Department of Health

Health Care Delivery Systems

Adopted Permanent Rules Relating to Aggregate Group Purchaser Data

Rules as Adopted

4652.0010 INCORPORATIONS BY REFERENCE.

The ICD-9 diagnostic codes referenced in part 4652.0100, subparts 4 and 19, are contained in the fourth edition of the International Classification of Diseases, Clinical Modification, 9th Revision, 1994, and corresponding annual updates. This document is subject to annual revisions and is incorporated by reference. It is published by the United States Department of Health and Human Services, Health Care Financing Administration, and may be purchased through the Superintendent of Documents, United States Government Printing Office, Washington, D.C. 20402. It is available through the Minitex interlibrary loan system.

The CPT codes referenced in part 4652.0100, subparts 4 and 19, are contained in the Physician's Current Procedural Terminology, (CPT manual) 4th edition, 1993. It is subject to frequent change. It is published by and may be purchased from the American Medical Association, Order Department: OP054193, P.O. Box 10950, Chicago, Illinois 60610. It is available through the Minitex interlibrary loan system.

4652.0100 DEFINITIONS.

Subpart 1. **Scope.** For the purposes of chapter 4652, the terms in this part have the meanings given them.

Subp. 2. **Billing and enrollment expenses.** "Billing and enrollment expenses" means all costs associated with group and individual billing, member enrollment and premium collection and reconciliation functions. Billing and enrollment expenses includes costs for the collection and reconciliation of cash, group and membership set-up and maintenance, contract,

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identification card, and directory preparation and issuance, electronic data interchange expenses pertaining to billing and enrollment, and enrollment materials. Examples of traditional expense categories that a group purchaser may allocate in whole or in part to billing and enrollment expenses ~~also includes allocations from~~ are: finance and information ~~services~~ systems.

Subp. 3. **Charitable contributions expenses.** "Charitable contributions expenses" means all costs related to contributions made for charitable purposes.

Subp. 4. **Chemical dependency services expenses.** "Chemical dependency services expenses" means all costs related to inpatient and outpatient chemical dependency services that are coded using one or more of the following codes or amended equivalent codes:

A. ICD-9 diagnosis code ranges 303.00 to 305.92; and

B. CPT codes 90801, 90841, 90843, 90844, 90844.22, 90846, 90847, 90847.22, 90849, 90853, 98900, 98902, 98910, and 98912.

Chemical dependency services expenses also means all costs related to inpatient and outpatient chemical dependency services that are coded using codes from another coding system where the commissioner determines that the codes indicate diagnoses or procedures comparable to or consistent with codes listed in items A and B.

Subp. 5. **Claim processing expenses.** "Claim processing expenses" means 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 expenses pertaining to claim processing, and fraud investigation. Examples of traditional expense categories that a group purchaser may allocate in whole or in part to claim processing expenses ~~may also include allocations from~~ are: information systems and legal ~~services~~.

Subp. 6. **Commissioner.** "Commissioner" means the commissioner of the Minnesota Department of Health and

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authorized agents.

Subp. 7. **Customer service expenses.** "Customer service expenses" means all costs associated with individual, group, or provider support relating to membership, open enrollment, grievance resolution, claim problems, and specialized phone services and equipment. Examples of traditional expense categories that a group purchaser may allocate in whole or in part to customer service expenses ~~may include allocations from~~ are: information ~~services~~ systems, finance, legal, and sales and marketing.

Subp. 8. **Dental services expenses.** "Dental services expenses" means all professional and other costs provided under dental services contracts or riders.

Subp. 9. **Durable medical goods expenses.** "Durable medical goods expenses" means all costs for such items as wheel chairs, eyeglasses, hearing aids, surgical appliances, bulk and cylinder oxygen, equipment rental, and other devices or equipment that can withstand repeated use.

Subp. 10. **Emergency services expenses.** "Emergency services expenses" means all costs for medical care provided in the emergency room of a hospital.

Subp. 11. **General administration expenses.** "General administration expenses" means all costs not attributed or allocated to the categories of 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, and charitable contributions. Examples of traditional expense categories that a group purchaser may allocate in whole or in part to general administration expenses ~~includes~~ are: human resources, facility maintenance, payroll, general accounting, finance, executive, internal audit, treasury, actuarial, finance, information systems, office management and occupancy costs, general office supplies and equipment, legal, board, outside consulting services, membership

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fees in trade organizations, public relations, and mail room. General administration expenses does not include taxes and assessments.

Subp. 12. **Group purchaser.** "Group purchaser" means a person or organization that purchases health care services on behalf of an identified group of persons, regardless of whether the costs of coverage or services is paid for by the purchaser or by the persons receiving coverage or services, as further defined in rules adopted by the commissioner. Group purchaser includes, but is not limited to, integrated service networks; community integrated service networks; health insurance companies, health maintenance organizations, nonprofit health service plan corporations, and other health plan companies; employee health plans offered by self-insured employers; trusts established in a collective bargaining agreement under the federal Labor-Management Relations Act of 1947, United States Code, title 29, section 141, et seq.; the Minnesota comprehensive health association; group health coverage offered by fraternal organizations, professional associations, or other organizations; state and federal health care programs; state and local public employee health plans; workers' compensation plans; and the medical component of automobile insurance coverage.

Subp. 13. **Home health care expenses.** "Home health care expenses" means all costs for medical care services delivered in the home under the direction of a physician.

Subp. 14. **Inpatient hospital services expenses.** "Inpatient hospital services expenses" means all costs for those services furnished by a hospital for inpatient services, including hospice care. Inpatient hospital services expenses does not include costs of mental health services and chemical dependency services.

Subp. 15. **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. 16. **Member.** "Member" means a person who has been

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enrolled as a subscriber or an eligible dependent of a subscriber for whom the group purchaser has accepted the responsibility for the provision of basic health services under a contract.

Subp. 17. **Member liability.** "Member liability" means the total amount payable by the member for health care services. Member liability includes deductibles, coinsurance, copayments, and amounts beyond plan maximums.

Subp. 18. **Member month.** "Member month" means the equivalent to one member for whom the group purchaser has recognized premium revenue for one month.

Subp. 19. **Mental health services expenses.** "Mental health services expenses" means all costs related to inpatient and outpatient mental health services that are coded using one or more of the following codes or amended equivalent codes:

A. ICD-9 diagnosis code ranges 290 to 302.9 and 306 to 319; and

B. CPT codes: 90801, 90841, 90843, 90844, 90844.22, 90846, 90847, 90847.22, 90849, 90853, 98900, 98902, 98910, and 98912.

Mental health services expenses also means all costs related to inpatient and outpatient mental health services that are coded using codes from another coding system where the commissioner determines that the codes indicate diagnoses or procedures comparable to or consistent with codes listed in items A and B.

Subp. 20. **MinnesotaCare tax expenses.** "MinnesotaCare tax expenses" means all payments made for the MinnesotaCare tax under Minnesota Statutes, section 295.52.

Subp. 21. **Minnesota resident.** "Minnesota resident" means a person who is listed on the records of the group purchaser as a member having a zip code within Minnesota. The group purchaser may use subscriber records if it does not have separate records for each member.

Subp. 22. **Other health professional services expenses.** "Other health professional services expenses" means costs for

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all services provided by health professionals other than physicians and dentists, including chiropractors, therapists, social workers, nurse practitioners, and medical dental services. Other health professional services expenses does not include costs of mental health services and chemical dependency services.

Subp. 23. **Other taxes and assessments expenses.** "Other taxes and assessments expenses" means all payments or amounts payable to government agencies except for the MinnesotaCare tax under Minnesota Statutes, section 295.52. Other taxes and assessments expenses does not include fees or fines paid to government agencies.

Subp. 24. **Outpatient services expenses.** "Outpatient services expenses" means all 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. Outpatient services expenses does not include costs of mental health services and chemical dependency services.

Subp. 25. **Pharmacy and other nondurable medical goods expenses.** "Pharmacy and other nondurable medical goods expenses" means all costs to provide pharmaceuticals and nonreusable supplies or pieces of equipment that are used to treat a health condition.

Subp. 26. **Physician services expenses.** "Physician services expenses" means costs for all services provided by or under the supervision of licensed medical doctors, doctors of osteopathy, and ophthalmologists. Physician services expenses does not include costs of mental health services and chemical dependency services.

Subp. 27. **Product management and marketing expenses.** "Product management and marketing expenses" means all costs associated with the management and marketing of current products, including costs relating to product promotion and advertising, sales, pricing, broker fees and commissions, internal commissions and commissions processing, marketing materials, account reporting, changes or additions to current

products, and enrollee education regarding coverage. Examples of traditional expense categories that a group purchaser may allocate in whole or in part to product management and marketing expenses ~~may include allocations from~~ are: information systems, underwriting, legal, finance, actuarial, public relations, and network management.

Subp. 28. **Provider relations and contracting expenses.** "Provider relations and contracting expenses" means 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. Examples of traditional expense categories that a group purchaser may allocate in whole or in part to provider relations and contracting expenses ~~may include allocations from~~ are: finance, legal, accounting, actuarial, and information systems.

Subp. 29. **Quality assurance and utilization management expenses.** "Quality assurance and utilization management expenses" means 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. Examples of traditional expense categories that a group purchaser may allocate in whole or in part to quality assurance and utilization management expenses ~~may include allocations from~~ are: information systems and legal.

Subp. 30. **Regulatory compliance and government relations expenses.** "Regulatory compliance and government relations expenses" means 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. Examples of traditional expense categories that a group purchaser may allocate in whole or in part to regulatory compliance and government relations

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expenses ~~may include allocations from~~ are: information systems, finance, actuarial, sales and marketing, underwriting, contract, legal, utilization management, quality assurance, and compliance.

Subp. 31. **Research and product development expenses.** "Research and product development expenses" means 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. Examples of traditional expense categories that a group purchaser may allocate in whole or in part to research and product development expenses ~~may include allocations from~~ are: actuarial, information ~~services~~ systems, marketing, finance, underwriting, and wellness programs.

Subp. 32. **Skilled nursing facilities expenses.** "Skilled nursing facilities expenses" means all costs for those services furnished by a facility primarily engaged in providing skilled nursing care and related services for patients who require medical or nursing care or rehabilitation services. Skilled nursing facilities expenses does not include costs of mental health services and chemical dependency services.

Subp. 33. **Subscriber.** "Subscriber" means an individual, employee, or employee with dependents who has been enrolled with a group purchaser and for whom the group purchaser has accepted the responsibility for the provision of basic health services under a contract.

Subp. 34. **Total premium revenue.** "Total premium revenue" means all premiums charged on all health insurance policies written for Minnesota residents, including the change in unearned premium from the previous year, minus refunds based on experience.

Subp. 35. **Wellness and health education expenses.** "Wellness and health education expenses" means all costs associated with wellness and health promotion, disease prevention, member education and materials, provider education, and outreach services. Examples of traditional expense categories that a group purchaser may allocate in whole or in

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part to wellness and health education expenses ~~may include allocations from~~ are: marketing, medical services, and printing.

4652.0110 GROUP PURCHASER REPORTING.

Subpart 1. **Group purchasers must report; exceptions.** All group purchasers, except as noted in items A~~,~~ B~~,~~ ~~and~~ C to D, shall file with the commissioner a financial and statistical report on forms provided or approved by the commissioner.

A. An insurance company, as defined in part 4652.0100, subpart 15, that collected less than $3,000,000 in total health premiums for Minnesota residents in the year prior to the year that the data is covering may file a short report in lieu of filing a report that meets the requirements of part 4652.0120. The short report must be in writing, must state that the group purchaser collected less than $3,000,000 in total health premiums for Minnesota residents in the year prior to the year that the data is covering, and must provide the total number of members and subscribers covered at the end of the reporting period. For purposes of this item, "health premiums" means premiums for 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, the medical component of automobile insurance coverages, and personal accident coverages.

B. A state agency that reports under Minnesota Statutes, section 62J.40, is not subject to the reporting requirements of chapter 4652.

C. An employee health plan offered by a self-insured employer or an employee organization is not subject to the reporting requirements of chapter 4652. However, those employee health plans are encouraged to comply with these reporting requirements.

D. A group purchaser is not subject to the reporting requirements of this chapter if the coverages the group purchaser writes are limited to one or more of the following:

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accidental death and dismemberment coverages, short-term disability coverages, long-term disability coverages, long-term care coverages, workers' compensation coverages, automobile insurance coverages, and personal accident coverages.

Subp. 2. **Date for filing; reporting period.** The group purchaser shall file its report on or before April 1 of each year. The report must contain data for the preceding calendar year.

Subp. 3. **Organizations operating more than one group purchaser.** Group purchasers that are affiliated may elect to file a combined report, if they have elected to meet a combined growth limit under Minnesota Statutes, section 62P.04. Affiliated group purchasers that file a combined report must include in the report the name of each affiliated group purchaser.

Subp. 4. **Extensions.** The commissioner shall grant a group purchaser ~~that shows reasonable cause may obtain from the commissioner~~ an extension to file the report when the commissioner determines that the group purchaser has shown reasonable cause. To apply for an extension, 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 group purchaser can demonstrate that compliance with the reporting requirements imposes an unreasonable cost to the group purchaser, or that technical or unforeseen difficulties prevent compliance.

4652.0120 CONTENTS OF REPORT.

The report filed by a group purchaser must meet the requirements of items A to G. The information for each item 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, the medical component of automobile insurance coverages, and personal

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accident coverages.

A. The report must include total premium revenue and other revenue. "Other revenue" means, and must be specifically itemized into, the categories of minimum premium plan revenue, administrative services fee revenue, utilization review fee revenue, and reinsurance assumed revenue. Each revenue category must separate Medicare, and non-Medicare amounts.

B. The report must include total expenses incurred by type of policy, including insured business, self-insured business, Medicare, medical assistance, and general assistance.

C. The report must include total expenses incurred by service category, including physician services, other health professional services, inpatient hospital services, outpatient services, skilled nursing facilities, home health care, emergency services, pharmacy and other nondurable ~~medical~~ medical goods, durable medical goods, chemical dependency services and mental health services, dental services, and total indirect health care expenses. Each service category must be itemized by type of policy as specified in item B. For Medicare Supplement coverages and for coverages designed solely to provide payments on a per diem, fixed indemnity, or non-expense-incurred basis, the report may list total expenses rather than itemizing the expenses for these coverages by service category.

D. The report must include total member liability, or its actuarial estimate, for all covered persons.

E. The report must include total indirect health care expenses by the following categories: 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 information required for this report may be estimated from existing accounting methods with allocation to

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specific categories.

F. The report must include the total number of members and subscribers, as of the end of the reporting period, by type of policy, including family policies and individual policies and member months for the reporting period. Member months must be totaled for the calendar year of the report. This information must be reported separately for medical and dental contracts. Group purchasers that do not maintain member information may submit actuarial estimates of total number of members covered under all health policies.

G. The report must include a statement that the revenue and expense amounts reported under items A and B reconcile to audited financial statements. A group purchaser that does more than 80 percent of its business in Minnesota shall reference the appropriate entries from its audited financial statements and shall do so either by using the audited financial statements for its entire health care business or by separating its experience for Minnesota residents. The group purchaser's choice of method must be consistent from year to year. A group purchaser that does 80 percent or less of its business in Minnesota shall have an actuary or financial officer certify that the amounts reported reconcile to the audited financial statement in a manner consistent with prior reporting years and shall include an accounting or actuarial memorandum describing the methods used to identify and separate Minnesota data.

4652.0130 REVIEW OF REPORTS.

Subpart 1. **Record complete.** No report required by this chapter is considered to be filed until the commissioner has determined that the report is complete. "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 chapter 4652.

Subp. 2. **Review by commissioner.** The commissioner shall review each report required by chapter 4652 in order to

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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 60 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.

Subp. 3. **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 30 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. 4. **Amending reports.** If a group purchaser discovers a material error in its statements or calculations in any of its submitted reports ascertained by the commissioner to be complete, the group purchaser shall immediately inform the commissioner of the error and, within a reasonable time, submit a written amendment to the report. Submission of an amendment under this subpart does not affect the date of filing.

Subp. 5. **Error in reports.** If the commissioner discovers a material error in the statements or calculations in a report, the commissioner shall require the group purchaser to amend and resubmit the report by a date determined by the commissioner.

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