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STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE MINNESOTA DEPARTMENT OF HEALTH

In the Matter of the Proposed
Adoption of Rules of the State
Health Department Governing
Health Maintenance Organizations,
Minnesota Rules Chapter 4685.

REPORT OF THE
ADMINISTRATIVE LAW JUDGE

The above-entitled matter came on for hearing before Administrative Law Judge Howard L. Kaibel, Jr., on Monday, July 31, 1989 in the Health Department Board Room, in Minneapolis, Minnesota.

This Report is part of a rule hearing proceeding held pursuant to Minn. Stat. §§ 14.131 - 14.20, to determine whether the Agency has fulfilled all relevant substantive and procedural requirements of law, whether the proposed rules are needed and reasonable, and whether or not the rules, if modified, are substantially different from those originally proposed.

Members of the Agency panel appearing at the hearing were: Kent E. Peterson, Director of Alternative Delivery Systems; Dawna L. Tierney and Robin P. Lackner, Health Policy Analysts; and John A. Breviu, Special Assistant Attorney General.

Approximately 15 interested persons attended the hearing and 13 of them signed the hearing register. The hearing continued until all interested persons, groups and associations had the opportunity to be heard concerning the adoption of the proposed rules.

This Report must be available for review to all affected individuals upon request for at least five working days before the agency takes any further action on the rule(s). The agency may then adopt a final rule or modify or withdraw its proposed rule. If the Commissioner of the Minnesota Department of Health makes changes in the rule other than those recommended in this report, she must submit the rule with the complete hearing record to the Chief Administrative Law Judge for a review of the changes prior to final adoption. Upon adoption of a final rule, the agency must submit it to the Revisor of Statutes for a review of the form of the rule. The agency must also give notice to all persons who requested to be informed when the rule is adopted and filed with the Secretary of State.

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

FINDINGS OF FACT

Procedural Requirements.

1. On June 8, 1989, the Department filed the following documents with the Chief Administrative Law Judge:

(a) A copy of the proposed rules certified by the Revisor of Statutes.
(b) The Order for Hearing.
(c) The Notice of Hearing proposed to be issued.
(d) A Statement of the number of persons expected to attend the hearing and estimated length of the Agency's presentation.
(e) The Statement of Need and Reasonableness.
(f) A Statement of Additional Notice.

2. On June 19, 1989, a Notice of Hearing and a copy of the proposed rules were published at 13 State Register 2968 to 2981.

3. On June 16, 1989, the Department mailed the Notice of Hearing to all persons and associations who had registered their names with the Department for the purpose of receiving such notice.

4. On June 30, 1989, the Department filed the following documents with the Administrative Law Judge:

(a) The Notice of Hearing as mailed.
(b) The Agency's certification that its mailing list was accurate and complete.
(c) The Affidavit of Mailing the Notice to all persons on the Agency's list.
(d) The names of Department personnel who will represent the Agency at the hearing together with the names of any other witnesses solicited by the Agency to appear on its behalf.
(e) A copy of the State Register containing the proposed rules.
(f) All materials received following a Notice of Intent to Solicit Outside Opinion published at 12 State Register 1109 on November 23, 1987, and a copy of the Notice.
(g) The Petition requesting a rule hearing.

The documents were available for inspection at the Office of Administrative Hearings from the date of filing to the date of the hearing.

5. The period for submission of written comments and statements remained open through August 14, 1989, the period having been extended by order of the Administrative Law Judge to 14 calendar days following the close of the hearing. Pursuant to Minn. Stat. § 14.15, subd. 1, an additional three (3) business days were allowed for filing of responsive comments. The record therefore closed on August 17, 1989.

Statutory Authority.

6. The Commissioner's general statutory authority to adopt "necessary or proper" rules such as those contained herein is provided in Minn. Stat. § 62D.20. More specific statutory authority to adopt rules for computing HMO liabilities, including unreported incurred expenses, is provided in Minn. Stat. § 62D.182. Finally, more specific authority for required reporting rules is provided in Minn. Stat. § 62D.08. There were no objections from any hearing participants to the statutory authority of the Commissioner to adopt the proposed rules, which has been adequately documented.

Fiscal Note.

7. Minn. Stat. § 14.11, subd. 1 requires state departments adopting rules to prepare a Fiscal Note whenever the cost of implementing the rule will exceed $100,000 in either of the first two years after adoption for all local public bodies in the state. The notice of hearing alleges without contradiction that the total cost of implementation of these rules to local governments will not exceed this $100,000 threshold amount. A Fiscal Note was consequently unnecessary.

Small Business Considerations.

8. Minn. Stat. § 14.115, subd. 7, Item c. specifically exempts providers of medical care from the small business protections in Health Department rulemaking. There was no indication in this proceeding that the rules present any undue hardship for any small businesses. The Department has demonstrated its compliance with Minn. Stat. § 14.115.

Nature of the Proposed Rules.

9. The general purpose of these rules is to revise HMO requirements in three areas: calculation of uncovered expenditures or liabilities; coordination of benefits (COB) when a beneficiary is covered by more than one insurance policy; and updating reporting provisions. The provisions were supported in their entirety by one of the state's largest HMOs and generally by others who had only a few proposals for improvement. They were proposed initially for adoption as "noncontroversial" rules without the need of a hearing. The HMOs did not exercise their right in uncontested rulemaking to request the hearing. The rules would consequently have been adopted without a hearing, but for the objections of hospital providers concerned about their role in coordination of benefits.

Testimony and written comments were generally limited to ideas for modifying or improving the proposed rules. All of the issues raised by the testimony and written comments, as well as modifications proposed by the Department at the hearing and in its post-hearing comments, have been carefully considered. Any provisions not specifically discussed have been found to be necessary and reasonable as proposed, based on the Department's Statement of Need and Reasonableness and oral testimony and exhibits presented at the hearing. The modifications agreed to by Department staff are minor improvements that do not constitute substantial changes requiring a new hearing.

Discusssion of Specific Concerns.

10. As indicated above, the hearing was conducted primarily because of concerns of hospitals or "providers" over their proper role in coordination of benefit situations. Although the rules do not govern them directly in any way, these providers get "caught up" in conflicts when attempting to obtain reimbursement for services they have provided when there are multiple insurers. Discussions between providers and insurers over these perceived problems had not taken place during the rule promulgation process and the hearing served as a forum for improved understanding of the coordination of benefits mechanism.

The rules govern only the action of insurers in cases of overlapping benefits. They do not endeavor to regulate the actions of providers such as hospitals.

Providers are nonetheless inevitably centrally involved in the process because they must submit the bills to the patients and insurers, reconciling the payments. Their role is further complicated by discounts that they give to particular HMOs and the need to keep the amounts of these discounts confidential.

A representative of one of the providers asked the Department to assist providers by spelling out their "role" in coordinating benefits. However, any revision of these proposed rules to impose any kind of requirements upon providers would possibly be a fundamental "substantial change" requiring notice to all providers and an opportunity to participate.

The Department is doubtful it has jurisdiction or power to regulate providers or their economic relationships with patients and insurers. They counseled providers to simply bill all potential payors and allow such payors to work out the conflicts among themselves.

However, this does not help the hospital if no one pays the bill. On the other hand, that is the situation now, without the proposed rules. Adoption of the proposed rules will not change it.

In short, the rules as proposed do not impose any new requirements or create any adverse impact on any affected interests. The failure to spell out a role for providers does not make them unreasonable. Perhaps they could be improved upon, although that may require legislation authorizing further Departmental intervention. However, the bottom line is that the rules as proposed, without further reference to providers, are needed for their proposed purpose and are a reasonable improvement in the way that HMO benefits are coordinated.

11. The HMOs who wished to see the rules improved were most concerned about language relating to documentation of arrangements to cover "uncovered expenditures". Specifically, they urged revision of § .0805, subpart 4A., relating to funding the adequacy of a "guarantee" of such expenditures. These HMOs proposed changing the requirement that guarantors "set aside" funds to cover the obligation, substituting more nebulous language such as requiring that the funds be "allocated".

This section of the proposed rules was initiated because of concern over the financial health of HMOs, as a protection for enrollees relying upon them for their medical care, from insolvency. In 1987 two Minnesota HMOs went bankrupt and a third avoided insolvency by merging with another HMO. Most other Minnesota HMOs also experienced major economic losses in 1987. The Legislature responded in 1988 with extensive economic requirements. These rules are proposed to implement those safeguards. They include provisions for calculating and covering potential liabilities in the event of insolvency.

The language dispute here gets to the heart of what the Legislature meant to ensure: adequate reserves to pay uncovered expenses in cases of bankruptcy. Whether these reserves are deposited directly with the state or guaranteed by another entity, "It is essential that the principal not be

available for use by the HMO to fund ongoing operations." (OPHC Information Letter/PPL No. 88-01). Similarly, it is crucial that such reserves should not be available for any other use that has any potential for diminution of the principle.

The Legislature was acutely aware of the danger of "guarantees" when the law was enacted. One of the HMOs bankrupted in 1987 had such a guarantee, but it was still in liquidation in December of 1988 and liquidators have been unable to obtain any funding from the "guarantor" to pay the liabilities. HMOs have the alternative of obtaining reinsurance or insolvency insurance to ensure payment of such liabilities. "Setting aside" guaranteed funding is essential to ensuring similar performance by guarantors.

The Department proposes in final written comments to further clarify this provision by inserting "in a restricted reserve or other method acceptable to the commissioner". This revision would not significantly alter the meaning of the provision as originally proposed. Either the original proposed language or the final proposed revision would reasonably meet the documented need.

The language is statutorily authorized and does not "defeat the intent of the legislature" as argued by Blue Plus. Ensuring that guarantor funds are restricted to provide real protection in the event of insolvency is not the same thing as requiring a deposit by an HMO. The proposed language would clearly further, rather than frustrate, the legislative intent.

12. Psychologists wrote to express their concern that the "right to receive and release needed information" section of the COB rules might conflict with their legal and professional obligation to protect the confidentiality of patient communications. This problem also arose when the uniform COB rules were first adopted by the Department of Commerce for non-HMO health insurers. The Department proposes in final written comments to remedy this concern by inserting the same exception that was inserted by the Department of Commerce: "unless applicable federal or state law prevents disclosure of the information without the consent of the patient or the patient's representative." This proposed revision was certainly implied in the original provision and would not be a substantial change, requiring a new hearing. With the revision, § .0950, § V is needed and reasonable.

13. Several HMOs suggested substituting the annual report for the required quarterly report at the end of the fourth quarter. However, the statute (Minn. Stat. § 62D.08, subd. 6) explicitly requires submission of an unaudited quarterly report within 30 days, precluding use of the annual report. Mr. Griffin, director of legislative and regulatory affairs for Physicians Health Plan agreed at the hearing that any proposed substitution would require legislative action, as the Department cannot change a statute by adopting a contrary rule. The rule as proposed is needed and reasonable.

14. MedCenters suggested that the provider list required in the proposed rules should be required only in a "format agreed to by the Commissioner" rather than on forms prescribed by the Commissioner. It is preferable in this case however to require the use of a standardized form by all HMOs to facilitate Departmental review and analysis of the filings. Uniformity here is essential to proper categorization, comparison and utilization of the data. The requirement is needed and reasonable as proposed.

15. Several HMOs suggested adding a requirement that the Department notify HMOs of disapproval of filings. This is already dealt with in the statute (Minn. Stat. § 62D.08, subd. 1) which provides that filings are deemed approved if they are not disapproved within thirty days. The Department assured HMOs that it will notify them of any disapprovals in writing, indicating the reason for disapproval. That is the clear intent of the statute and there is no need to restate the statute in the rule.

16. MedCenters also suggested revising the section of the proposed rule requiring notice of participating entity changes, by allowing them to be submitted "in a format" rather than "on forms" prescribed by the Commissioner. This is already provided for in the proposed rule (§ .3300, subp. 11) requiring that the notice "must be submitted on forms prescribed by the commissioner, or approved for use by the commissioner." This would allow HMOs to develop and use their own formats for Commissioner approval.

17. Proposed revised language submitted by MedCenters for § .0900 relating to subrogation has been carefully reviewed. It does not appear to be different from or superior to the Department's proposed language, except that it is three times as long. The Department's proposed language was clear to those participating in the hearing process. Its need and reasonableness were not objected to. HMOs must first provide covered services to enrollees and then pursue coordination of benefits with other insurers. That is the unambiguous intent of the language originally proposed and any revision at this point might imply some unintended change. It is important to avoid any such implication.

18. Although several HMOs suggested delaying the deadline for compliance to January 1, 1990, they did not submit facts indicating that the existing proposed dates are unreasonable. HMO representatives confirmed on the record that they are currently voluntarily coordinating benefits with one another and with other health insurance plans that have been legally subject to these uniform provisions as adopted by the Department of Commerce for several years. There should be no need to change procedures or hire additional staff to do what the HMOs have allegedly already been doing. The effective dates proposed are reasonable as noticed.

19. HMOs generally proposed limiting the description of driving distances to participating providers by exempting providers other than physicians and hospitals. However, the rule as proposed was clearly contemplated by the Legislature in Minn. Stat. § 62D.121 "Geographical Accessibility" requiring the commissioner to supervise provider availability. This supervisory responsibility includes providers which some HMOs proposed exempting, such as pharmacies. The Department has received complaints from enrollees in the past relating particularly to driving distances to pharmacies. The provision is consequently needed and reasonable as proposed.

20. Finally, the Commissioner should consider acquiescing in the request of HMOs to allow minor handwritten changes on filings. Although the rule as proposed is not unreasonable, it would be more reasonable and in accord with present Department staff practice to permit such filings. Department staff final comments indicate that they "would not reject filings with small editorial changes which are handwritten." It is undoubtedly reasonable and necessary that public filings be clean, legible and often typewritten. However, it is also true that negotiated contracts are frequently subject to

last-minute handwritten initialed changes and that requiring retyping of the entire document solely for filing with the Department would be a needless addition to the cost of health care. Department staff "reluctantly" suggests that amending the rule to allow "minor handwritten changes" might be acceptable. Staff would always have the option of rejecting such filings where extensive handwritten changes made the contract difficult to read. Revising the proposal to allow for "minor handwritten changes" or perhaps "minor legible handwritten changes" would improve the rule and would not be a substantial change.

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

CONCLUSIONS

1. That the Department gave proper notice of the hearing in this matter.

2. That the Department has fulfilled the procedural requirements of Minn. Stat. §§ 14.14, and all other procedural requirements of law or rule.

3. That the Department has documented its statutory authority to adopt the proposed rules, and has fulfilled all other substantive requirements of law or rule within the meaning of Minn. Stat. §§ 14.05, subd. 1, 14.15, subd. 3 and 14.50 (i) and (ii).

4. That the Department has demonstrated the need for and reasonableness of the proposed rules by an affirmative presentation of facts in the record within the meaning of Minn. Stat. §§ 14.14, subd. 2 and 14.50 (iii).

5. That the additions and amendments to the proposed rules which were suggested by the Department after publication of the proposed rules in the State Register do not result in rules which are substantially different from the proposed rules as published in the State Register within the meaning of Minn. Stat. § 14.15, subd. 3, Minn. Rule 1400.1000, Subp. 1 and 1400.1100.

6. That any Findings which might properly be termed Conclusions and any Conclusions which might properly be termed Findings are hereby adopted as such.

7. That a finding or conclusion of need and reasonableness in regard to any particular rule subsection does not preclude and should not discourage the Department from further modification of the rules based upon an examination of the public comments, provided that no substantial change is made from the proposed rules as originally published, and provided that the rule finally adopted is based upon facts appearing in this rule hearing record.

Based upon the foregoing Conclusions, the Administrative Law Judge makes the following:

RECOMMENDATION

It is hereby recommended that the proposed rules be adopted consistent with the Findings and Conclusions made above.

Dated: August 22, 1989.

HOWARD L. KAIBEL, JR.
Administrative Law Judge