Department of Health

Adopted Permanent Rules Relating to Aggregate Health Care Financial and Statistical Data From Group Purchasers

Rules as Adopted

4652.0100 DEFINITIONS.

[For text of subpart 1, see M.R.]

Subp. 1a. **Administrative services fee revenue.** "Administrative services fee revenue" includes all revenue from fees related to health administrative services only contracts written for Minnesota residents. An administrative services only contract means a contract between a group purchaser and a third party, including a self-insured, under which the group purchaser provides claims administration and other services.

[For text of subps 2 and 3, see M.R.]

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. A group purchaser may use a nationally recognized standardized reporting system to capture costs for chemical dependency inpatient, outpatient, and other professional services. Chemical dependency services expenses does not include prescription drugs or supplies administered or

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dispensed which are billed directly through a hospital or health care provider.

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 audit function, 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 are: information systems and legal.

[For text of subps 6 to 8, see M.R.]

Subp. 9. **Durable medical goods expenses.** "Durable medical goods expenses" means all costs for such items as wheel chairs, eyewear, 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. Emergency services expenses includes the room, board, and any services such as X-ray and laboratory services billed by the facility. Emergency services expenses does not include expenditures for physician services.

[For text of subps 11 and 12, see M.R.]

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. Home health care expenses includes costs for noninpatient hospice care.

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

[For text of subps 15 to 18, see M.R.]

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. A group purchaser may use a nationally recognized standardized reporting system to capture costs for ~~chemical dependency~~ mental health inpatient, outpatient, and other professional services. Mental health services expenses does not include prescription drugs or supplies administered or dispensed which are billed directly through a hospital or health care provider.

Subp. 19a. **Minimum premium plan revenue.** "Minimum premium plan revenue" means revenue from insurance plan policies written from Minnesota residents whereby an employer self-funds a fixed percentage of the estimated monthly claims and the insurer covers the remainder.

Subp. 20. **MinnesotaCare tax expenses.** "MinnesotaCare tax expenses" means all payments made for the MinnesotaCare tax under Minnesota Statutes, sections 295.52 and 295.582.

[For text of subps 21 to 24, see M.R.]

Subp. 24a. **Patient services revenue.** "Patient services revenue" means fee-for-service revenue received for medical and dental services delivered to patients by clinics that are owned by the group purchaser.

Subp. 25. **Pharmacy and other nondurable medical goods expenses.** "Pharmacy and other nondurable medical goods expenses" means all costs paid by the group purchaser to a

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pharmacist or medical supply company to provide pharmaceuticals and nonreusable supplies or pieces of equipment that are used to treat a health condition. Pharmacy and other nondurable medical goods expenses does not include the cost of pharmaceuticals and other nondurable medical goods administered or dispensed which are billed directly through a hospital or health care provider.

Subp. 26. **Physician services expenses.** "Physician services expenses" means costs for all services provided by or under the supervision of licensed medical doctors and doctors of osteopathy, including pharmaceuticals and supplies administered or dispensed from the physician's office and billed directly through the physician. Physician services expenses does not include costs of mental health services and chemical dependency services.

[For text of subps 27 and 28, see M.R.]

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, nurse triage, 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 are: information systems and legal.

[For text of subp 30, see M.R.]

Subp. 30a. **Reinsurance assumed revenue.** "Reinsurance assumed revenue" means total revenue from reinsurance plan policies for Minnesota residents received by a group purchaser who writes the reinsurance plan policies. Reinsurance assumed revenue does not include payments received for reinsurance claims.

[For text of subp 31, see M.R.]

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

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nursing care and related services for patients who require medical or nursing care or rehabilitation services. Skilled nursing facilities expenses includes room and board incurred at skilled nursing facilities. Skilled nursing facilities expenses does not include costs of mental health services and chemical dependency services.

Subp. 33. **Subscriber.** "Subscriber" means a person 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, where the contract is either directly between the person and the group purchaser or between the employer of the person and the group purchaser. The subscriber may or may not have dependents who are covered under the 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. Total premium revenue does not include minimum premium revenue, administrative services fee revenue, utilization review fee revenue, reinsurance assumed revenue, and patient services revenue.

Subp. 34a. **Utilization review fee revenue.** "Utilization review fee revenue" means all revenue from fees not part of premium revenue related to health utilization review products written for Minnesota residents.

[For text of subp 35, see M.R.]

4652.0110 GROUP PURCHASER REPORTING.

Subpart 1. **Group purchasers must report; exceptions.** All group purchasers, except as noted in items A to D, shall file with the commissioner a financial and statistical report on forms or computer format 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 the amount that the group purchaser collected 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.

[For text of items B to D, see M.R.]

[For text of subps 2 to 4, see M.R.]

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 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, reinsurance assumed revenue, and patient services revenue. Each revenue category must separate commercial, Medicare, Medicare supplement, and other public programs amounts.

B. The report must include total expenses incurred by type of policy, including commercial, self-insured, Medicare,

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Medicare supplement, and other public programs. The report must separately list member liability for each policy category.

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 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 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.

[For text of items D and E, see M.R.]

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. Each category must be itemized by commercial, self-insured, Medicare, Medicare supplement, and other public programs. Group purchasers that do not maintain member information may submit actuarial estimates of total number of members covered under all health policies.

[For text of item G, see M.R.]

4652.0140 VARIANCES.

Subpart 1. **Data from other sources.** On a request by a group purchaser or on the commissioner's own initiative, the commissioner shall determine whether to use data from other sources instead of collecting data required by this chapter. To make this determination, the commissioner shall consider whether:

A. the data from other sources are duplicative of

data required under this chapter;

B. the data from other sources are available at a reasonable cost;

C. the commissioner has the resources readily available to use the data from other sources; and

D. the commissioner will be able to use the data from other sources to meet all statutory data collection, analysis, and privacy requirements.

Subp. 2. **Aggregate reporting for systems.** An organization operating a group purchaser which is part of a system of group purchasers, hospitals, or clinics may request to report to the commissioner for all components of the system as an aggregate. If the commissioner determines that the commissioner will be able to use the data from the system as an aggregate to meet all statutory data collection, analysis, and privacy requirements, then the commissioner shall grant the request.

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