STATE OF MINNESOTA

COUNTY OF HENNEPIN

BEFORE THE MINNESOTA

COMMISSIONER OF HEALTH

IN THE MATTER OF PROPOSED
AMENDMENTS TO RULES RELATING
TO HEALTH MAINTENANCE ORGANIZATION
UNCOVERED EXPENDITURES, INCURRED BUT
NOT REPORTED LIABILITIES, COORDINATION
OF BENEFITS, AND ANNUAL REPORT AND
FILING REQUIREMENTS
MINNESOTA RULES CHAPTER 4685

STATEMENT OF NEED
AND REASONABLENESS

The Minnesota Commissioner of Health (commissioner), pursuant to Minnesota Statutes, section 14.05 through 14.20 presents facts establishing the need for and reasonableness of the proposed amendments to rules relating to health maintenance organization (HMO) uncovered expenditures, incurred but not reported liabilities, coordination of benefits, and annual report and filing requirements.

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Statutory Authority

The commissioner's general statutory authority for adopting these rules is contained in Minnesota Statutes, section 62D.20 which provides that the commissioner may adopt rules "that are necessary or proper to carry out the provisions of 62D.01 to 62D.20."

Specific authority for adopting rules relating to incurred but not reported expenses is found in Minnesota Statutes, section 62D.182 which provides that an HMO's liabilities be computed under rules adopted by the commissioner.

Specific authority for adopting rules relating to annual report information is found in Minnesota Statutes, section 62D.08 which provides in part that the commissioner may require such information as is reasonably necessary to enable the commissioner to carry out the duties under sections 62D.01 to 62D.29.

Specific references to other statutory authority will be given as appropriate in each part by part statement of need and reasonableness.

Small Business Considerations

These rules are exempt from the provisions of Minnesota Statutes, section 14.115 relating to the impact of rules on small businesses. The small business consideration provisions do not apply to services regulated by government bodies for standards and costs, such as providers of medical care, (Minnesota Statutes, section 14.115 subdivision 7, item c.) HMOs are providers of medical care regulated by the Minnesota Department of Health for standards and costs. A "health maintenance organization" is defined in Minnesota Statutes, section 62D.02 as a nonprofit corporation which provides or arranges the provision of health care services. This exemption is consistent with the findings of the Administrative Law Judge Report, OAH Docket 8-0900-247-1, HLTH-86-006-JL which found that proposed HMO rules were exempt from the small business consideration requirement in Minnesota Statutes, section 14.115.

General Statement of Need and Reasonableness- Uncovered Expenditures

The financial health of HMOs is of concern to the commissioner in order to protect enrollees who rely on HMOs for their health care. Recent events have focused the commissioner's attention on financial solvency issues. In 1987,

two HMOs in Minnesota became insolvent and a third was forced to merge with another HMO to avoid insolvency. In addition, most Minnesota HMOs experienced significant financial losses in 1987.

To address the financial solvency issue, the 1988 Minnesota legislature enacted several financial solvency safeguards. One safeguard enacted in 1988 increases the HMO's deposit requirement, (Minnesota Statutes, section 62D.041, subdivision 3.) The new law requires HMOs to deposit an amount equal to the difference between $500,000 and 33 percent of its uncovered expenditures in the preceding year. Because the deposit requirement relies upon the HMO's amount of uncovered expenditures in a preceding year, it is necessary to describe how the HMOs must calculate their uncovered expenditures.

The rationale for requiring a deposit based on uncovered expenditures is to protect enrollees from the uncovered expenditure liability in the event of insolvency. If an HMO becomes insolvent, participating entities which have provided health services prior to the date of insolvency, but have not been paid by the HMO, cannot bill the enrollee for services rendered. However, providers that are not participating with the HMO (and therefore do not have contracts or other agreements with the HMO), may potentially bill the enrollees for such services. The money the HMO is required to deposit is intended to pay for these potential expenses from nonparticipating providers for which the enrollee may be liable in the event of insolvency.

Uncovered expenditures are defined in Minnesota Statutes, section 62D.041, subdivision 1 which states in part,

> "uncovered expenditures" means the costs of health care services that are covered by a health maintenance organization for which an enrollee would also be liable in the event of the organization's insolvency, and that are not guaranteed, insured, or assumed by a person other than the health maintenance organization.

Uncovered expenditures vary in type and amount depending on the arrangements of the HMO. A common problem is the determination of whether an HMO's expenses are covered or uncovered. While an uncovered expenditure may include out-of-area services and referral services, an HMO may make various arrangements to cover these and other health care expenses.

The proposed rules are necessary to describe completely what constitutes an uncovered expenditure and describe ways in which uncovered expenses may be covered for the purposes of determining the HMO's deposit requirement.

Part by Part Statement of Need and Reasonableness-
Uncovered Expenditures

4685.0805 Uncovered Expenditures

Subpart 1. Defined

The proposed rule specifically sets up the criteria for initially defining when an expenditure is uncovered. Essentially, the difference between a covered expense and an uncovered expense is whether or not the provider has an agreement with the HMO to hold the enrollees harmless from charges (other than applicable copayments and services not covered under the enrollee's contract). A provider who has signed a contract with an HMO is considered a participating provider. The HMO's contract with a participating provider is required by law to have language obligating the provider to seek payment for covered services from the HMO and not to bill enrollees. Expenses from a provider other than a participating provider, are considered uncovered. The proposed rule gives examples of HMO expenses that are typically uncovered.

Minnesota Statutes, section 62D.041 defines uncovered expenses as expenses for which an enrollee would also be liable in the event the HMO becomes insolvent. The definition proposed in this subpart is necessary to more completely describe when an enrollee may be liable for an expense. In short, an enrollee

may potentially be liable for any expense from a non-participating provider. This definition is reasonable as it is the same definition used by the National Association of Insurance Commissioners (NAIC) in their guidelines for covered health care expenditures (please see appendix A). In addition, the Federal Office of Prepaid Health Care has adopted the same principle for determining which expenses are uncovered for federally qualified HMOs (please see appendix B).

Subpart 2. Documentation required

This subpart provides that when an expenditure meets the criteria in subpart 1, and is therefore considered uncovered, it can be considered covered if the expenditure is guaranteed, insured, or assumed. The proposed subpart also provides that when an HMO claims that its uncovered expenditures are guaranteed, insured or assumed, it must provide documentation of such arrangements to the commissioner with its annual report.

In an effort to protect their liabilities, HMOs make various arrangements to cover their uncovered health expenses. The HMO may arrange for insurance, a guarantee, or an assumption of the risk of the uncovered expenditure, as explained in detail in the following proposed subparts.

It is reasonable to allow HMOs to reduce their amount of uncovered

expenditures if the HMOs have made secure arrangements to cover those expenditures. As stated previously, the money required to be in deposit is intended to pay for services for which an enrollee may be billed. If insurance or guarantees or assumptions reduce the amount for which an enrollee may potentially be billed, the HMO should be allowed to reduce the amount it keeps in deposit. However, the commissioner needs evidence of the HMO's arrangements for covering uncovered expenditures in order to be assured that such expenditures will be covered in the event of insolvency, and enrollees will not be liable for expenses from nonparticipating providers.

The proposed requirement for documentation of arrangements for covering uncovered expenditures is consistent with requirements in law. Existing Minnesota Statutes require HMOs to give the commissioner notice of any agreements regarding reinsurance "or any other type of coverage for potential costs of health services," (Minnesota Statutes, section 62D.08, subdivision 4 and section 62D.08, subdivision 1.) In addition, new Minnesota law adopted in 1988 requires HMOs to provide the commissioner with relevant information about any organization which guarantees to satisfy an HMO's net worth or deposit requirement, (Minnesota Statutes, section 62D.042, subdivision 5). As stated previously, the deposit requirement is based on uncovered expenditures. This requirement for documentation of arrangements simply clarifies documentation requirements that currently exist in law.

Subpart 3. When insured

This subpart describes the types of insurance that can be used by the HMO to cover its uncovered expenditures. Specifically, reinsurance and insolvency insurance can be used by the HMO to cover uncovered health care expenses.

HMOs often buy reinsurance to avoid the risk of expenses that the HMO has little or no control over, such as emergency services or services outside the service area. Reinsurance is defined in the American Institute of Certified Public Accountants Exposure Draft on Accounting by Prepaid Health Care Plans as a contract in which an insurance company agrees to indemnify an HMO for certain health care costs incurred by members, (please see appendix C). Because the HMO has little or no control over the costs of services from nonparticipating providers, it may choose to reinsure those risks to protect itself from unknown and uncontrollable expenses. In addition, an HMO may purchase reinsurance from an insurance company to pay for costs that exceed a specific expense per claim. This type of reinsurance is often called catastrophic insurance or stop-loss insurance. If the HMO receives receipts from this type of reinsurance and uses those receipts to pay nonparticipating providers, then this reinsurance also covers uncovered expenditures.

Insolvency insurance is often purchased as a rider to an HMO's reinsurance contracts. This type of insurance continues the HMO's plan benefits after

insolvency. Most insolvency insurance contracts provide that continuation of benefits includes payments to nonparticipating providers for their services before the date of insolvency, (please see appendix D). For example, if an enrollee received services from a nonparticipating provider before the HMO went insolvent, but the provider did not bill the HMO until after the date of insolvency, the insolvency insurance would cover the nonparticipating provider's expenses. If the HMO's insolvency insurance provides for payments to nonparticipating providers before the date of insolvency, the insolvency insurance can be used to cover the HMO's uncovered expenses.

It is reasonable to allow the HMO to reduce its uncovered expenditures if it has reinsurance or insolvency insurance. Both of these types of insurance reduce the HMO's liability for uncovered expenditures, and consequently, reduce the enrollee's potential risk of being billed for services from nonparticipating providers.

Subpart 4. When guaranteed

Another way in which an HMO can reduce its risk, is to find a guaranteeing organization to agree to guarantee the HMO's expenses from non-participating providers. This is a new subpart which states that an HMO's uncovered expenditures may be considered guaranteed if the HMO demonstrates to the commissioner that the guaranteeing organization has set aside an amount of

money that equals the amount of their guarantee, or issued a letter of credit to the HMO in the amount of the guarantee, or if the guarantor has demonstrated that it has the power to tax. In addition, the HMO must demonstrate that the guarantee is unconditional, irrevocable, can be drawn upon by the commissioner, and can be used after the date of the HMO's insolvency.

It is reasonable for the HMO to be allowed to reduce its uncovered expenditures by demonstrating it has a guarantee. However, this allowance should be balanced with assurances that the guarantee will be available to pay for services from nonparticipating providers if the HMO becomes insolvent. One of the two HMOs which became insolvent in 1987 had a guarantee with another organization. This HMO is still in liquidation as of December 1, 1988, and as of that date, the liquidators have not been able to obtain any money from that guarantee to pay nonparticipating providers.

As stated previously, the purpose of the deposit requirement is to protect enrollees in the event of an HMO's insolvency. The deposit is intended to pay for health services from providers who have not signed agreements with the HMO and therefore may bill enrollees for health services. Without assurances that there is an amount of money in the form of a guarantee which will be available at the time of insolvency, a guarantee is useless. If nonparticipating providers are not paid by an insolvent HMO or a guarantor, the providers will

definitely seek payment from the HMO enrollees.

The proposed rules describe requirements designed to ensure that if an HMO has a guarantee, there will be money from that guarantee available to pay for any uncovered expenditures in the event of insolvency. First, the HMO must demonstrate that the guaranteeing organization has an amount of money set aside which is available to be used in the event of insolvency, or has issued a letter of credit, or has demonstrated that it has the power to tax. Obviously, if the guarantor sets aside an amount of money equal to the guarantee, the commissioner can be satisfied that the money is available and accessible if necessary. However, often it is not reasonable or possible for an organization to set aside an amount of money in a reserve or restricted fund. A guarantor may provide a guarantee in the form of a credit line, which is common if the guarantee is from banking institutions. Finally, if the guarantor is a governmental entity with the power to tax to obtain necessary revenues, the commissioner can be assured that there will be money available to pay nonparticipating providers in the event of insolvency.

The proposed rules impose additional requirements on any guarantee which the HMO claims will be used to cover uncovered expenditures as a means of ensuring that there is indeed money available in the event of insolvency. These requirements are virtually identical to the statutory requirements imposed on an HMO which uses a letter of credit to satisfy up to one half of its deposit

requirement. The recently enacted law relating to requirements for letters of credit is Minnesota Statutes, section 62D.041, subdivision 9. This statute states in part that a letter of credit is acceptable provided that:

(1) nothing more than demand for payment is necessary for payment;
(2) the letter of credit is irrevocable;
(3) according to its terms, the letter of credit cannot expire without due notice from the issuer and the notice must occur at least 60 days before the expiration date and be in the form of a written notice to the commissioner;
(4) the letter of credit is issued or confirmed by a bank which is a member of the federal reserve system;
(5) the letter of credit is unconditional, is not contingent upon reimbursement to the bank or the bank's ability to perfect any lien or security interest, and does not contain references to any other agreements, documents, or entities;
(6) the letter of credit designates the commissioner as beneficiary; and
(7) the letter of credit may be drawn upon after the date of insolvency of the health maintenance organization;

Given these requirements are imposed by law on a letter of credit used to satisfy the HMOs deposit requirement, it is reasonable that a guarantee (which is ultimately used to lower the HMO's deposit requirement) meet the same requirements.

Subpart 5. When Assumed

This subpart explains that an HMO may claim that certain expenses are uncovered if an entity other than the HMO agrees to cover such costs. If the HMo can demonstrate that another entity assumes the risk of any uncovered expenditures even in the event of insolvency, it is reasonable for the HMO to

be allowed to consider such expenditures covered.

This subpart is intended as a catchall provision. If the HMO finds alternative means of covering its uncovered expenditures, the HMO is permitted to demonstrate these methods to the commissioner. In certain situations the commissioner may request financial information relating to the capability of the entity to assume the risk of uncovered expenditures.

It is reasonable to permit the HMOs to devise alternative methods for covering its uncovered expenses. This subpart is similar to the catchall item used by the federal government for federally qualified HMO's calculation of uncovered expenditures. The Federal Office of Prepaid Health Care has a line item entitled "other arrangements" in its worksheet for calculation of uncovered expenditures. (Please see appendix B.)

Subpart 6. Calculating Uncovered Expenditures

This is a new section which explains how the HMO can calculate its uncovered expenditures in the preceding year in order to determine its required deposit amount. First, the HMO makes an initial determination of what expenditures in the preceding year were uncovered according to the definition in proposed subpart 1. Next, the HMO may subtract any amounts of money it received through reinsurance agreements which paid for expenses from non-participating

providers according to the criteria established in proposed subpart 2 item A. Then, the HMO may subtract the amount of uncovered expenditures that were assumed by entities other than the HMO in the relevant year.

This subtotal must be multiplied by 33 percent as required by Minnesota Statutes, section 62D.041 which provides that the deposit must be equal to 33 percent of the HMO's uncovered expenditures in the preceding year. Last, the HMO may subtract from this figure, any amounts that the HMO calculates guarantees, or insolvency insurance would reduce those expenditures in the event of insolvency.

This subpart is necessary to establish a standard formula to be used by all HMOs in calculating their uncovered expenditures in the same manner. Without a formula, there is potential for variability in the HMOs' calculations of their uncovered expenditures. The formula is reasonable as it simply summarizes the criteria described in the preceding subparts.

General Statement of Need and Reasonableness- Incurred But Not Reported Liabilities

The financial health of HMOs is of concern to the commissioner in order to protect enrollees who rely on HMO's for their health care. Recent events related to the finances of Minnesota HMOs have focused the commissioner's attention on financial solvency issues. In 1987, two HMOs in Minnesota became insolvent and a third was forced to merge with another HMO to avoid insolvency. In addition, most Minnesota HMOs experienced financial losses in 1987.

Minnesota Statutes, section 62D.04 requires the HMO to demonstrate it is financially responsible as a condition for continued operation. In an attempt to strengthen HMO financial solvency, the 1988 Minnesota legislature enacted several financial solvency safeguards. One financial solvency safeguard which was adopted in 1988 requires the HMO to maintain a positive working capital, Minnesota Statutes, Section 62D.042, subdivision 6. Another provision adopted by the 1988 legislature requires the HMO to maintain liabilities sufficient to pay all reported or unreported claims incurred, Minnesota Statutes, section 62D.182. This new law further provides that liabilities shall be computed under rules adopted by the commissioner.

Minnesota Statutes, section 62D.042 define working capital as current assets

minus current liabilities. In order to maintain a positive working capital, the HMO must have assets sufficient to pay its current liabilities. Current liabilities include claims reported and claims not reported (please see appendix E). While reported claims are relatively easy to calculate, unreported claims are more difficult to determine. There is potential for variability in calculating unreported claims because such claims are estimates based on past experience and adjusted for current trends.

When the HMOs filed their 1987 annual financial statements, the accounting firm auditing one HMO required that HMO to list $2 to $3 million more under incurred but not reported (IBNR) claims than the HMO had estimated (please see **City Business**, April, 18, 1988, appendix F). Obviously, such a dramatic difference in the estimate of outstanding claims changes the organization's financial picture. As stated above, an HMO is required by law to maintain a positive working capital. If the HMO underestimates its liabilities, its working capital may appear to be positive, when in fact it is not.

The proposed rules on incurred but not reported liabilities are necessary to ensure that HMOs are accurately estimating their IBNR costs. The proposed rules are also necessary to comply with the statutory mandate that the commissioner adopt rules relating to the computation of liabilities.

Part by Part Statement of Need and Reasonableness- Incurred But Not Reported Liabilities

4685.0815 Incurred But Not Reported Liabilities

This is a new part which describes how incurred but not reported liabilities must be calculated.

Subpart 1. Written Records of Claims

The proposed rules require the HMO to keep accurate records of its process for calculating claims, to keep records on incurred but not reported claims separate from other claims payable, and to have claim records available for the commissioner when the HMO is under an examination.

Incurred but not reported (IBNR) costs are defined in the American Institute of Certified Public Accountants' Exposure Draft on "Accounting by Prepaid Health Care Plans" as costs associated with health care services that have been incurred during the financial reporting period but that have not been reported to the HMO until after the financial reporting date (please see appendix C).

The calculation of IBNR costs is determined from past experience and adjusted

for current trends, as explained below. Each organization will have a slightly different formula for calculating IBNR claims, therefore it is reasonable to require the HMO to keep accurate documentation of how the estimates of unreported costs are calculated. It is also necessary to require that records of IBNR claims are kept separate from other claim records. Because estimates of IBNR costs are based on past experience, it is necessary for the HMO to distinguish between reported claims in a given period and unreported claims for that period. The records of these claims must be kept separate, in order for it to be possible to check the accuracy of the HMO's calculation of IBNR.

Subpart 2. Calculation of Incurred But Not Reported Claims

This subpart defines how IBNR claims must be calculated by the HMO. Specifically, IBNR claims are required to be calculated in conformity with generally accepted accounting principles and actuarial standards. This proposed subpart provides that IBNR claims are calculated by taking past claim experience and adjusting this figure for changing trends.

This formula for calculating IBNR is reasonable as it is based on generally accepted accounting principles. Estimated liabilities are based on the past experience of the company, according to **Accountants' Handbook**, edited by R. Wixon, The Ronald Press Company, New York, 1965. In addition, **Miller's 1985**

Comprehensive GAAP Guide, M. Miller, Harcourt Brace Jovanovich, New York, 1985, describes the accounting principles for estimating unreported losses for insurance companies. According to Miller, IBNR claims are usually estimated "by using past loss experience adjusted for current trends," (please see appendix G).

The requirement that the calculation for IBNR claims be consistent with generally accepted accounting principles and actuarial standards is necessary and reasonable as it is currently required of all data reported in the HMO's annual financial statement.

Existing Minnesota Rules Part 4685.1960 require the HMO to retain a certified public accountant to audit its annual financial statements and "express an opinion as to whether the sections audited are in conformity with generally accepted accounting principles applied on a consistent basis." In addition, existing Minnesota Rules require the HMOs to use the National Association of Insurance Commissioners (NAIC) annual report blank, Minnesota Rules Part 4685.1910. The NAIC annual report blank requires a statement of a qualified actuary indicating that the amounts reported in the balance sheet are "in accordance with accepted actuarial standards consistently applied and are fairly stated in accordance with sound actuarial principles," (please see appendix H).

The factors that are specifically mentioned in the proposed rules as reasonable adjustments are examples of factors that may potentially affect an HMO's unreported costs. Essentially, an estimate of incurred but not reported costs is an estimate of outstanding claims. Factors that affect claim rates generally will also affect IBNR rates. In addition, factors that affect the speed in reporting a claim will affect IBNR rates.

Changes in providers, enrollees, or products (coverage) will have an affect on IBNR claims. For example, if an HMO makes several new agreements with providers to accept a fixed prepaid sum per enrollee per month, the HMO will not have as many claims incurred but not reported as it had when it relied on providers to bill the HMO for services performed. Similarly, if an HMO changes its product in a manner which discourages the use of health services from nonparticipating providers, the IBNR costs may be affected because there may be less costs from nonparticipating providers who bill the HMO. Finally, if the HMO obtains new enrollees in an age group where there is historically less utilization than other age groups of enrollees, the HMO's overall claims will be affected and consequently the IBNR costs will be affected.

If the HMO or its contracting providers obtain more sophisticated claims or billing information systems, claims will be reported quicker. It follows that there will be fewer claims incurred but not reported during a given period if reporting mechanisms have been updated. If there is a trend for lower or

higher rates of utilization of health services, there will be corresponding changes in the number of services incurred but not reported during the period. Organizational changes, medical advancements, and new procedures all affect utilization and correspondingly, will affect claim costs. It follows that each of these factors will also affect the amount of incurred but not reported costs.

Finally, the proposed rules permit the HMO to consider other factors in its determination of IBNR costs if the HMO can demonstrate how such factors will affect IBNR claims. This "catch-all" provision is necessary because the preceding list of factors is not exhaustive. It is reasonable and necessary to permit the HMO to calculate its IBNR costs by taking into consideration all factors that will affect claim costs. There is no specific, conclusive formula for calculating IBNR costs because every organization is different. Certain trends and factors may affect the outstanding claims of one organization, but may not affect the outstanding claims of another organization.

General Statement of Need and Reasonableness-

Coordination of Benefits

The proposed rules address coordination of benefits (COB) provisions in health maintenance organization contracts. The purpose of coordination of benefits provisions is 1) to simplify and facilitate the expedient payment of medical or dental claims incurred by a person who is covered by more than one group health plan; and 2) to help contain health care costs by avoiding duplication of benefits when there is more than one plan of coverage.

A majority of individuals obtain group health coverage through their employer. When more than one family member works, there is often duplicate group health coverage for family members. There have been instances where an individual was covered by more than one health plan, and the health plans got into disputes about which plan was obligated to pay for a specific health service. The person with duplicate coverage is unable to collect benefits or be reimbursed under a plan not because of an absence of coverage, but rather because the insurers or HMOs involved are each denying primary liability. Coordination of benefits rules are intended to help resolve these types of

disputes between health plans by establishing a "primary-secondary" system for benefit payment.

Coordination of benefits keeps health care costs contained by preventing a person with duplicate coverage from profiting from an illness. Without coordination of benefits, both carriers could potentially pay for the same service. The purpose of health coverage is to pay for health services and not to provide individuals with a profit. Duplication of coverage means health care costs are unnaturally inflated which results in higher costs for everyone. Coordination of benefits permits individuals to receive 100 percent of allowable medical expenses but no more.

COB rules permit plans to work together to provide the enrollee with total coverage for services which may be only partially covered under a single health plan. Successful COB can eliminate many out-of-pocket expenditures (in the form of copayments or deductibles) for the consumer.

Essentially, COB rules allocate the responsibility to pay for a health care service between two health plans covering the same service for one enrollee. According to COB rules, the primary plan is the carrier with the first responsibility to pay for the individuals' medical expenses. The secondary plan is responsible for paying any remaining expenses not covered by the primary carrier up to the amount it would have paid had it been the primary

carrier.

In most cases, the secondary plan's costs are less than they would have been if they had to pay first. This means the secondary plan experiences a savings on that individual. COB rules require the secondary plan to keep track of any savings and use this savings to pay for services only partially covered by either plan. Any savings not used for reimbursements for the individual are used to reduce future group premium rates; This is another way in which COB helps keep health care costs contained.

The cost containment benefits from COB are in line with the basic legislative purpose for the creation of HMOs. When the Minnesota legislature passed the enabling legislation for HMOs in 1973, the statute specifically expressed that HMOs were established as an alternative method for "the delivery of health care services, with a view toward achieving greater efficiency and economy in providing these (health care) services." (Minnesota Statutes section 62D.01, subdivision 2.) Given the purpose stated by the legislature that HMO's serve as cost containment organizations, it is reasonable and necessary for HMOs to follow COB rules to reduce unnecessary health care costs which may result from duplication of coverage.

During the 1960's the group insurance industry developed the current system for COB. This system was adopted by the National Association of Insurance

Commissioners (NAIC) in December of 1970. The NAIC is an association which includes members from state regulatory associations and health plan companies from every state. Because health plan companies are regulated on a state by state basis, yet health plan companies issue policies in several states, the NAIC was established to develop uniform model rules and laws to help achieve consistency in the health plan regulatory environment. NAIC model rules and laws on a variety of issues are generally adopted by regulatory agencies across the nation.

A uniform, national approach to coordination of benefits is necessary because it allows policies that are outside the jurisdiction of the state of Minnesota to be coordinated with policies that are within the jurisdiction of the State of Minnesota on the basis of the same rules. The NAIC model COB rules, or substantially similar rules, have been adopted by most states. In states where the NAIC rules are not formally adopted, many health plan companies informally agree to apply the NAIC model rules as a means of resolving issues related to COB.

The Minnesota Department of Commerce ("Commerce"), adopted coordination of benefits rules governing insurance companies and nonprofit health service plan corporations in April of 1986. The Report of the Administrative Law Judge (please see appendix I) found that Commerce's rules were reasonable and necessary. Commerce's rules are virtually identical to model coordination of

benefits provisions developed by the National Association of Insurance Commissioners (NAIC) in 1985.

Because HMOs coordinate benefits with insurers, nonprofit health service plans and other HMOs, both within and outside the state, it is important to adopt the model coordination of benefits rules and include HMOs in the move toward national consistency and uniformity in this matter. Currently, many Minnesota HMOs are voluntarily following the NAIC model COB rules. For, example Physicians Health Plan's group contract includes the model COB contract language which is similar to the NAIC model, (please see appendix J).

In January 1988, the NAIC revised its model coordination of benefits rules. The 1988 changes include stronger consumer oriented coordination of benefits provisions. Essentially, the revisions remove the alternatives allowing the secondary carrier to pay less than 100 percent of allowable expenses and reorganize the provisions of the regulation to make it more understandable. The Report of the Coordination of Benefits Working Group at the NAIC annual meeting in December 1987, stated that the alternatives were deleted because "in the state survey conducted by the (NAIC) working group, the commissioners overwhelmingly concluded that it was not in the best interest of their citizens to retain the two alternatives." (please see appendix K).

The proposed rules are identical to the 1988 NAIC model rules. As such, the

rules as proposed deviate from the rules adopted by Commerce to the extent that the proposed rules incorporate the changes adopted by the NAIC in 1988.

The Department of Commerce's statement of need and reasonableness regarding COB is included as appendix L since Commerce's rules were determined necessary and reasonable, and Commerce's rules followed the 1985 NAIC model.

Part by Part Statement of Need and Reasonableness-
Coordination of Benefits

4685.0905 Purpose and Applicability

This section states the purpose of the rules. Specifically, it explains that the coordination of benefits provision is intended to avoid duplication and reduce payment delays.

4685.0910 Definitions.

Subpart 1. Scope

This part sets up the coordination of benefits definitions to be used to determine the coordination of benefits.

Subpart 2. Allowable Expense.

The definition of "allowable expense" is an expense that is at least covered in part by any of the plans involved except where there is a statutory requirement to the contrary. This definition is a crucial for understanding the mechanics of COB. According to this definition, the secondary plan may have to pay for benefits for a service it does not cover, if that service is covered by the primary plan and provided there is an existing savings or benefit reserve. For example, if the primary plan covers skilled nursing care and the secondary plan does not, the secondary plan would treat skilled nursing care as an allowable expense. (There are situations under which a secondary plan may be responsible for paying for allowable expenses which it does not usually cover. These situations are explained under proposed Part 4685.0925 Procedures to be Followed by the Secondary Plan.)

The definition of allowable expense can exclude coverage of items such as dental care, vision care, prescription drugs or hearing aid programs which are often not considered part of basic coverages. This exception is allowed so that a plan which does not provide such benefits is not forced to cover such coverages because if another plan covers them they can be considered allowable expenses. In addition, plans that only provide coverage for such items, may limit allowable expenses to those items. Again, this exception permits limited coverage plans, such a dental plans, to coordinate benefits on a compartmentalized basis.

Since HMOs often provide benefits in the form of services rather than cash, this subpart also requires that a reasonable cash value for such services be determined to calculate coordination of benefits.

A continuing problem in regard to benefits provided is the compensation for private hospital room versus that of a semiprivate hospital room. Because plans vary in that regard, a specific provision in the definition notes that the difference between the cost of the two is not an allowable expense unless medically necessary according to generally accepted medical practice.

Health care providers have argued that this provision relating to private

hospital rooms is unnecessary because the definition of allowable expense includes the notion of "necessary" expenses. They suggest that there may be cases where an individual will be put in a private hospital room because the private rooms are assigned on the basis of availability. However, this provision was included in the NAIC model because there have been problems in the past concerning reimbursement for private and semiprivate rooms. This provision makes it clear that the extra cost for a private room is only an allowable expense in situations where the private room was medically necessary. If there are no semiprivate rooms available, obviously, a private room is medically necessary. This provision is consistent with cost containment philosophy underlying the purpose of HMOs. When a semiprivate room is available and medically appropriate for an individual, it is important that the third party payer limit payment to the cost of that room to slow the inflation of health care costs.

This subpart also requires that if different coordination of benefit provisions apply to different parts of a contact, then the definition of "allowable expenses" in that coordination of benefits provision must include the expenses or services to which the coordination applies. This is merely a requirement of specificity so that the enrollee is capable of ascertaining, with reasonable certainty, what rights to compensation they have.

Subpart 3. Claim

The term "claim" is defined in these proposed rules in order to preclude any possible disputes over definitions which may vary by health plan. A broad definition of what constitutes a claim is used, making a claim merely a request that benefits be paid or provided. This encompasses as many different ways of attempting to seek the benefits of a contract as can reasonably be expected. Once again, because the types of health plan contracts vary widely, with HMOs actually providing the services and other health plans providing for compensation for provision of the services, the definition of what constitutes a claim needs to be described and included in the proposed rules.

Subpart 4. Claim Determination Period.

The need for a definition of "claim determination period" arises for many of the reasons stated above: to assure undisputed determination of the responsibility for payment of a particular claim or any part thereof. A period not less than 12 consecutive months is used. This particular time period adopts the customary calendar year period which most plans are based on.

The use of the claim determination period is essential for the process of

coordination of benefits because coordination of benefits is applied on a cumulative basis rather than claim by claim. As each claim is submitted in a claim determination period, the secondary plan determines its benefits based on all claims which were submitted up to that point in time during the claim determination period. The mechanics of the claim determination period is further explained under proposed Part 4685.0925 Procedure to be Followed by Secondary Plan.

Subpart 5. Coordination of Benefits

This subpart defines coordination of benefits succinctly as a provision establishing an order in which plans pay their claims.

Subpart 6. Hospital Indemnity Benefits

Because hospital indemnity benefits are not defined in statute or readily agreed to by custom or usage by various health plans, a definition is included in the rules. The definition clarifies that hospital indemnity benefits are not an expense incurred type of benefit system but rather a fixed payment amount based upon number of days in the hospital.

Subpart 7. Plan

Because coordination of benefits only applies to group contracts and because "plan" is not a term of universal use and other terms such as "program" or "contract" may be used, a definition of "plan" is included. The definition of plan had to be sufficiently broad to include all variations of the type of coverage intended to be subject to these rules.

In addition to the definition of "plan" found in this subpart, an additional requirement states that the definition of "plan" in the group contract must further state the types of coverage that will be considered in applying the coordination of benefits provision to that contract. This places the burden on the persons drafting the group contract to be explicit as to what is covered. So as to be as precise as possible, in addition to a description of what is included in the plan, this subpart also has examples of contracts and coverages explicitly excluded. The definition makes clear that "plan" applies to group contracts and not to contracts generally available to the public.

Subpart 8. Primary Plan

The critical question these proposed rules attempt to resolve is which of two plans is primary and which is secondary. Accordingly, a definition of primary plan is necessary. Simply stated, the primary plan is the plan that pays first and therefore usually pays the largest portion of the claim. This definition provides that plan is primary if it has no order of benefit

determination rules or it has rules that differ from these rules. Consequently, it is possible that there be more than one primary plan.

If these rules apply, the primary plan is that plan which is determined to be primary by application of these rules.

Subpart 9. Secondary Plan

This definition specifies that when there is coverage under more than one plan, the secondary plan is the plan required to make payment after the primary plan. As noted in regard to the definition of primary plan, a secondary plan is also a plan which the application of these rules indicates is the secondary plan.

Subpart 10. This Plan

The phrase "this plan" is defined to allow separate sections of the group contract to be treated differently and have their own coordination of benefit provisions. Because group contracts contain multiple types of benefits which in the past were separate coverages or were not covered at all, not all benefits need to be subject to COB. An HMO or insurer can chose to limit the benefits that will be incorporated in a COB provision. For example, an HMO could limit COB to hospitalizations, and none of its other health benefits

would be subject to COB. In this example, the HMO would be automatically primary for all non-hospitalization benefits. It is important to note that if a plan does not coordinate some or all of its benefits, it is considered primary against a plan that does coordination of benefits.

4685.0915 Coordination of Benefits; Procedures

The preceding subparts set up the framework for determining coordination of benefits.

Subpart 1. General.

This subpart mandates that the primary plan must pay or provide its benefits without any consideration that a secondary plan or plans exist. A secondary plan is allowed to take the benefits of another plan into account if it is determined to be secondary under these rules. Finally, the benefits of the plan which covers the person as an employee or subscriber are considered before the benefits of the plan that covers a person as a dependent.

At its face, this may seem to be an obvious statement of fact. However, the provision is necessary because often times the plan or plans involved in a claim will all claim to be secondary or dispute the fact that they are

primary, with a reasonably good basis. As discussed above, coordination of benefits rules are intended to resolve conflicts over which plan is primary and which plan is secondary. By establishing a priority between competing plans, beneficiaries will not have conflicts with plans that are disputing about which plan is primary. In addition, the plans themselves will have less administrative problems and expenses that potentially could occur over such disputes. Coordination of benefits rules also reduce the possibility that an insured or enrollee will receive no compensation or multiple compensation.

Subpart 2. Dependent Child: Parents Not Separated or Divorced.

In the past, the practice within the health plan industry was to designate the coverage of the male parent as primary when a child was covered as a dependent under both parents' policies. The new model NAIC rules and Commerce's rules changed this practice by establishing the "birthday rule" to determine which plan is primary.

This subpart requires the plan whose insured's birthday occurs earliest in the calendar year to be the primary plan for a dependent child provided the parents are not separated or divorced. The word birthday is intended to mean the month and date of the calendar year, not the year of birth.

As stated previously, the purpose of the coordination of benefits provisions

is to establish criteria for determining which plan is primary and which plan is secondary. While the "birthday rule" is an arbitrary criteria established for making that determination, using gender as criteria for benefit determination is offensive to many people. Consequently, the "birthday rule" was created to replace it.

The NAIC selected January 1, 1987 as the date the birthday rule would be implemented nationally. Commerce's rules required insurers to implement the birthday rule no later than January 1, 1987.

Subpart 3. Dependent Child: Separated or Divorced Parents

This subpart provides that if the court ordered one of the parents to pay for health care expenses of the child, the benefits on that plan are considered primary. Absent a court order relating to health benefits, the health plan of the parent with custody of the child is primary, followed by the plan of the spouse of the parent with custody of the child, and finally, the plan of the parent not having custody of the child. If the parents have joint custody of the child, the birthday rule will apply, as explained in proposed subpart 2.

Again, this criteria for establishing which plan is primary is consistent with the lines of responsibility for the dependent child. Obviously, if the court orders one parent to have responsibility for health care, that parent's health

plan will pay first. In the case of joint custody, the birthday rule is used as that is the arbitrary criteria established for making a determination of which plan is primary when both parents have responsibility for the dependent child, and both parents have health coverage for the child.

Subpart 4. Active/Inactive Employee

Under this subpart, the benefits of a plan which covers a person as an employee are considered primary over the benefits of a plan which covers a person as a laid off or retired employee.

This provision, again is necessary to help clarify which plan is primary and which plan is secondary when determining order of benefits.

Subpart 5. Longer/Shorter Length of Coverage

This provision gives a final method for determining which plan is primary. Briefly, if none of the above mentioned rules determines which plan is primary, then the plan which covered the person for the longest period of time is considered the primary plan. This provision describes various rules for determining the length of coverage under a plan. The first is that if an old plan ends and a new plan begins and if the claimant was eligible under the latter plan within 24 hours after the first ended then they are treated as one

continuous plan. This provides for situations such as when for all practical purposes the employee continues in the same type of employment. This might occur when the company has been purchased and a new plan substituted for the old or changes made for the employer's benefit which technically constitute a new plan but which employees often are not aware are a new plan.

4685.0925 Procedure to be Followed by Secondary Plan

This part explains the procedures to be followed by the plan that is determined to be secondary. Simply, the primary plan pays the full benefit due under the contract as though no other coverage existed. The secondary plan then pays the balance of the allowable expense or their normal benefit, whichever is less. In essence, the benefits from the primary plan plus the secondary plan will equal total allowable expenses.

Subpart 1. Total allowable expenses

The proposed rules provide that any savings that the secondary plan experiences may be used to pay for an allowable expense, but by no more than the amount the secondary plan has saved. As stated previously, these proposed rules define allowable expenses as any expenses of which at least a portion is covered under at least one of the health plans covering the person for whom

the claim is made. Consequently, a secondary carrier may have to pay benefits for a service it does not cover if that service is covered by the primary plan and if the secondary plan has experienced a savings from COB. As the NAIC Report to the Advisory Committee explains, "(T)his is not as shocking a concept as it may first appear." COB is applied on a cumulative basis rather than a claim by claim basis. The secondary plan will never pay more than it would pay had it been primary. However, any savings the secondary plan experiences as a result of COB must be used to pay for allowable expenses even if the secondary plan might not typically cover such expenses. As one health plan industry representative quipped, "This is the price of admission into the arena of COB savings."

Subpart 2. Reducing benefits of a secondary plan

This subpart builds on the subpart above. Under the proposed rules, the secondary plan is permitted to reduce the benefits it would normally pay so that total benefits paid by all plans during a claim determination period are not more than total allowable expenses. In brief, as stated previously, the secondary plan pays the difference between some maximum amount, but never more than total expenses incurred by the individual.

The following example will help illustrate the mechanics of the proposed rules.

In 1988, Jane Doe has incurred a health service expense of $1100. Company A insures Ms. Doe as an employee under a plan covering 80% of the service after satisfaction of a $100 deductible. Jane also has coverage with Company B as a dependent spouse. Company B's plan covers the service at 100%.

Company A		Company B	
Allowable expenses	1100	Allowable expenses	1100
less deductible	100	Less Co. A's benefit	800
	1000	Co. B pays	300
x 20% coinsurance	200		
Co. A pays	800	Co. B's savings	800

The savings that Company B experiences is considered a benefit reserve. This savings must be used by Company B to pay for allowable expenses during a claim determination period even if Company B normally would not pay for such services. An expansion of the example with Jane Doe will help explain why these rules are reasonable.

Later in 1988, Jane Doe incurred additional health services expenses which totaled $500. Company A covers such services at its usual 80%; however, Company B does not cover such services. According to the proposed COB rules, Company B must use its benefit reserve to pay for these services.

Company A		Company B	
Allowable expense	500	Allowable expense	500
x 20% coinsurance	100	Less Co. A's benefit	400
Co. A pays	400	Co. B pays	100

If a benefit reserve exists, the secondary carrier, Company B, may have to pay for services it normally would not cover, but only because Company B has been relieved of the responsibility for paying for some other services. The secondary plan never pays more than it would have paid had it been primary. In practice, the secondary plan almost always experiences a savings. Under successful COB, the individual with dual coverage gets complete coverage (because both plans pay for allowable expenses) but not duplicate coverage.

In the example directly above, absent a benefit reserve, Company B would not have to pay anything. For example, if Jane Doe incurred the $500 health service expense and that was the only expense in a claim determination period, Company B would not have an obligation to pay any amount for that expense because Company B does not have to pay more than it would pay had it been primary, and in this instance, had it been primary, Company B would not pay for that expense.

It is important to remember that coordination of benefits is calculated for total claims in a claim determination period. Consequently, if Jane Doe incurred that $500 expense at the beginning of a claim determination period, and then incurred additional expenses, Company B would have to recalculate total claims. If Company B experienced a savings on those additional expenses, Company B would reimburse Ms. Doe for part of the $500 expense as explained in the following example.

Jane Doe incurs a $500 expense which is covered by Company A at 80% after the satisfaction of a $100 deductible, and is not covered by Company B. Later in that same year, Ms. Doe incurred a $1000 expense which is covered by Company A at 80% and is covered by Company B at 100%.

Company A		Company B	
1. Allowable expenses	500	Allowable expenses	500
less deductible	100		
	400		
x 20% coinsurance	80		
Co. A pays	320	Co. B has no savings, doesn't pay	
2. Allowable expenses	1000	Allowable expenses	1000
x 20% coinsurance	200	less Co. A's benefit	800
Co. A pays	800	Co. B pays	200
		Co. B saves	800

Company B recalculates for total claims in that year,
and pays for part of the allowable expenses from the $500 180

Co. B total savings 620

The proposed rules require the secondary carrier to keep track of a benefit reserve for a claim determination period, or one year. The benefit reserve need only be made available to the person on whose behalf they were incurred. At the end of a claim determination period, the secondary plan closes out the benefit reserve and starts with a clean account. Any funds left in the benefit reserve at the end of the period belong to the health plan, a source of revenue that will enable the HMO to keep overall health plan cost down.

4685.0930 MISCELLANEOUS PROVISIONS

Subpart 1. Reasonable cash values of services

This subpart explains that a secondary plan which provides services can recover the cash value of these services from the primary carrier even if the secondary carrier does not bill the enrollee for the services.

An HMO differs from an insurer because it usually provides health services through its organization. Some HMOs do not generate bills for services they render. Consequently, if an individual receives health services from the HMO,

but the HMO is the secondary plan, the HMO may bill the primary plan for its obligation for the cost of the health services performed.

Subpart 2. Coordination of benefits with a noncomplying plan

There may be health plans which do not comply with the provisions proposed in these rules. For example, some plans always claim to be secondary or in excess of any other health coverage, and some plans may not be subject to insurance regulation. This subpart is intended to allow plans to coordinate with noncomplying plans.

According to the proposed subpart, a plan may coordinate benefits with a noncomplying plan. If the complying plan is primary it will pay benefits first. If the complying plan is secondary, it must still pay its benefits first; however, it need only pay the amount it is obligated to pay as a secondary plan. This provision is included to assure prompt payments.

The proposed rules further provide that if the noncomplying plan fails to provide the information needed by the complying plan to determine its benefits, the complying plan may assume that the benefits of the noncomplying plan are identical to its own benefits and make payments accordingly. Once information becomes available to the complying plan, the complying plan must adjust its benefits according to the facts.

Finally, this proposed subpart provides that if a noncomplying plan pays less benefits than the individual would have received had the complying plan paid the benefits due as a secondary plan and the noncomplying plan paid its benefits due as the primary plan, the complying plan must provide the individual with benefits in an amount which equals the amount the individual would have received if the noncomplying plan paid its full amount. However, the complying plan shall not be required to pay more than it would have paid had it been primary. This proposed subpart also permits the complying plan to obtain rights of subrogation for this payment against the noncomplying plan. This provision is intended to benefit the insured by making sure that they receive the same level of benefits they would have received had there been no duplication of coverage requiring application of COB rules. This provision is also necessary to make sure the individual does not have to wait to be paid until the two companies resolve their conflicts.

Subpart 3. Allowable Expense

This subpart recalls the definition previously discussed in proposed Part 4685.0910 and provides that similar terms may be substituted for the words necessary, reasonable, or customary. In addition, this subpart also provides that terms such as medical care or dental care may be substituted for health care to more accurately describe the coverages to which COB applies.

Subpart 4. Subrogation

This subpart provides for a right of subrogation if the plan chooses to have a subrogation right. Subrogation is defined in G.E. Palmer, Law of Restitution, (1978), section 1.5(b) as

> an equitable remedy which operates when a victim of loss is entitled to recover from two sources, one of whom bears a primary legal responsibility. If the secondary source pays the obligation, it succeeds to the rights of the party it has paid, against the third party, who was the primarily responsible party.

This subpart provides that the plan is not required to have provisions for subrogation. COB and subrogation are not similar functions although they may be considered by some to be related functions. This provision makes it clear that COB and subrogation are distinct and a plan may choose to do one without doing the other.

4685.0935 Effective Date

Subpart 1. Applicability of coordination

This subpart provides that this set of COB rules applies to group health care

contracts issued on or after the effective date of this regulation. As stated previously, COB rules apply to group health contracts. It is not mandatory that a health plan conduct COB. However, if the health plan does COB, that health plan must follow these rules.

Subpart 2. Deadline for compliance

This subpart provides that contracts issued before these rules are effective must be brought into compliance by the later of the next anniversary or renewal date of the contract, or the expiration of any applicable collectively bargained contract under which the health plan contract was written. This subpart is reasonable because it provides that any changes to the group contract as a result of these new COB rules will occur in a logical an orderly fashion. It would be disruptive to the group contract holders, the individuals covered by the contract, and the health plans to require changes in the health plan contracts midterm. As stated previously, most group contracts include COB provisions which follow the intent of these rules. It would be unreasonable to require perhaps minor contract changes at a great expense to the health plans without a justifiable corresponding benefit to individuals.

4685.0940 Model COB Contract Provisions

Subpart 1. General

The first subpart simply explains that a model COB provision for use in group contracts is contained in the rules. In addition, this item reiterates the requirement that a health plan follow the provisions of the rules if the health plan choose to coordinate benefits.

Subpart 2. Flexibility

This subpart permits a health plan to use its own coordination of benefits language in it contracts. For a variety of reasons, health plan companies often want to use their own language even when model provisions are provided. However, the intent is that any language be consistent with the requirements of these rules.

Subpart 3. Prohibited Coordination and Benefit Design

This subpart prohibits the coordination of benefit language of any plan from making that plan secondary or from reducing benefits because another plan

exists, except in the case of Medicare. Coordination of benefit requirements exist because individuals are entitled to coverage under two or more different policies.

4685.0950 TEXT OF MODEL COORDINATION OF BENEFITS PROVISIONS FOR GROUP CONTRACTS.

This part requires the HMO to use COB language which is substantially similar to the proposed model in their group contracts. By providing a model to be used in each contract, there will be less variations between health plans which might cause confusion or disputes as to which plan is primary and which is secondary.

I. Applicability.

This section of the model provisions activates the coordination of benefit provisions when there is health care coverage for the employee or coverage under another plan as well as the plan which contains this provision. Once activated the coordination of benefit provisions apply according to the order of priority set by the model COB language.

Again, this section restates the general COB rules: when the subject plan is

primary under the order of determination rules, the subject plan pays first and pays the full benefit. When another plan is determined to be primary, the benefits payable under the subject plan are reduced. The reduction is described later in the model contract provisions.

II. Definitions

The model contract provisions include simplified definitions of "plan," "this plan," "primary plan," "secondary plan," "allowable expense," and "claim determination period." All of these definitions have been discussed above in proposed Part 4685.0910 which is the definition section.

These definitions are necessary for the contract holder to understand the COB contract provisions.

III. Order of benefit determination rules.

This section of the model contract provisions sets forth the method for determining which plan is primary and which plan is secondary.

This section restates in a simplified manner the procedure described under proposed Part 4885.0915 Coordination of Benefits; Procedures.

IV. Effect on benefits of this plan

This section explains what occurs after the primary and secondary plan have been determined. This occurrence has already been explained above. Briefly, the primary plan pays as if no other plan exists. The secondary plan is in a different situation given the existence of a primary plan. Therefore, the secondary plan must modify its benefit terms. The secondary plan will reduce the amount of benefits it would have paid because the primary plan has paid benefits. The benefits of the primary plan plus the benefits of the secondary plan will equal total allowable expenses within a claim determination period. Again, the rules are intended to assure that the individual does not receive compensation beyond the costs of health care services because of dual coverage. However, the individual will not receive less than they would have received if there had not been dual coverage.

V. Right to receive and release needed information

This section of the model contract provisions permits the health plan to get the facts it needs to pay the claim without the consent of any person. Certain facts relating to claims and health services rendered are necessary for COB. Since the purpose of these rules is to facilitate the determination as to which plan is primary and which plan is secondary, there needs to be

provisions for obtaining and sharing the necessary facts.

VI. Facility of payment

In certain instances, payment of a claim may be made by another plan inadvertently which should have been paid by the subject plan. This section provides that if a payment is made by another health plan that should have been paid by the subject plan, the subject plan may pay the other health plan. Since the intention of the proposed rules is to insure prompt payment on behalf of individuals, this provision provides that payment for services does not irrevocably fix the responsibilities of the parties.

This section also notes that HMOs provide benefits and other health plans provide payment for benefits. In either circumstance, this section encourages provision of services or payment for services first and discussion of priority later.

VII. Right of recovery

This section follows the preceding section which provides that payment of a claim or provision of benefits does not irrevocably fix the responsibilities of the parties. A plan making a payment that it was not obligated to pay is allowed to recover the excess from the persons it has paid or on whose behalf

it has paid, insurance companies or other organizations. According to this section, the health plan may seek recovery from anyone who might reasonably be obligated to repay them.

Again, as explained above, without this type of section, the health plans would be so cautious in assuring that they do not improperly pay that claims would be delayed.

This section also points out that the amount of payments includes the reasonable cash value of any benefits provided in the form of services. Because HMOs provide services, they may seek payment for the cost of services delivered.

General Statement of Need and Reasonableness- Annual Report and Filing Requirements

The proposed rules amend existing rules relating to uniform reporting and filing requirements. The proposed amendments are necessary to reflect recent changes in laws governing HMOs and to revise and clarify administrative and procedural steps in the filing process. Since the existing rules were adopted in 1973, HMOs have been steadily increasing in enrollment, in numbers of organizations and in complexity of operations. Correspondingly, the amount of material filed with the commissioner by HMOs is increasing, and the nature of the filed material is changing. The existing rules need to be revised to reflect the changes in the HMO industry.

Based on current experience with the filing process, the Department and HMOs have found that the process is often unduly lengthy, in part because of a lack of clear, defined filing requirements. Some of the existing requirements are ambiguous, some of the requirements are outdated, and some are administratively inefficient. The proposed rules explain and clarify steps which will facilitate timely review of filed materials within the statutorially prescribed 30 day review period.

Annual reporting requirements need to be updated to keep pace with changing

statutes. The rules relating to reporting requirements were last amended in 1985. Since that time, amendments to the HMO Act of 1973 (HMO Act) passed by the 1988 Minnesota legislature require changes in existing rules. The proposed rules reflect the changes necessary to comply with new statutes.

The Department worked with representatives from the HMOs in drafting these proposed rules. In July of 1988, the Department sent out a working draft of the proposed rules to people who had contacted the Department to receive information relating to HMO rulemaking. Department staff met with industry representatives in August and September and listened to their comments and suggestions on the draft rules. Many of the HMO representatives' suggestions were incorporated into the final draft of these rules.

Part by Part Statement of Need and Reasonableness- Annual Report and Filing Requirements

4685.0100 Definitions

This definition is amended to update the National Association of Insurance Commissioners' (NAIC) annual statement blank which is submitted as part of the annual report from 1985 to 1988. Each year the NAIC annual report blank is revised based on recommendations from a technical advisory committee to the

NAIC. A joint committee of the NAIC and National Association of Health Maintenance Organization Regulators, (NAHMOR) meets annually to approve changes to the annual report blank. The report blank is printed and distributed by Brandon Insurance Service Co. in Nashville, Tennessee.

The NAIC annual report blank, as revised from year to year, is used by the Federal Office of Health Maintenance Organizations as the reporting form for federally qualified HMOs and is generally used as the annual report form by HMOs throughout the country. In practice, it is difficult to use outdated NAIC annual report forms, because the revised forms are the only forms that are printed and distributed by Brandon Insurance Service Co. in a given year. Consequently, even though the existing rules require the submission of a 1985 annual report blank, in the years between 1985 and 1988, most of the HMOs have submitted annual report blanks dated for the year in which they were preparing their statements.

4685.1910 Uniform Reporting

This section updates the NAIC reporting blank from the 1985 version to the 1988 version. The reason for updating the blank is explained directly above.

4685.1940 NAIC BLANK FOR HEALTH MAINTENANCE ORGANIZATIONS, REPORT #2: STATEMENT OF REVENUE AND EXPENSES

Subpart 1. Separate statements.

This part is amended to require a separate statement of revenue and expenses for all Medicare contracts. Minnesota Statutes, section 62D.08 subdivision 3, item (e), which was enacted in 1988, requires HMOS to annually submit a report addressing the experience of HMO contracts sold to Medicare enrollees. The new law requires the information in the report to include the information specified in Minnesota Statues, section 62D.30, subdivision 6. That particular statute requires HMOs to submit annual reports summarizing their demonstration project experience on forms developed by the commissioner. The information which is currently required to be submitted for annual reports on demonstration projects, must now be submitted for all HMO Medicare contracts.

Under existing rules, a statement of revenue and expenses is required to be submitted for HMO demonstration project annual reports. It follows that under the proposed rules, this statement is also required to be submitted for Medicare contracts.

A statement of revenue and expenses on Medicare business is important for the commissioner to monitor the operations of the HMO. HMO medicare contracts

with the federal government are a significant line of business for several HMOs in Minnesota. This business is dependent in part on the payments from the government. In the fall of 1987, four HMOs terminated selected Medicare contracts because of poor financial experience. If the commissioner had received financial data on these types of contracts, the commissioner could have anticipated the terminations and may have identified a plan of corrective action before the enrollee contracts were terminated.

Subpart 4. Uncovered expenses.

Subpart 4 is a new section which requires HMOs to calculate their uncovered expenses annually on a separate schedule. HMOs are required to calculate uncovered expenditures in the preceding year in order to determine the amount of deposit required by new law enacted in 1988. Minnesota Statutes, section 62D.041, subdivision 3 requires HMOs to keep a deposit "equal to the difference between the amount on deposit ($500,000) and 33 percent of its uncovered expenditures in the preceding year."

HMOs must document their uncovered expenditures in the preceding year in order to determine the amount of their required deposit. It is reasonable to require the HMOs to submit their calculations annually because the Department must have documentation of the HMO's uncovered expenditures in order to

determine the amount of each HMO's deposit. The Department also needs documentation of the calculation to ensure that HMOs are calculating their uncovered expenditures consistently. The uncovered expenditure forms will require all HMOs to calculate their uncovered expenditures in the same manner. Without uniform forms, there is potential for great variability in the uncovered expenditures calculation. The actual formula for the calculation is proposed under a separate part in the rules. (See proposed part 4685.0805.)

It is reasonable to require that the uncovered expenditure calculation be included in the annual report because the annual report is the statement that describes the HMO's financial condition in the preceding year, and the uncovered expenditures calculation is part of the HMO's previous year's financial transactions.

4685.1950 NAIC BLANK FOR HEALTH MAINTENANCE ORGANIZATIONS, REPORT #4: ENROLLMENT AND UTILIZATION TABLE

Subpart 2. Total members at end of period.

This part is amended by requiring enrollment and utilization data to be submitted by county instead of geographic area, and to require separate utilization data on Medicare enrollees.

The enrollment data provides information which is essential to the Department's regulatory function. Minnesota Statutes, section 62D.01 specifically requires the commissioner to trace "the development of HMO's." Information on enrollment is necessary to analyze the growth of HMOs particularly as they expand into nonmetropolitan areas. The Department's current data on enrollment is requested by consumers, consultants, employers, developers, and legislators.

The Department also needs enrollment data to monitor the availability and accessibility of the HMO's health services. Minnesota Statutes, section 62D.04, subdivision 1 (a) provides that the HMO must "demonstrate the availability and accessibility of adequate personnel and facilities." HMO enrollees are not permitted under the HMO contract to receive health services from any available health care provider. Because HMOs are allowed to restrict their enrollees' access to providers, the commissioner is required by law to monitor the availability and accessibility of health services. Under existing laws and rules, an HMO must demonstrate to the commissioner that it has enough providers to meet the health care needs of enrollees before an HMO can enroll individuals in a specific area. As an HMO expands its operations, it generally develops new service areas on a county-wide basis. HMOs that are federally qualified are required to develop service areas by county.

Once an HMO is in operation, the commissioner must continually monitor the availability of health care services in the HMO's service areas. In order to monitor availability of services, the commissioner must have information on enrollment and numbers of providers in specific geographic areas. Given the fact that most service areas are granted on a county basis, it is reasonable to require enrollment data by county.

Under the existing rules, the Department monitors enrollment data by five geographic areas, (please see appendix M). These areas are arbitrary divisions and are too large to get accurate information about growth or changes in HMO enrollment in specific areas of the state. The current requirement for reporting enrollment by geographic area is also too broad to give the commissioner information necessary to determine the availability and accessibility of providers. The proposed rules give the commissioner more useful information with which to monitor the ratio of enrollees to health care providers.

The commissioner has the authority to request specific information to be included in the annual report as "necessary to carry out her regulatory responsibilities" under Minnesota Statutes 1988, section 62D.08, subdivision 3 item (e). Although current statutes do not require the submission of enrollee data by county, this specific information is necessary for the commissioner to carry out her duties which include monitoring the availability and

accessibility of health care services.

The requirement for enrollment and utilization data for Medicare enrollees is added to comply with Minnesota Statutes 1988 section 62D.08 subdivision 3 (e) as explained above which requires HMOs to submit annual reports on the experience of HMO Medicare contracts. This data is currently required of demonstration projects, and consequently must also be required of Medicare contracts.

The data on enrollment according to Medicare contracts is also necessary to make sense of the revenue and expense data required under proposed part 4685.1940. An analysis of costs compared to enrollment or changes in enrollment can indicate potential problems with a particular line of business. As explained earlier, Medicare contracts are a significant line of business, and in the past, some HMOs have terminated Medicare contracts in specific counties. The commissioner is required to judge the HMO's ability "to meet its obligations to enrollees and prospective enrollees" under Minnesota Statutes, section 62D.04, subdivisions 1 and 4. This data is necessary to provide at least a fundamental screening for the commissioner to monitor the HMO's ability to continue to provide health services to enrollees.

Subpart 3. Type of service.

This subpart is amended by requiring itemization of total patient days incurred, annualized hospital days per 1,000 enrollees, and average length of stay for Medicare contracts. This enrollment and utilization information is presently required for total HMO enrollment and demonstration project enrollment. As explained above, in accordance with Minnesota Statutes 1988, section 62D.08 subdivision 3 (e), HMOs must submit annual reports on HMO Medicare contracts which contain all of the information required to be submitted on demonstration projects. In addition, as also previously explained, this type of data is necessary for the commissioner to monitor the ability of the HMO to continue in operation or continue offering certain lines of business.

4685.1980 Quarterly Reports

New legislation enacted in 1988 requires HMOs to submit unaudited financial statements on a quarterly basis on forms prescribed by the commissioner, Minnesota Statutes, section 62D.08, subdivision 6. This part is a new section which lists the schedules of the NAIC annual report form which can be used for quarterly financial reporting. The forms required by the proposed rules are the standard reports which are necessary to describe the financial condition

of an organization. The financial forms required are the balance sheet; statement of revenue, expenses and net worth; and the statement of changes in financial position. A part of the NAIC report 4, that dealing with enrollment data, is also required. Enrollment data is necessary in monitoring the financial condition of the HMO. Enrollment is a measure of the potential income of the HMO; any increases or decreases in enrollment will affect the HMO's ability to manage its finances. The current computerized financial model used by the department to monitor the HMO's finances includes enrollment data to determine the financial condition of the HMO.

The forms required for quarterly reports are the same forms which are required for quarterly reports by the Federal Office of Health Maintenance Organizations. Any other states requiring quarterly reports, require these forms. HMOs which are federally qualified HMOs are currently submitting these same forms to the federal government.

4685.2100 ANNUAL REPORTS

This part is amended to require an annual list of providers by county, including the provider's address and area of specialty. As stated earlier, the commissioner needs minimum data on numbers of providers and enrollees in specific areas in order to monitor the availability of health services. The

data on enrollment by county are proposed to be submitted in the annual report as described in the proposed amendments to 4685.1950, subpart 2, above. It is reasonable to request a provider list by county because the commissioner cannot monitor availability and accessibility without both pieces of information.

Recently, there have been major clinics in areas outside of the Twin Cities which have terminated their contracts with HMOs. In these situations, the Department had to reevaluate the availability and accessibility of the HMOs' health services. Without specific, updated data on numbers of providers and enrollment, the Department could not make any meaningful determinations about accessibility and availability of health services. In the situations where there were clinic terminations, the Department had to request information on numbers of providers and enrollees from the HMO.

HMOs are currently required by law to notify the Department of any changes in providers, including additions and terminations, under Minnesota Statutes, section 62.08, subdivision 5. The provider report submitted at the end of the year will validate the provider changes information that the Department has received throughout the preceding year. The provider report submitted at the end of the year will guarantee that the Department's information on providers is current and reliable. In the past there have been occasions where the HMOs have failed to notify the Department of provider changes when they occurred.

If this happens the Department may have inaccurate data. The Department needs the annual list as a check to be certain that inaccurate information will not be carried from year to year. Without reliable data, the commissioner will not be able to adequately monitor the accessibility and availability of HMO health care services.

Again, Minnesota Statues, section 62D.08, subdivision 3 (e) gives the commissioner the authority to request additional data in the annual report which is necessary for the commissioner to carry out her responsibilities.

4685.2250 USE OF FILED MATERIALS

This is a new section which provides that an HMO may not implement any modifications in the documents required to be filed under existing law, until the modifications have been filed with the commissioner and the filing is approved or deemed approved.

Minnesota Statutes, section 62D.08, subdivision 1, states that an HMO must "file notice with the commissioner of health prior to any modification of the operations or documents described in the information submitted (for a certificate of authority)," (emphasis added). The law further provides that "if the commissioner of health does not disapprove the filing within 30 days

it shall be deemed approved and may be implemented by the HMO." (emphasis added). Based on this language, the law requires the HMO to file the document before any modification is implemented. Then the HMO will either 1) receive notice of approval from the commissioner within 30 days; 2) receive notice of a disapproval within 30 days; or 3) if the HMO has not received a notice of a disapproval within 30 days, the filing is deemed approved. The filing may be implemented after steps (1) or (3) above take place.

In addition, Minnesota Statutes, section 62D.08 refers to Minnesota Statutes, section 62D.03 which is the section concerning requirements for a certificate of authority. According to Minnesota Statutes, section 62D.03, an HMO cannot initially implement any of the documents described in statute unless the commissioner approves such documents. It follows that an HMO must obtain approval before using any new or modified document.

While the proposed rule is a restatement of existing law, the rule is necessary because past practice has not followed existing law. The proposed rules are needed to inform the HMOs that the Department's past practice will be altered in order to comply with Minnesota statutes.

In the past, the Department's policy concerning contract filings has been a "file and use" policy. The HMOs have been allowed to use a filing without obtaining prior approval provided they file the contract. However, if the

department disapproves a filing, the HMO may no longer use that document. Obviously, this creates a problem when the HMO is using a contract that has been filed but not approved. The HMO could potentially be operating with a contract that the Department believes conflicts with current law.

The proposed rules clarify that HMOs are required to "file and not use" documents until they are approved or deemed approved. This proposed section is reasonable and necessary because it complies with existing law and informs the HMOs that the Department is changing its past practice.

4685.3300 PERIODIC FILINGS

Subpart 1. Filing requirements.

The original rule is proposed to be repealed because it is obsolete. This subpart was adopted when the commissioner and Board of Health met monthly and approved or disapproved the HMO's filings. The existing subpart provides that filings will be acted upon at the next official Board of Health meeting following the filing date. The existing rules also provide that the filings need to be received at least 15 days before the next meeting, in order to put the filing on the agenda. The Board of Health was abolished in 1977. Currently, the commissioner approves or disapproves the HMO's filings as part

of her normal day to day regulatory responsibilities. Since there are no official meetings at which these filings are acted upon, this subpart is out of date and should be repealed.

Subp. 1a. Final Form

This is a new section which merely requires all filings required by statute to be submitted to the commissioner to be in final typewritten form. In the past, the Department has received HMO contract filings with handwritten contract language. It is reasonable to require all filings to be typewritten. The HMOs' filings are kept on public record. Documents available for public inspection should be typewritten to ensure that such documents are legible to the general public. In addition, the Department can reasonably request typewritten filings for legibility given the number of filings staff must review and consult. Originally, the Department proposed that the filings be submitted in final printed form, the Department accepted typewritten form as a compromise.

Subpart 2. Provider Agreements

This subpart is deleted because it is unworkable. The existing rule requires

the filing of any "substantive" change in the form of provider contracts. By stating that only substantive changes need to be filed, the existing rules permit the HMO to make judgments about what is a substantive change and what needs to be filed. The commissioner may not see important changes in provider contracts because the HMOs consider the changes nonsubstantive.

In addition, the proposed rule is more consistent with Minnesota law. Minnesota Statutes, section 62D.08 subdivision 1 requires an HMO to file notification with the commissioner prior to "any" modification in the form of provider contracts. The law clearly requires the filing of any change, therefore the existing rules should be deleted.

Subpart 2a. Insufficient Information

This new subpart clarifies the requirement that HMOs submit the supporting information required to determine whether the filed material complies with existing laws and rules or the filing will be disapproved. Existing rules, Minnesota Rules part 4685.3300, subpart 5 require the HMO to submit any data requested by the commissioner or the filing will be disapproved. This section is deleted because it is not efficient or administratively workable. In the past, under the existing rules, there have been occasions where the Department has requested additional information from the HMO. However, the HMO has not

been able to supply such information in a timely manner. While the Department waits to receive the information, the 30 day review period may expire. At this point it is not clear whether or not the Department should disapprove the filing or request an extension to the review period.

Extensions to the review period are problematic. In situations where the Department has requested extensions, the time periods for review are abandoned. Without any definite deadlines for actions by either party, the filing can become unduly lengthy.

The proposed rules establish clear time lines which will eliminate the need for extensions to the 30 day review period. The HMOs and the Department will each be aware of what time frames are in place, what deadlines apply, and when to expect information.

Under the proposed rules, the HMO has the responsibility to file all the supporting information required to determine the legal propriety of the filed material at the time the document is filed. It is reasonable to place this requirement on the HMO because the commissioner cannot determine the legality of the filing if important information is missing.

If the HMO does not submit all of the necessary information, the Department will disapprove the filing. In the disapproval letter the commissioner will

specifically state what additional information is needed. The proposed rules then allow the HMO to refile the additional information without a filing fee provided the HMO submits the information within 30 days. Once the Department receives the information, the Department's 30 day review period begins again.

The proposed rules are reasonable because they retain the basic requirement that the HMO must submit all of the supporting information reasonably required by the commissioner. However, the proposed rules establish workable timelines for the commissioner and the HMO to ensure an efficient filing process. If the HMO does not initially submit adequate supporting information, the filing is disapproved and the HMO will be notified of what information is necessary in order to determine the legality of the filing. Then, the HMO can file an amended filing provided the HMO responds within 30 days. The commissioner then has 30 days to review the amended filing with the additional information, etc. Under the proposed rules there are no extensions; each party has 30 days to act.

Subpart 4. Service Area

This subpart is deleted, but the content of the subpart is revised and included in proposed subpart 9 below. The existing subpart is repealed because it lacks specificity. The existing rule simply requires an HMO to

submit "sufficient supporting documentation of the service area, facility and personnel."

The proposed new subpart is more concrete and specific. It contains the same general requirement for documentation when an HMO proposes to amend its service area. The proposed rule gives a description of what "sufficient supporting documentation" entails.

Subpart 4a. Form Identification

This is a new section which simply requires the HMO to identify every filing with the HMO's name, address and telephone number, and a unique form identification number on the first page of the document. The HMO is also required to identify the contract as either a group or individual contract.

Given the large number of filings the Department must review and keep on file for public inspection, it is reasonable to require a unique number and uniform identification. In fiscal year 1988, the Department reviewed 296 contract filings. This compares to 133 in fiscal year 1987 and 34 in fiscal year 1983. A unique form number will enable the department, HMO enrollees, HMOs, and the public to easily refer to a specific filing. In addition, when the HMO files an amendment to a filing, it will be efficient from both the Department and the HMO's perspective to identify the contract that the amendment amends by

its unique form number.

It is reasonable to require HMOs to include identifying information on all filings. The Department has received filings, such as amendments or riders or endorsements, without any identification of the HMO printed on the form. Typically, the cover letter accompanying the form identifies the HMO. However, these amendments, riders or endorsements are ultimately distributed to enrollees. If the cover letter is separated from the contract form, it is impossible for enrollees to identify the source of the forms.

Subpart 5. Additional Data

This existing subpart is repealed, because subpart 2 of the proposed rules requires the HMO to submit all supporting information at the time of the filing. The existing rule allows the HMO to submit additional data after the date of filing.

As explained previously, the 30 day deadline imposed on the commissioner for contract review is not enough time to request and receive additional information from the HMO. It is not feasible for the commissioner to review a

filing, request additional information, wait for the HMO to send the information, and then make a determination within 30 days.

The proposed rule requires the HMO to initially submit all supporting information. If the supporting information is not adequate, the commissioner will disapprove the filing, and then the HMO may refile the information necessary.

Subpart 5a. Duplicate Copies

This is a new subpart which simply requires HMOs to submit two copies of every filed document and indicate the name of the contact person for the HMO. This requirement is intended to facilitate the processing of the filing and to ensure timely notification to the correct person at the HMO. One copy of the document will be kept by the Department and the other copy will be mailed to the contact person with a letter indicating that the filing is approved or disapproved.

One copy of every filed document is necessary for the department to maintain public files and for auditing purposes. A copy of every filed document is necessary to audit HMOs for the use of disapproved or unfiled documents.

Subpart 6. Approval or disapproval.

This is a new subpart which clarifies the approval and disapproval process. According to the provisions of Minnesota Statutes, section 62D.08 subdivision 1, the commissioner is required to make a decision on the filing within 30 days or the filing is automatically deemed approved. Many of these proposed sections of rule are intended to explain and clarify the administrative steps within the filing process. The proposed rules describe the Department's responsibilities in the filing process and inform the HMO of the commissioner's responsibilities. The rules explain that the HMO can expect a copy of the filed document stamped approved or disapproved within 30 days. If the filing is disapproved, the commissioner must state the specific reason for denial.

Subpart 7. Amended filings

The health maintenance organization is allowed to file an amended filing without a filing fee, under this proposed subpart. Specifically, the commissioner will not require an additional fee for a filing which amends a previously disapproved filing provided the health maintenance organization files the amended filing within 30 days of receiving notice of disapproval.

This proposed subpart further provides that once an HMO files an amended filing, the commissioner has 30 days to act on the amended filing. An amended filing may only address the issues that were the subject of the disapproval. In addition, any filing which is amended and refiled without a filing fee under this subpart, must be filed with the same identification number as the original filing.

It is reasonable to waive the filing fee for a filing which is amended and resubmitted after a disapproval. In these situations, Department staff have already reviewed the initial filing and made a determination on the filing. The amended filing will simply be correcting whatever it was which caused the initial filing to be disapproved. Once staff receive the amended filing, staff will only have to review the amendments to see if the changes comply with Minnesota law.

Once an initial filing has been made, and a filing fee has been paid, the HMO should not be required to submit another complete filing with a fee provided they submit the amended filing within 30 days. If the HMO takes more than 30 days, staff will have to rereview the entire filing in order to determine whether the amendments to the filing are appropriate. Therefore, in these circumstances, the HMO must start the process from the beginning and submit a totally new filing and a filing fee.

An amended filing may not include information which goes beyond the issues in the original filing that were the subject of disapproval. If the amended filing contains new information, staff will have to conduct a new review. In such circumstances, the HMO should be required to file a new filing with a filing fee to cover the costs of a new review by staff.

It is reasonable to require the HMO to use the same form number on an amended filing that the HMO is refiling because of a disapproval. The amended filing is essentially the same as the initial filing. On the other hand, if the HMO does not refile an amended filing within 30 days of notice of a disapproval, and the HMO must start the filing process from the beginning, the HMO must file the document with a different number and a new filing fee. Essentially, each filing submitted with a fee is considered a new filing.

Subpart 8. Endorsements

This is a new section which provides that when a health maintenance organization files an endorsement, amendment, or rider to existing contracts, the health maintenance organization must indicate the form numbers of the contracts with which the endorsement, amendment or rider will be used.

This subpart is necessary because the Department cannot determine the meaning

of an endorsement or amendment unless it knows the how the endorsement, amendment, or rider relates to the larger contract. The Department must examine the corresponding contract to determine the impact and legality of the amendment. It is reasonable and administratively efficient to require this identification when an HMO files an endorsement, amendment or rider.

Currently, when an HMO files an amendment of endorsement, it does not routinely identify the documents which the amendment is amending. The requirement to do so will ensure that the Department has the most complete version of the contract including amendments.

Subpart 9. Service area expansion.

Existing rules require the HMO to submit "sufficient supporting documentation of the service area, facility and personnel" when requesting to expand its service area. The proposed amendment to existing rules explains what "sufficient supporting documentation" entails. The purpose of the amendment is to give the HMO a complete description of the documentation that will be considered sufficient by the commissioner.

The items of information required under the proposed amendment are reasonable

and necessary for the commissioner to be assured that the HMO's health services are accessible. Minnesota Statutes, section 62D.04 subdivision 1 provides that the HMO must assure that health services are "provided in a manner as to enhance and assure both the availability and accessibility of adequate personnel and facilities."

First, the HMO must give the Department a detailed map with the proposed service area outlined. A map is necessary in order to accurately define the area proposed to be served by the HMO. The most reasonable and efficient means of describing a specific area is to submit a detailed map. In addition, the most efficient means for determining distances from the borders of the proposed service area to provider locations is to examine a map.

The proposed amendments require the HMO to chart provider locations on the map and describe the driving distances from the boundaries of the proposed service area. These requirements are necessary for the commissioner to assess the geographic accessibility of provider locations. The map and description of driving distances will be used to determine if the enrollees residing at the boundaries of the service area have adequate access to health care services.

Other factors which are necessary to determine whether or not health care services are accessible, as required under Minnesota Statues 62D.04, subdivision 1, include the provider's hours of operation and provider's

specialty. Obviously, health care services may not be accessible if the providers' hours of operation are limited. In addition, if the HMO's providers in a proposed service area are predominately specialists, routine general practice health services may not be accessible to enrollees. Similarly, if there are no specialists under contract with the HMO, there is a potential that specialists services will not be adequate and accessible to the enrollees. Information on hours of operation and specialty of providers is essential for determining if the HMO should be granted a new service area.

The proposed rules also require evidence of contractual arrangements with providers. It is reasonable to require this information because the commissioner does not obtain this type of information under the current regulatory structure. Currently, HMOs are required to submit the form of provider contracts, not each provider contract. In situations where the HMO is expanding into new service areas, it is reasonable to require HMOs to provide evidence of contractual arrangements with providers in order for the commissioner to be assured that the HMO has a network of contracted providers available for potential enrollees.

The proposed rules simply require a copy of the signature page of the provider contract or an affidavit attesting that the providers are under contract. This requirement for evidence is not onerous or burdensome. It is necessary to assure the commissioner the HMO has personnel and facilities available.

The HMO must also submit evidence that its contracting providers have admitting privileges at the hospital(s) that potential enrollees will use. Normally, admitting privileges information is contained in the provider contracts. As stated above, the commissioner does not obtain individual provider contract information. Before granting an HMO a new service area, the commissioner must have evidence that contracting providers have admitting privileges at the hospital(s) that will be used by potential enrollees as a basic assurance that hospital services will be available and accessible.

Finally, the proposed rules retain the requirement in the existing rules which provides that the HMO must submit any other information relating to documentation of service area, facility and personnel availability and accessibility to allow a determination of compliance with part 4685.1000.

This provision which is in the existing rules is necessary because the Department cannot anticipate every contingency. There may situations where the commissioner needs additional information about the health care facility, personnel or service area in order to be satisfied that health care services in a proposed services area will be accessible to potential enrollees.

Subp. 10. Marked up copies.

This is a new subpart which requires the HMO to include a marked up copy of any form which amends a previously approved form. The marked up copy must have changes, additions or deletions noted. The marked up copy will facilitate the Department's review of the filing. For example, if a 30 page contract which was approved in a previous year is submitted with minor changes in the following year, a marked up copy will dramatically reduce the amount of time necessary for review. Without a marked up copy, staff will have to approach the entire 30 page filing as a new document. With a marked up copy, staff can generally look at the few changes.

It is reasonable to require marked up copies. Most of the HMOs make contract changes by editing, or marking up their previously approved contracts. In addition, almost all of the HMOs currently submit marked up copies voluntarily.

Subpart 11. Notice of participating entity changes

This is a new section which requires the HMOs to submit notice of participating entity changes on forms prescribed or approved by the commissioner. HMOs are currently required to inform the commissioner of any changes in participating entities, "including any change in address, any

modification of the duration of any contract or agreement, and any addition to the list of participating entities," Minnesota Statutes, section 62D.08, subdivision 5.

While the statute does not specifically require the HMO to submit information on the specialty or type of provider, Minnesota Statutes, section 62D.08 subdivision 1, requires the HMO to file notice with the commissioner prior to any change in information as the commissioner of health may reasonably require to be provided. Information pertaining to any change in providers including the provider's name, address, duration of contract, and specialty or type of provider, is necessary for the commissioner to monitor the availability and accessibility of the HMO's network of health care services.

Currently, the HMOs submit information relating to provider changes on forms of their own design. There is considerable variability in the manner in which the HMOs report such changes (please see appendix N which contains an example of various HMO provider forms). Note that none of the HMOs submit information relating to the specialty or type of provider. When the HMOs simply submit the name of a person or even the name of a health center, it is impossible to ascertain what type of health services are offered by the provider. For example, a provider's name cannot indicate whether the person is a general practitioner, an ophthalmologist, or an orthopedic surgeon. Similarly, a health center could be a general practice clinic or a specialty clinic, or a

surgicenter. Information about the type of provider is essential for the commissioner to be assured that a comprehensive system of health services are accessible to enrollees.

This reporting requirement is not unreasonable or unduly burdensome. Some HMOs already provide information on the type of provider. Uniform provider change forms will guarantee that the commissioner will get the same type and amount of information pertaining to provider changes from all of the HMOs. The uniform forms will also enable the department to keep uniform records on the HMO's providers.

Supplement to Statement of Need and Reasonableness

Coordination of Benefits

The National Association of Insurance Commissioners (NAIC) revised the model coordination of benefits (COB) regulation in 1989. The Department of Health (hereinafter, "Department") was not aware of these revisions when it originally published its proposed rules regarding COB. The Department proposes that these revisions be incorporated into the proposed rules relating to COB. A proposed amendment describing the exact nature of the revisions is attached as appendix A.

As stated in the Department's statement of need and reasonableness, a uniform and national approach to COB is necessary. The NAIC has developed and periodically modified the model COB regulation based upon the expertise and study of an NAIC task force which continually examines the issue of COB. It is reasonable and necessary to adopt the most recent version of the NAIC model COB rules.

These revisions do not constitute a substantial change to the proposed COB rules. Minnesota Rules Part 1400.1100 explain that a substantial change affects classes of people who could not have reasonably been expected to comment on the rules, or goes to a new subject matter of significant substantive effect, or makes a major substantive change that was not raised by the original notice, or results in a rule fundamentally different in effect from that contained in the notice of hearing.

These revisions do not make a substantive change to the rules, nor do they affect any new classes of people. The proposed COB rules allocate the responsibility to pay for a health care service between two plans covering the same service for one enrollee. Briefly, the proposed rules establish a method for determining which plan is primary and has the first responsibility to pay for health care services, and which plan is secondary and responsible for paying for remaining expenses not covered by the primary carrier up to the amount it would have paid had it been the primary carrier. The 1989 revisions to the COB rules simply amend one of the COB definitions and clarify procedures when parents are divorced. These changes are slight modifications to the rules as proposed and do not constitute a major change.

Essentially, the 1989 revisions to the model COB regulation modify the definition of an "allowable expense" to permit an allowable expense to be reduced if cost containment aspects of the health coverage are not followed. For example, if the benefit is reduced because an individual did not comply with second surgical opinion requirements, the amount of the reduction is not considered an allowable expense. In addition, the revisions clarify

procedures to be followed by two plans covering a dependent when the parents have joint custody of the dependent. A detailed explanation of the revisions follows.

4685.0910 Definitions

Subpart 2. Allowable Expense

The definition of allowable expense is revised to permit benefits under the primary plan to be reduced if a person does not comply with plan provisions relating to cost containment such as second surgical opinions or preferred provider arrangements. For example, a primary plan provides a benefit for 90 percent coverage of a health service from a preferred provider, and 80 percent coverage of a health service from other providers. An individual obtains services from a non-preferred provider and the total bill is $100. The allowable expense is $90 since the benefit may be reduced by 10 percent because the individual did not follow plan provisions. According to the proposed COB rules, the primary carrier would pay 80 percent of $90, the secondary carrier may pick up the remaining 20 percent of the $90, and the individual would pay the difference between the bill and the allowable expense, or $10.

If the individual in the preceding example went to a preferred provider, and the bill was $90, the allowable expense would be $90. In this situation, the primary carrier would pay 90 percent of $90, the secondary carrier may pick up the remaining 10 percent of $90, and the individual would have no out-of-pocket expense.

This reduction is reasonable because it is in line with one of the important purposes of COB, that is cost containment. Health plans that have provisions for preferred providers or second surgical opinions, do so to control health care costs. An individual who has coverage under two plans, may not have any incentive to follow the provisions of the primary plan because the secondary plan would be obligated to pay for the individual's out-of-pocket expenses if the total bill is considered an allowable expense. However, if the reduction for not following the primary plan's rules, is not considered an allowable expense, the individual will have an incentive to follow the plan provisions in order to escape any out-of-pocket expenses.

The 1989 revision also makes it clear that an HMO who is secondary cannot refuse to pay benefits to an HMO enrollee who obtains services from a nonparticipating provider. As explained on page 45 of the Department's statement of need and reasonableness, a secondary carrier may have to pay for

services it normally would not cover if it has been relieved of the responsibility of paying for some other services.

4685.0950 Text of Model Coordination of Benefits Provisions for Group Contracts

II. Definitions

The model contract provisions include simplified definitions of COB terms. The 1989 revision amends the definition of allowable expense to include reductions for noncompliance with plan provisions such as second surgical opinions, as discussed above.

III. Order of Benefit Determination Rules

This model contract provision repeats the procedure for COB. The 1989 revision includes a clarification that in cases where parents have joint custody of a child and neither parent is responsible for health care expenses, the primary plan will be determined according to the "birthday" rule. The birthday rule is explained on page 39 of the Department's statement of need and reasonableness. The plan who covers the parent whose birthday occurs earliest in a calendar year is determined to be primary.

The other changes described in the amendment are typographical errors