STATE OF MINNESOTA **BEFORE THE MINNESOTA**

COUNTY OF HENNEPIN **COMMISSIONER OF HEALTH**

IN THE MATTER OF PROPOSED AMENDMENTS TO RULES RELATING TO HEALTH MAINTENANCE ORGANIZATION FEES MINNESOTA RULES CHAPTER 4685

STATEMENT OF NEED AND REASONABLENESS

The Minnesota Commissioner of Health (hereinafter "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 fees.

STATUTORY AUTHORITY

The commissioner of health'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.29." Specific authority for prescribing the fees paid by HMO for filing documents is contained in Minnesota Statutes 62D.21 which provides that the

commissioner shall prescribe fees for other filings not specifically described in law. Further authority for prescribing the fees paid by HMOs is also vested in the commissioner through Minnesota Statutes 62D.211 which provides that the commissioner may adjust the renewal fee by rule. Finally, Minnesota Statutes, section 144.122, pertaining to the commissioner's license and permit fees states in part:

> "The state commissioner of health, by rule and regulation, may prescribe reasonable procedures and fees for filing with commissioner as prescribed by statute and for the issuance of original and renewal permits, licenses, registrations and certifications issued under its authority ... Fees proposed to be prescribed in the rules and regulations shall be first approved by the department of finance. All fees proposed to be prescribed in rules and regulation shall be reasonable. The fees shall be in an amount so that the total fees collected by the commissioner will, where practical, approximate the cost to the commissioner in administering the program."

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 rules do not apply to services regulated by government bodies for standards and costs, such as providers of medical care, (Minnesota Statues 14.115, subdivision 7, item 3.) HMOs are providers of medical care and are regulated by the Minnesota Department of Health for standards and costs. A "health maintenance organization" is defined in Minnesota Statutes, section 62D.02, subd. 4, as a non-profit corporation which provides or arranges the provision of health care services.

This exemption is consistent with the findings of the Administrative Law Judge when the commissioner proposed rules changing HMO fees in 1985 and 1988. The Report of the Administrative Law Judge, OAH Docket Nos 8-0900-247-1, HLTH-86-006-JL, and OAH Docket No. 8-0900-3156-1, found that the Department's proposed HMO rules were exempt from the small business consideration requirements in Minnesota Statutes, section 14.115.

COMMISSIONER OF FINANCE APPROVAL AND OTHER APPROVALS

Minnesota Statutes, section 16A.128, 144.122, and Minnesota Rules Part 1400.0500 require the approval of the commissioner of finance if the proposed rules modify a fee charged by an agency. The Minnesota Commissioner of Finance has reviewed the supporting information justifying the reasonableness of the proposed fee changes and approved the fees set forth in the proposed rules. A statement which is signed by the Director of Budget Operations, Department of Finance is attached as appendix A. The Sonar and Rules are also being sent for review to the Legislative Commission to Review Administrative Rules (LCRAR), the Chair of the House Appropriations Committee, and the Chair of the Senate Finance Committee.

GENERAL STATEMENT OF NEED AND REASONABLENESS

Health maintenance organizations (HMOs) are assessed various fees to pay for the cost of their regulation. Minn. Rules 4695.2800 requires HMOs to pay fees in various categories. All of the current fees have been evaluated and it has been found that

filings fees, and renewal fees are in need of amendment.

Filing fees are assessed to reflect the amount of staff time devoted to the review and analysis of filed documents. Filing fees generate revenues to support the staff time spent on such activities.

Renewal fees support non-revenue generating regulatory activities.

The HMO renewal fees are made up of a per HMO renewal fee, which is paid in the form of a yearly lump sum payment, and a separate per enrollee fee, based on the number of enrollees enrolled in the HMO at December 31 of the previous year. These fees pay for the costs associated with complaint investigations, public inquiries, policy analysis, rulewriting, legislative bill drafting, enforcement, administration, staff training, and other general operating costs.

Current revenues do not cover the costs of regulation. The HMO Section's projected costs for FY 1991 (July 1, 1990 - June 30, 1991) are $702,459.00. The anticipated revenues for FY 1991, assuming no change in fees, is $613,700.

Thus, the difference between the receipts for fiscal year 1991 and the operating costs for fiscal year 1991, assuming no change in fees, would result in a deficit of $88,759.

In addition, the HMO Section has already accumulated a deficit of $264,745 which must be recovered in a timely manner. (See appendix B for detail of revenues and expenses.)

The Department of Health has analyzed the section's financial situation and has made an initial decision to reduce administrative costs. The budget for supplies and

operating expenses for FY 1991 has been reduced approximately 35%. The reductions total $35,900 and include expenses encompassing printing costs, consultant services, professional services, data processing, purchased services, communications, travel, supplies, and equipment. The projected FY 1991 budgeted amount of $67,400 is $35,900 less than the original budgeted FY 1991 amount of $103,300. The reduction is intended to be permanent and thereby applicable in projections for fiscal years in the future.

The current deficit would have been much worse if the HMO section had fully filled all HMO staff positions in 1989 and 1990. In addition, as a means of federal and state cost-sharing, two FTE (full-time equivalent) HMO staff positions are paid for with federal funding. These positions share state regulatory functions with the federally-funded Medicaid administration. By utilizing federal funds to pay for these positions, the HMO Section is making more efficient use of its state funding and federal funds are also effectively used. Another staff position is partially funded by a combination of state HMO funds and the Medical Technology Assistance Review Panel (MedTARP), another state program, established under Minnesota Statute, section, 256.9691. State HMO funds pay for 0.75 FTE of the position and the State MedTARP appropriation pays for 0.25 FTE of the position. This staff member has had a partial reassignment of her HMO duties to the MedTARP duties. The reassignment of costs for this position has reduced HMO costs by about $6,000. The projected expenses for FY 1991 and future years is based upon the reduced operating costs.

Further cuts cannot be made to the HMO Section if the section is to perform all of the tasks delegated by the Legislature. The HMO section provides consumer protection to 1.2 million enrollees through the following activities:

- The financial audit function (3 state staff), monitors and enforces financial solvency and compliance with other financial requirements of 12 HMOs. The audits include both routine comprehensive examinations at least once every three years and special examinations whenever a plan of correction may be needed. Rehabilitation and liquidation are conducted if necessary.

- The quality assurance monitoring function, (1.5 state staff), reviews the effectiveness of HMO quality of care evaluation activities. This is done through quality of care examinations which monitor the HMO quality assurance program, arrangements for accessible and available services and the internal complaint handling system.

- The compliance investigation function, (2 state staff), receives and investigates written enrollee complaints about HMO operations yearly, and responds to all public inquiries about HMO operations. The number of written complaints the HMO section receives has climbed dramatically in recent years. In FY 1989 the number of written complaints the Section received was 724. However, in

FY 1990 that number has climbed to 1015. Department estimates show that the number of written complaints will rise to 1,351 in FY 1993.

- The compliance and enforcement function, (4 state staff), approves or disapproves approximately 500 amendments to certificates of authority (enrollee contracts, provider agreements, and operating procedures) submitted by HMOs. Enforcement activities include necessary legal action on cases involving potentially significant violations of the HMO Act. The policy development function analyzes HMO regulatory issues to promulgate necessary rules and disseminate important information related to HMO operations.

- The remaining 3.25 state staff positions (Section Director and 2.25 clerical), are devoted to management and administrative support.

The budget reductions described earlier (above), are not sufficient to balance the HMO section's budget. Given the projected budget for regulatory activities, it is necessary to increase filing fees and renewal fees or anticipated revenues will not meet projected expenses. According to Minnesota Statutes, section 16A.128, Fee Adjustment, the HMO section must collect fees in an appropriate amount to support the section's functions.

> "adjustments must be made so the total fees nearly equal the sum of the appropriation for accounts plus the agency's general support cost and statewide indirect costs attributable to the fee function."

This approach has been upheld by the Administrative Law Judge in the Department's previous rulemaking procedure. The ALJ stated that the Department is not required to demonstrate the need and reasonableness of its budget or the need and reasonableness of any legislative appropriation that has been made. The ALJ stated that an agency's projected costs are sufficient evidence to establish the need for and reasonableness of their recovery.

> "The Department is not required to demonstrate the need and reasonableness of its budget or the need and reasonableness of any legislative appropriation that has been made. Agency budgeting is not subject to the rulemaking requirements of the Administrative Procedure Act and those budgets, when approved, must be presumed to be necessary and reasonable. Consequently, when the agency's projected costs are known, sections 16A.128, subd. 1a. and 144.122(a) establish the need for and reasonableness of their recovery."

See, In the Matter of the Proposed Adoption of Rules of the State Health Department Governing Health Maintenance Organizations, Part 4685.2800, Docket No. 8-0900-3156-1, Report of the Administrative Law Judge Dated March 31, 1989.

After extensive analysis, the Department decided to increase the fee for filing quarterly financial reports from $50.00 to $100.00, and increase the fee for filing an amendment to a certificate of authority from $50.00 to $90.00. The proposed rules also raise the renewal fees for a certificate of authority from $10,000.00 to $16,000.00 and the per enrollee fee from $.35 to $.46. Detailed explanation of the need and reasonableness for each of these increased fees are in the part by part analysis which follows.

Part by Part Statement of Need and Reasonableness

4685.2800

Subpart 1. Filing Fees

Item C. Quarterly Financial Report Fee

The proposed rule requires HMOs to pay a $100 quarterly report filing fee. This is a $50 increase over the current filing fees. Filing fees are established to reflect the amount of staff time devoted to the filing. Under Minn. Stat. section 62D.08, subd. 6, which was enacted in 1988 and amended in 1990, HMOs must submit to the Commissioner unaudited financial statements on a quarterly basis. The reports are submitted for each quarter except the fourth quarter when the annual report generally replaces the need for a quarterly report.

The current rate of $50 does not adequately cover the cost of review, analysis, and processing. The proposed fee of $100 is a more accurate assessment of the cost of processing a quarterly report than is a $50 fee reflecting the time involved in the thorough analysis required and performed.

The staff activities associated with the filing of a quarterly financial report include conducting a completeness review, checking the validity and accuracy of the financial statements, entering the data from the reports into a computerized financial solvency model, producing a report with financial solvency aggregate measures to identify financially troubled HMOs, generating other summary reports, and filing the reports as

nonpublic documents.

Staff of the HMO section involved in the analysis of the quarterly financial report information include the Manager of Financial Compliance, a health services analyst, and a secretary. Based upon the Department's experience, approximately 4 1/2 hours of total staff time is utilized in handling each quarterly financial report.

The weighted average hourly rate plus fringe benefits for the staff conducting these functions is $18.52 per hour. Supplies and expenses add approximately 7.8% to staff costs and Department and statewide overhead expenses add approximately 15.6% to staff costs. Therefore, the total annual cost associated with the filing of the quarterly financial reports is $3702.60. (4 1/2 hours x $18.52/per hour = $83.35 plus 7.8 percent of 83.35, plus 15.6 percent of $83.35 = $102.85 x 36 reports =3702.60.) With 12 HMOs (see appendix C), and 36 quarterly reports, the fee would be $102.85 per HMO ($3702.60/36 = $102.85). (see appendix D)

The proposed fee of $100 is reasonable because the proposed fee is based on the amount of staff time utilized to prepare the quarterly financial report multiplied by a weighted average hourly rate. This fee approximates the costs associated with processing and reviewing each quarterly financial report.

Item D. **Amendments To Certificate of Authority Fee**

Under this item, HMOs will be required to pay a $90 filing fee for amendments to a certificate of authority, including the filings required under Minnesota Statutes, section 62D.08, subdivision 1. Examples of filings include articles of incorporation, bylaws, provider contracts, evidences of coverage, master group contract, individual contracts, dental contracts, management contracts,guaranteeing organization contracts, internal complaint procedures, internal prior authorization administrative procedures, and amendments. This is a $40 increase over the current filing fees of $50. Filing fees are established to reflect the amount of staff time devoted to the filing. The fee for an amendment to a certificate of authority was originally $25, set in 1973. The fee was raised in rulemaking in 1986 to $50. A fee of $90 is a more accurate assessment of the cost of reviewing, analyzing, and making the decision on an amendment to a certificate of authority than is a $50 fee.

The staff activities associated with the filing of an amendment to a certificate of authority include the logging in of the amendments on the computer, review of documents, associated legal and policy research, preparation of approval or denial letter, filing and recordkeeping. The proposed fee allows for the fact that the complexity of amendments submitted is wide and varied. Some amendments are reviewable within a 1/2 hour, while others require large amounts of staff hours. For example, if an amendment concerns an issue of first impression staff meetings may be

held to determine the Department position. Some amendments are only resolved after numerous telephone calls between the Department and the HMO and a number of meetings both internally and externally. Analysis of filings have resulted in a denial of 25% of filings. These denials in turn, result in more staff time being devoted to amendments. The Department does not charge an additional filing fee for the subsequent review of denials if refiled within 30 days.

The staff involved in the review of amendments to the certificate of authority include the HMO Section Director, the Manager of Regulatory Compliance, a health services analyst and a secretary.

The HMO Section Director devotes 5% of his time to the review of amendments to the certificate of authority, the Manager of Regulatory Compliance devotes 20 % of her time to the review of amendments to the certificate of authority. The health services analyst devotes 60% of her time to the review of amendments and the secretary devotes 5% of her time to the review of amendments. The proposed fee is based upon the annual salaries of the above HMO staff who work on the review of amendments to the certificate of authority, the percentage of the time each staff member devotes to such review, and the total number of amendments filed with the HMO Section per year (490 contracts in 1990). An analysis of these figures shows that the reasonable cost for the analysis of the amendments is $90.00. (see appendix E)

As with quarterly financial reports, the proposed fee is reasonable because it approximates the costs associated with the processing and reviewing of each amendment to the certificate of authority.

Subpart 2. Renewal Fee.

The proposed increase in the filing fees will result in an additional $4,780, for the portion of FY 1991 in which we project the fees will be charged. However, these increases alone will not cover increasing regulatory costs. The proposed increases in the renewal fees, from $10,000 to $16,000 for a renewal of certificate of authority fee and from 35 cents to 46 cents for the per enrollee renewal fee will increase the anticipated revenue sufficiently to meet projected expenses for FY 1991, including the accumulated deficit.

(Please see appendix F, a chart which shows the projected budget for fiscal year 1991, 1992, and 1993 and the anticipated revenues assuming the existing fee structure and the proposed fee structure.)

The following is the HMO Section's projected budget and anticipated revenue figures for FY 1991 without the proposed fees in place.

The projected budget for fiscal year 1991 includes the following expenses:

- $522,887 for salaries including fringe benefits
- $67,400 for supplies/expenses

- $21,959 for attorney general costs

- $90,213 for indirect costs (Department and Statewide)

The total operating costs for fiscal year 1991 equals $702,459. The accumulated deficit of $264,747 is to be retired over 3 fiscal years, $88,707 each year. Deficit retirement over only one year would have resulted in a much higher fee in 1991 and reductions for 1992 and 1993. HMOs can reasonably make the payment over three years instead of spreading the repayment over more years. In addition, extending the deficit over a a period of more than 3 years will not reduce the fee significantly.With the addition of the $88,707 for deficit repayment, the total costs for FY 1991 to be recovered will be $790,707.

As shown in Appendix F, the total anticipated revenues for fiscal year 1991, assuming no change in fees, is $613,700. Thus, the difference between the total receipts for fiscal year 1991 and the operating costs without deficit repayment for fiscal year 1991, assuming no change in fees, would result in a deficit of $88,759.

The method by which the Department determines fees is set by Minnesota Statutes, section 144.122 which states that the commissioner of health, may, by rule or regulation, prescribe reasonable procedures and fees for filing with the commissioner as prescribed by statute and for the issuance of original and renewal permits, licenses, registrations and certifications issued under its authority.

> "Fees proposed to be prescribed in the rules and regulations shall be first approved by the department of finance. All fees

> proposed to be prescribed in rules and regulation shall be reasonable. The fees shall be in an amount so that the total fees collected by the commissioner will, where practical, approximate the cost to the commissioner in administering the program."

Thus, the fees charged must recover the estimated costs of that function where possible. Fees are charged for specific functions such as annual reports, quarterly reports, examination fees, and amendments to the certificate of authority. However, the HMO section cannot recover the cost of rule-making, policy analysis, complaint investigation, administration and other general operating costs from a specific fee. The law permits a renewal fee for recovery of such costs.

Prior to 1987, the only fees charged to the HMOs were filing fees and examination fees. The HMO section received any additional revenues from the State General Fund. In 1986, the Department increased filing fees through rulemaking. The Department also attempted to create an annual report fee based on the number of enrollees enrolled in an HMO. However, this approach was rejected by the ALJ who concluded that the Department lacked statutory authority to adopt a per enrollee fee. In 1987, the Minnesota Legislature enacted Minnesota Statutes, section 62D.211. This statute provides that each HMO shall,

> "submit to the commissioner each before June 15 a certificate of authority renewal fee in the amount of $10,000 each plus 20 cents per person enrolled in the HMO on December 31 of the preceding year. The commissioner may adjust the renewal fee in rule under the provisions of Chapter 14."

Minnesota Rules, section 4685.2800 was amended in 1989 increasing the per enrollee

fee to 35 cents per person enrolled. The $10,000 per HMO fee for a certificate of authority remained unchanged. The proposed rules increase the per HMO renewal fee for each HMO from $10,000 to $16,000 and the fee charged per enrollee from 35 cents to 46 cents.

With this proposed rule, the Department is attempting to maintain the same proportions between the per HMO renewal fee and the per enrollee fees as are in the current rule. There are certain expenses associated with the per HMO renewal fee that are indicative of each HMO no matter the size of the HMO. A description of activities those fees cover is contained in the General Statement of Need and Reasonableness. In addition, the Department finds that more work is generated from HMOs with larger enrollment. In 1987, the Legislature recognized this fact and gave the Department the authority to assess fees based upon a per enrollee methodology.

The proportion of the per HMO fee in FY 1990 was 24.5% of the total revenue and per enrollee fee was 67.3% of the total revenue. The other 8.2% of total revenue is raised through various filing charges. (Please see exhibit G for a listing of those filing charges.) Thus, in order to maintain the same proportions, the per enrollee fee will be about $16,000.00. In order to maintain the 67.3% proportion in HMO enrollment fees, the cost to the HMO will be 46 cents per enrollee, based on 1.15 million enrollees. (see appendix G).

It is reasonable to divide the proposed fee increase between a certificate of authority renewal fee and a per enrollee fee. By enactment of Minn. Stat. Section 62D.211, the Legislature mandated that a per-enrollee methodology can be used in setting renewal fees, that the bulk of the expenses attributable to the regulation of HMOs must be recovered through a certificate of authority renewal fee, and that the renewal fee must be adjusted, when necessary, by the Commissioner.

See, In the Matter of the Proposed Adoption of Rules of the State Health Department Governing Health Maintenance Organizations, Part 4685.2800, Docket No. 8-0900-3156-1, Report of the Administrative Law Judge dated March 31, 1989.

The proposed fee increase is also reasonable in that it will only have a minuscule impact on the HMOs' overall expenses. Neither the HMOs nor the HMO consumers of Minnesota will be adversely impacted by this proposed fee increase. An illustration of the impact of the proposed fee increase on HMO total expenses is attached as appendix H.

As stated previously, Minnesota Statutes, section 16A.128, directs the HMO section to collect fees in an amount to support the section's functions. This position was supported by Administrative Law Judge, Jon L. Lunde, who stated that an agency's projected costs are sufficient evidence to establish the need for and reasonableness of their recovery. See, In the Matter of the Proposed Adoption of Rules of the State Health Department Governing Health Maintenance Organizations, Part 4685.2800,

Docket No. 8-0900-3156-1, Report of the Administrative Law Judge Dated March 31, 1989.

There are two major reasons for the accumulated deficit amount of $264,745. First, the 1989 deficit was primarily due to the delay in promulgating a fee increase from $0.20 to $0.35 per enrollee. The Department proposed the rule in November 1988 and held a hearing in late December of that year. There were extensive challenges to the fees and while the Department was eventually successful, the rule was promulgated too late to apply to the 1989 renewal fee. HMO Section expenses in FY 1989 were $588,594 and only $387,526 in revenues were collected. Failure to collect the increase in FY 1989 contributed $201,068 to the accumulated deficit.

The second reason for the deficit is that HMO enrollment and number of HMOs has declined during the past 3 years rather than increasing as projected. There was a particularly large decline in FY 1989. Since renewal fees are based on the number of HMOs and number of HMO enrollees, the amount the Department is able to collect in revenues with the existing formula has decreased. Further exacerbating the situation is the fact that the number of HMOs has declined, based on HMO licenses held, and the number of total enrollees appears to be stable. In FY 1989, 14 HMOs paid a renewal fee of $10,000 to the Department. In FY 1990, only 12 HMOs will pay the renewal fee, thus, the Department will lose $20,000 in renewal fees.