in their growth limit calculation.

Are government programs such as HCFA included in the interim limits? JoMarie indicated that they are reviewing this issue.

Review of Expenditure Definitions

The group reviewed the indirect health care expenditure definitions. There were no suggestions for further changes. JoMarie asked if this would be the work group's recommendation to the Department. This met with general approval although no formal vote was taken.

Premium and Reserve Definitions

The group then discussed premium and reserve definitions. JoMarie explained that MDH staff has discussed how new reserve regulations will be monitored by the department. These new regulations apply mainly to HMOs and non-profit health service plans. The department does not plan to include the information required to meet this new legislation in the aggregate data surveys - which are what these rules address. The information will be gathered via existing data reporting mechanisms and will not be part of the survey of aggregate data. However, the emergency rules ask for aggregate reserve information. This category will be dropped from the permanent rules.

MDH is required to monitor the trend in aggregate premiums and collect total revenue and premium revenue data. Carriers are required to pass on savings from growth limits to consumers in the form of lower premiums. MDH would like to see total revenue, premium revenue and other revenue in the survey. However, the emergency rules' definitions are problematic and do not give the information intended. Specifically, there are subtotals for earned and unearned premium and a grand total. Instead, earned premium should equal paid premium plus the change in unearned premium.

Bob P. wondered how we would handle dividends. Technically, these amounts should be subtracted from premiums. Language should be added to the definition outlining that "refunds based on experience" should be excluded.

Bob P. also asked about the status of using data from the Department of Revenue for data collection from providers. MDH continues to look into this with the Department of Revenue, however, there is some concern about tying data collection to the MinnesotaCare tax collection. MDH staff have met with staff from Revenue regarding this already and they will continue to consider this option.

The group then discussed where to draw the line between insured and self-insured cases. There is a broad spectrum of arrangements, so a clear definition is difficult to find. For instance, where do Minimum Premium Plans (MPP) fall? Bob suggested we look at taxable status to determine where the ERISA exemption applies. JoMarie mentioned that for this year, she told companies who asked about this issue to break out MPP premium (which reflects only administration) from other premium. A separate reporting line for MPP may be incorporated into future survey forms.

How would we define "other revenue". Before the work group can make a recommendation regarding this, we need to define the scope. Is MDH only interested in health care related revenues? For instance, some plans sell services such as information services technologies, quality assurance programs or processing systems. Should revenue from these services be disclosed? Does other revenue pertain only to Minnesota residents? A definition of "other revenue" may be a problem because the boundaries are not as clearly defined as for premium.

Michelle Hegarty also mentioned a concern about looking at trends in premium revenue. Taxes are not included in expenditures, but are priced for in premium. This may make comparisons of trends difficult, particularly when new taxes are imposed or existing taxes are changed. However, total taxes will be provided in another portion of the survey. Also, in monitoring changes in premium, changes like plan design differences and membership differences need to be considered. JoMarie asked if the expenditure adjustment methodologies could be applied to premium, too. On the surface it appears that they can, however, there may be additional issues to consider.

What data are we collecting from self-insureds? Are we capturing what employees of self-insured plans may have to pay? JoMarie explained the data collection process for self-insureds and that we are not receiving data directly from the employer. Several in the group speculated that we would not get much data from self-insured plans. JoMarie explained that we are getting better compliance than expected, however, by no means the entire self-insured population. Many of the HMOs and Blue Cross and Blue Shield are providing voluntary data. Some TPAs are providing data and many commercial insurers are also.

Time Line for Completion of Rules Project

The plan is for the work group to review a draft of the rules and the statement of need and reasonableness (SONAR) by the June 15 task force meeting. A draft of the rules and SONAR will be sent to work group members on June 3 to allow for time to review before our meeting on June 10. At the next meeting, the work group will make its recommendations regarding the rules and initial feedback regarding the SONAR. The task force will give its comments at the June 15 task force meeting. There will then be an informal review period of about 1½ months where the drafts will be sent to the Data Institute and other interested parties (including work group members). The Department will also do its internal review during this time.

The proposed rules will be published in the State Register in early August. Interested persons will be notified of this by mail. A 30-day public comment period will follow, during which persons can suggest changes to the proposed rules and request a hearing. If there are 25 or more requests for a hearing, a hearing will be held, probably in late September. If no hearing is needed, the final rules will be adopted in early October. If a hearing is required, the final rules will be adopted in mid December.

Review of Draft Rules

The emergency rules indicate that an individual report is required for each "affiliated company" that is part of an organization. However, enforcement of the interim limits may be monitored based on the aggregated information of all affiliated companies within that organization. MDH is looking into allowing an organization to submit a single form when a single expenditure limit is elected. MDH will likely allow this and make a change in part 0110, subpart 3.

Carrie noted a problem with the term group purchaser. It would seem to exclude anyone in the individual market and causes much confusion. JoMarie acknowledged the concern and explained that we intend to include the actual definition in the rules to alleviate confusion. The group also suggested we include language clarifying this in the scope section. The following includes notes from the discussion of the definitions included in the rules.

Chemical Dependency

This definition was developed based on UDDC information. There is confusion about using "and"in reference to the codes. Actually, codings may appear in combination or may not. We should add wording indicating that varying combinations of these codes may be used. Dave wondered how we will handle additions and changes to the codes. JoMarie mentioned that we will review these rules annually, at least at first. We could modify the codes then. Bob recommended that we add language indicating it is okay to use the "amended equivalents".

Do we need to more clearly outline the hierarchy of data? It may be helpful in the chemical dependency and mental health definitions to note that these expenses should be pulled out first and then the remaining expenses should be put in the specific categories. We also need to address that the principle diagnosis should be used. Finally, for those groups that are capitated, this should include a reasonable breakout of the capitation - if the capitation includes both chemical dependency and mental health costs.

Dentist

This definition can be deleted because the term will not be used in the permanent rules.

Durable medical goods

We should retain reference to repeated use which was used in the emergency rules. Carrie will also provide a list of additional types of costs included. We should at least reference to wheelchairs. The word supplies should be deleted.

Emergency services

Should ambulance charges be included? They may currently be reported under several categories. For most, this is a very small amount in comparison to the total costs. We will continue to discuss where to report ambulance costs, but will not mention explicitly in the definitions for now.

General administration

We should add a note indicating that taxes and assessments aren't included. We should also make that clear in the total line for indirect health care expenditures on the form.

Inpatient hospital

Should this include skilled nursing facility charges? There is interest in splitting this out at MDH because these costs are much different than other types of inpatient costs and may provide valuable information regarding trends of care. Skilled nursing facility costs are also broken out in the HCFA forms. However, many in the group voiced strong concerns about adding another element to the report. While it is possible to segregate these expenses, it is an additional burden to report and many work group members voiced concerns with this. JoMarie will take this feedback back to the department. The group will know, hopefully at the next meeting, the department's decision regarding this.

Hospice charges are included here and should be mentioned specifically.

Insurance company

If definition stays in the permanent rules, it should refer to section 60 C also.

Medical member months

We need to correct reference to dental - it should read medical.

Member liability

Should non-covered benefits be included? COB situations will make quantifying this a problem. For instance, the primary carrier may list a significant amount as "non-covered" which is later picked up under the secondary contract. The primary carrier most often has no way of identifying if a COB situation exists. However, amounts in this may quantify health care spending by consumers on amounts outside their contract (to the extent they submit claims to their carrier). If this part were excluded, we would miss that portion of total spending. This item is also not mentioned in statute specifically, unlike the other parts of the definition. Eliminating it would be difficult for many people also. Some in the group recommended we omit this reference since it is not clearly outlined in statute. MDH will pursue this further. Also, the term "data" is plural and "actuarially" is spelled incorrectly.

Mental Health

MDH will check that we have all codes listed correctly. We will add similar language as outlined under chemical dependency.

MinnesotaCare Tax

We should eliminate the word direct from the definition.

Other taxes and assessments

We should change "payments made to .... " to "payments or amounts accrued to government agencies".

MDH should also look at the wording of this to consider renters who pay property tax to the owner. We will exclude taxes for those who own property, this should be treated consistently.

Next meeting

We did not have time to finish definitions. Each member was asked to review the remaining definitions and call/write JoMarie with comments. We will meet again on June 10 from 9:00 to 11:00 to discuss the draft that will be presented to the Task Force. Health Partners will host the meeting. At that time, the group will review another rules draft and a copy of the SONAR.

Appendix B

CHAPTER 4652
DEPARTMENT OF HEALTH
HEALTH SYSTEMS DEVELOPMENT DIVISION
DATA REPORTING AND COLLECTIONS; AGGREGATE DATA; COMMERCIAL INSURANCE COMPANIES; OTHERS

4652.0100 [Emergency] DEFINITIONS.

Subpart 1. **Scope.** For the purposes of parts 4652.0100 to 4652.0170 [Emergency], the terms in this part have the meanings given them.

Subp. 2. **Billing and data processing expenses.** "Billing and data processing expenses" means all direct costs incurred in the processing of charges to patients' accounts, preparing and submitting claim forms, cashiering, credit and collection functions, and maintaining and operating the data processing system of the organization. Direct costs include wages and benefits, professional fees, supplies, purchased services, and any other resource used in accomplishing these activities. Also included are all wages and benefits and other direct costs incurred in the administration of the coordination of benefits procedures that exist for group contracts or other health plan contracts. Coordination of benefits refers to the set of provisions establishing the general order in which benefits are determined when a person is covered by more than one plan.

Subp. 3. **Chemical dependency services.** "Chemical dependency services" has the meaning given in Minnesota Statutes, section 254B.01, subdivision 3.

Subp. 4. **Commissioner.** "Commissioner" means the commissioner of the Department of Health.

Subp. 5. **Dental services.** "Dental services" means a diagnostic, preventive, therapeutic, or corrective procedure furnished by a dentist or under the supervision of a dentist, as defined in rule by the Board of Dentistry. It includes services characterized as experimental, cosmetic, or voluntary.

Subp. 6. **Dentist.** "Dentist" means a person who is licensed to provide health services under Minnesota Statutes, section 150A.06, subdivision 1.

Subp. 7. **Department.** "Department" means the Minnesota Department of Health.

Subp. 8. **Durable medical goods.** "Durable medical goods" means a device or equipment that can withstand repeated use, is provided to correct or accommodate a physiological disorder or physical condition, and is suitable for use in the recipient's residence, including a nursing facility, if that is the patient's place of residence. Durable medical goods includes vision products, such as eyeglasses.

Subp. 9. **Earned and unearned premium.** "Earned premium" has the meaning given in Minnesota Statutes, section 60A.02, subdivision 10. "Unearned premium" has the meaning given in Minnesota Statutes, section 60A.02, subdivision 11.

Subp. 10. **Education program expenses.** "Education program expenses" has the meaning given in part 4650.0102, subpart 13.

Subp. 11. **Emergency services.** "Emergency services" has the meaning given in part 4650.0102, subpart 14.

Subp. 12. **Fees expenses.** "Fees expenses" means all costs associated with the organization's new or renewal certification with state or federal regulatory agencies and examination costs related to regulation, including any fines levied against the organization.

Subp. 13. **General administration expenses.** "General administrations expenses" means all costs associated with the overall management and administration of the organization, such as costs of governing boards, executive wages and benefits, including stock options, legal staff functions that primarily concern the overall management and operation of the organization and excluding legal staff already allocated to other functions, auxiliary and other volunteer groups, public relations not included in selling and promotion or government relations, purchasing, communications, printing and duplicating, receiving and storing, and personnel management. It also includes all costs related to fiscal services, such as general accounting, budgeting and costs, payroll accounting, accounts payable, plant and equipment, and inventory accounting.

Subp. 14. **Government relations expenses.** "Government relations expenses" means all wages and benefits, donations, and financial and other support, for the purpose of lobbying and influencing policymakers and legislators, including membership in trade organizations, and all expenses associated with public policy development, such as response to rulemaking and interaction with government agency personnel. Membership in trade association projects that are directly related to research and education are excluded.

Subp. 15. **Group purchaser.** "Group purchaser" has the meaning given in Minnesota Statutes, section 62J.03, subdivision 6.

Subp. 16. **Health carrier.** "Health carrier" has the meaning given in Minnesota Statutes, section 62A.011, subdivision 2.

Subp. 17. **Health plan.** "Health plan" has the meaning given in Minnesota Statutes, section 62A.011, subdivision 3.

Subp. 18. **Inpatient hospital services.** "Inpatient hospital services" has the meaning given in part 4650.0102, subpart 21.

Subp. 19. **Insurance company.** "Insurance company" means an organization licensed under Minnesota Statutes, chapter 60A, to offer, sell, or issue a policy of accident and sickness insurance as defined in Minnesota Statutes, section 62A.01.

Subp. 20. **Insurer.** "Insurer" has the meaning given in Minnesota Statutes, section 72A.491, subdivision 14.

Subp. 21. **Loss reserves.** "Loss reserves" has the meaning given in Minnesota Statutes, section 60A.12, subdivision 5.

Subp. 22. **Medical assistance.** "Medical assistance" means the program established under title XIX of the Social Security Act, United States Code, title 42, section 1396, and Minnesota Statutes, chapter 256B. Medical assistance includes general assistance medical care or GAMC, as defined in part 9505.0500, subpart 12, unless otherwise specified.

Subp. 23. **Medicare.** "Medicare" means the health insurance program for the aged and disabled under title XVIII of the Social Security Act, United States Code, title 42, section 1395.

Subp. 24. **Member.** "Member" means a person who has been enrolled as a subscriber or an eligible dependent of a subscriber and for whom the insurer has accepted the responsibility for the provision of basic health services as may be contracted for.

Subp. 25. **Member month.** "Member month" means the equivalent to one member for whom the insurer has recognized premium revenue on a prepaid basis for one month.

Subp. 26. **Mental health services.** "Mental health services" has the meaning given in Minnesota Statutes, section 245.462, subdivision 19.

Subp. 27. **Minnesota comprehensive health association.** "Minnesota comprehensive health association" means the association created by Minnesota Statutes, section 62E.10.

Subp. 28. **MinnesotaCare.** "MinnesotaCare" means the program established in Minnesota Statutes, section 256.9352, subdivision 1.

Subp. 29. **Nondurable medical goods.** "Nondurable medical goods" means a nonreusable supply or piece of equipment that is used to treat a health condition, including drugs.

Subp. 30. **Outpatient services.** "Outpatient services" has the meaning given in part 4650.0102, subpart 29.

Subp. 31. **Other health professional services.** "Other health professional services" means a medically necessary health service provided by health professionals other than physicians and dentists, for services other than mental health and chemical dependency.

Subp. 32. **Physician.** "Physician" means a person who is licensed to provide health services within the scope of the person's profession under Minnesota Statutes, chapter 147.

Subp. 33. **Physician services.** "Physician services" means a medically necessary health service provided by or under the supervision of a physician.

Subp. 34. **Quality assurance expenses.** "Quality assurance expenses" means all direct costs associated with any activity or program established for the purpose of quality of care evaluation and utilization management. Direct costs include wages and benefits for personnel time devoted to, or in direct support of, such activities as quality assurance, development of practice protocols, utilization review, peer review, provider credentialing, and all other medical care evaluation activities, including the communication of information regarding these activities. Direct costs also include all professional fees, supplies, purchased services, and any other resource used in accomplishing these activities, and the implementation of programs of wellness education, patient education or health promotion, including the cost of professional staff and materials, participant's notification of services, and mail costs.

Subp. 35. **Regulatory and compliance reporting expenses.** "Regulatory and compliance reporting expenses" means all direct costs associated with, or directly incurred in, the preparation and filing of financial, statistical, or other utilization, satisfaction, or quality reports, or summary plan descriptions that are required by federal, state, and local agencies or other third parties. Direct costs include wages and benefits for personnel time, professional fees, supplies, purchased services, and the cost of any other resource used to fulfill these requirements.

Subp. 36. **Research program expenses.** "Research program expenses" has the meaning given in part 4650.0102, subpart 35.

Subp. 37. **Selling and promotion expenses.** "Selling and promotion expenses" means all direct costs related to marketing activities such as advertising, printing, marketing representative wages and fringe benefits, commissions, broker fees, travel, occupancy, and other expenses allocated to the marketing activity. All costs associated with health promotion, wellness education, and patient education programs are excluded. Costs

associated with health promotion and education should be distinguished from costs incurred while educating enrollees and patients about the services available from the organization.

Subp. 38. **Service plan corporations.** "Service plan corporations" has the meaning given in Minnesota Statutes, section 62C.02, subdivision 6.

Subp. 39. **Taxes and assessments expenses.** "Taxes and assessments expenses" means the direct payments made to government agencies including the MinnesotaCare tax under Minnesota Statutes, section 295.52, contributions to the Minnesota Comprehensive Health Association under Minnesota Statutes, section 62E.10, the medical assistance provider surcharge under Minnesota Statutes, section 256.9657, assessments by the health coverage reinsurance association, assessments by the Minnesota life and health insurance guaranty association, and any new assessments imposed by federal or state law. This category does not include fees or fines paid to government agencies.

Subp. 40. **Unearned premium reserve.** "Unearned premium reserve" has the meaning given in Minnesota Statutes, section 60A.12, subdivision 4.

Statutory Authority: *MS s 62J.35*

History: *18 SR 1572*

4652.0110 [Emergency] SCOPE.

The following group purchasers, as defined under part 4652.0100 [Emergency], subpart 14, are subject to the reporting requirements established by part 4652.0120 [Emergency]: all insurance companies, as defined in part 4652.0100 [Emergency], subpart 19, that reported $10,000 or more in total health premiums to the Department of Commerce in 1991; and all health service plan corporations as defined in part 4652.0100 [Emergency], subpart 38. Employee health plans offered by self-insured employers will be encouraged to comply with these reporting requirements.

Statutory Authority: *MS s 62J.35*

History: *18 SR 1572*

4652.0120 [Emergency] REPORTING REQUIREMENTS.

Subpart 1. **Basic contents.** A group purchaser must file with the commissioner a financial and statistical report by the dates specified in part 4652.0140 [Emergency], subpart 1. The report must include statistical and financial information for the reporting period specified in part 4652.0140 [Emergency].

Subp. 2. **Financial information.** Financial information for the financial and statistical report must include the following items for health and medical related claims, excluding any disability and accidental death and dismember claims, short-term disability claims, long-term disability claims, long-term care, or personal accident claims:

A. a statement of total earned and unearned premium revenues for the group purchaser, by type of policy, including group policies and individual policies;

B. a detailed statement of other revenues for the group purchaser, including unearned premium reserves and loss reserves;

C. a statement of total expenses incurred by the group purchaser, by type of policy, including group policies and individual policies;

D. a statement of expenses incurred by the group purchaser by service category, including physician services, other health professional services, hospital inpatient services, hospital outpatient services, emergency services, drugs and other medical nondurable goods, vision and other medical durable goods, chemical dependency services, mental health services, and dental services;

E. a statement of total subscriber liability or copayment, or its actuarial estimate, for all members covered by the group purchaser; and

F. a statement of total administrative expenses for the group purchaser and for each of the following functions, as defined in part 4652.0100 [Emergency]; billing and data processing; quality assurance; regulatory and compliance reporting; selling and promotion; general administration; government relations; and research program expenses and education program expenses; fees; and taxes and assessments. The statement required by this item may be estimated from existing accounting methods with allocation to specific categories based on a written methodology that is available for review by the commissioner and that is consistent with the methodology described in this part.

Subp. 3. **Statistical information.** Statistical information for the financial and statistical report must include the total number of members, as defined in part 4652.0100 [Emergency], subpart 23, for the health carrier, and by type of policy, including group policies and individual policies. Group purchasers that do not maintain enrollee dependent information may submit actuarial estimates of total number of members covered under all health policies.

Subp. 4. **Additional information.** The report must include certification by the governing authority of the group purchaser organization or its designee that the contents of the report are accurate and valid.

Statutory Authority: *MS s 62J.35*

History: *18 SR 1572*

4652.0130 [Emergency] PROVISIONS FOR FILING REPORTS.

Subpart 1. **Forms to be specified.** Group purchasers must file the information required by part 4652.0120 [Emergency] using the forms, instructions, and definitions designed and issued by the commissioner.

Subp. 2. **Filing.** Documents may be filed personally or delivered to the commissioner at the department's official offices during normal business hours.

Subp. 3. **Record complete.** No report required by this chapter is considered to be filed until the commissioner has determined that the report is complete according to part 4652.0170 [Emergency], subpart 1.

Statutory Authority: *MS s 62J.35*

History: *18 SR 1572*

4652.0140 [Emergency] FILING OF FINANCIAL AND STATISTICAL REPORT.

Subpart 1. **Filing report.** A group purchaser must file with the commissioner a financial and statistical report, as required by part 4652.0120 [Emergency], by February 15, 1994, for the period July 1, 1993 to December 31, 1993, and by April 1 of each successive year, for the preceding calendar year.

Subp. 2. **Failure to file.** A group purchaser that fails to file a financial and statistical report and has not requested an extension of time under part 4652.0160 [Emergency] to file that report, is in violation of parts 4652.0120 to 4652.0170 [Emergency].

Statutory Authority: *MS s 62J.35*

History: *18 SR 1572*

4652.0150 [Emergency] FILING OF REPORTS BY CORPORATIONS OR OTHER ORGANIZATIONS OPERATING MORE THAN ONE GROUP PURCHASER.

Each individual group purchaser must file a report, as required by part 4652.0120 [Emergency]. A corporation or organization operating more than one group purchaser may report for each group purchaser to the commissioner. The corporation or organization must provide all information separately for each group purchaser it operates.

Statutory Authority: *MS s 62J.35*

History: *18 SR 1572*

4652.0160 [Emergency] FILING OF REPORTS; EXTENSIONS.

A group purchaser that shows reasonable cause may obtain from the commissioner an extension to file the financial and statistical report. The group purchaser must provide the commissioner with a written request for an extension to file, specifying the reason or reasons for the requested extension, and the proposed date for filing the report. "Reasonable cause" means that the facility can demonstrate that compliance with the reporting requirements imposes an unreasonable cost to the facility, or that technical or unforeseen difficulties prevent compliance.

Statutory Authority: *MS s 62J.35*

History: *18 SR 1572*

4652.0170 [Emergency] REVIEW OF REPORTS.

Subpart 1. **Completeness.** The commissioner shall review each report required by part 4652.0120 [Emergency] in order to ascertain that the report is complete. If the report is found to be complete or if the commissioner has not notified the group purchaser within 30 days of receiving the report that the report is incomplete, then the report is deemed to be filed as of the day it was received. "Complete" means that the report contains adequate and appropriate data for the commissioner to begin the review and is in a form determined to be acceptable by the commissioner according to parts 4652.0120 to 4652.0140 [Emergency].

Subp. 2. **Incomplete report.** A report determined by the commissioner to be incomplete must be returned to the group purchaser with a statement describing the report's deficiencies. The group purchaser must resubmit an amended report to the commissioner. If the report is resubmitted within 14 days and is determined to be complete by the commissioner, then it shall be deemed to be filed as of the day it was first received by the commissioner.

Subp. 3. **Amending reports.** If a group purchaser discovers any error in its statements or calculations in any of its submitted reports ascertained by the commissioner to be complete, it must inform the commissioner of the error and submit an amendment to a report.

Subp. 4. **Error in reports.** If the commissioner discovers a significant error in the statements or calculations in a report, the group purchaser may be required to amend and resubmit the report by a date determined by the commissioner.

Subp. 5. **Timely.** "Timely" means that the report has been submitted within the time prescribed by part 4652.0140 [Emergency]; that an extension of this reporting time, as permitted by part 4652.0160 [Emergency] has not been necessary; and that the report has been determined to be complete under subpart 1.

Statutory Authority: *MS s 62J.35*

History: *18 SR 1572*

4652.0180 [Emergency] OFFICIAL OFFICES.

For purposes of parts 4652.0100 to 4652.0170 [Emergency], the official office of the commissioner of health is: Minnesota Department of Health, 717 Delaware Street Southeast, Minneapolis, Minnesota 55414.

Statutory Authority: *MS s 62J.35*

History: *18 SR 1572*