# STATE OF MINNESOTA
# DEPARTMENT OF HEALTH

**In The Matter Of The Proposed Rule Amendments Of The Department Of Health Governing Aggregate Data From Group Purchasers - Chapter 4652**

**STATEMENT OF NEED AND REASONABLENESS**

## General Statement Of Need And Reasonableness

The purpose of this rulemaking is to amend rules that set out reporting requirements for group purchaser financial and statistical data. The rules state who is required to report the data and list the data elements which must be annually reported. The rules specifically define the data elements to ensure that uniform and accurate data are reported. The rules also include provisions for reporting dates, extensions, and review of reports.

The rules were first adopted as emergency (temporary) rules, governing the 1994 collection of 1993 data. The rules were then adopted as permanent rules in late 1994. Under the permanent rules, the Department has collected one year's worth of data, namely, the 1995 collection of 1994 data. The Department has learned a great deal from the 1994 data and from the comments made to us by the persons and organizations who provided the data. These rules are being amended to respond to the suggestions received and the problems identified during the collection of 1994 data. No major problems were identified and no major policy suggestions were received. The problems and suggestions all centered on refining data categories and defining or clarifying definitions of terms used in the rules. This rulemaking addresses these problems and suggestions.

Legislative History - Health Care Reform - MinnesotaCare Act - Data Collection Objectives

Minnesota's health care reform initiative encompasses a wide range of activities. The primary goal is to provide universal coverage for health care while maintaining the quality of the care and reducing the rate of growth in current health care expenditures. Cost containment was clearly a central part of the 1992 HealthRight Act and is the vehicle to achieve savings that could be used to expand coverage to the currently uninsured. The 1992 legislation provided a framework for the overall approach to cost containment; the rate of growth in health care spending must be reduced by 10 percent each year beginning in 1993 and the Commissioner of Health was required to establish enforceable statewide and regional limits on the rate of growth of health care spending for Minnesota residents. The 1992 legislation established a 25-member commission (The Minnesota Health Care Commission) of providers, payers, and consumers to develop a cost containment strategy and report back to the Legislature in 1993. The Minnesota Health Care Commission met bimonthly for a period of six months to develop and report its cost containment strategy to the Legislature. The Commission's basic proposal, with some modification of the details, was passed by the Legislature as part of the 1993 health reform legislation. The Legislature has amended this health reform legislation in 1994 and 1995.

The framework underlying the strategy of cost containment chosen by the state of Minnesota requires that one be able to quantify state health care expenditures and monitor the expenditures and their trends over time. There is currently limited data available on health care spending at the state level. The federal Health Care Financing Administration (HCFA) infrequently publishes estimates on health care spending by state; once in 1982 and just recently in 1993. However, the method used by HCFA actuaries does not provide the detailed information needed to effectively establish information on health care spending and trend at the state level. In addition, much of the work done in estimating state-level spending is developed by manually pulling together a diverse set of information from various data sources and this time-consuming compilation of disparate data sources must be re-enacted every year to keep the numbers up to date.

Minnesota's objective was to develop its own method and state infrastructure for collecting information on health care spending for the purposes of quantifying and monitoring health care expenditures over time. State-level data would be more accurate and more timely. In addition the data could be used to inform policy makers on the impact of health care reform and to document the state's progress toward meeting statewide cost containment goals.

The Health Care Commission recommended using a two stage strategy for data collection that included: (1) a short-term initiative to provide immediate information from payers on a significant, but not complete, picture of health care spending to be used to establish a growth trend for 1991; and (2) a more comprehensive data collection plan to provide more detailed data based on aggregate surveys of providers and payers and encounter-level data that can be used to monitor spending and growth patterns over time. The framework for defining the elements to include in health care spending is based on the framework used by HCFA National Health Expenditure accounts to estimate national expenditures.

The short-term data collection strategy used to establish the 1991 baseline of health care expenditures clearly did not capture all health care expenditures of interest. The data do not represent all payers nor all types of health care expenditures. Other expenditures of interest that were not reviewed as part of the short-term strategy include out-of-pocket expenditures, charity care and bad debt, technology, research and education, and capital expenses. Several provider groups felt strongly that by relying on payer-level data to set expenditure limits, the Department would miss several important components, namely bad debt, charity care, and out-of-pocket costs. In response, a physician-clinic survey was developed to supplement hospital financial information as part of the long-term data collection strategy.

The goal of the long-term data collection strategy was to collect aggregate data on health care revenues and expenditures by payer type and service category for all public and private payers. The state has several data sources that, while not all-inclusive, are helpful in building the process for data collection for other payers and providers. Minnesota has long-standing data collection requirements for aggregate financial data from hospitals and HMOs and detailed information on state public programs. The largest gaps include the lack of information on services by physicians and other providers.

The data collection strategy involves collecting: 1) aggregate data on health care revenues and expenditures by payer type and service category for both public and private programs, and

2) disaggregated claims paid and encounter level data provided by payers. This data will be used to track total health care expenditures and revenues in the State of Minnesota. Attention will be given to the data collection and aggregation process to avoid any double counting. The two levels of data will be used to document revenues and expenditures and to cross check the data provided through each method. More detailed information will be needed for both the provider and payer groups including but not limited to the identification of Minnesota and non-Minnesota residents and the county of residence to be able to establish statewide cost containment goals.

Aggregate data from HMOs (and eventually ISNs) and hospitals will be based on modified versions of existing annual financial reporting forms. New surveys were developed for the 1995 collection of 1994 data from commercial insurers, Blue Cross/Blue Shield, self-insured plans, and physician clinics. These surveys will be revised pursuant to this rulemaking.

In order to estimate and monitor health care spending in the State of Minnesota, more precise state-level data is needed. A primary objective has been to collect uniform and consistent state-level data in a routine and efficient manner on an ongoing basis. The Health Care Commission's report to the Legislature outlined the key assumptions for data collection. These include the following: 1) Health care revenue and spending data will be routinely collected from both payers and providers of health care services. 2) Data will be collected annually based on consistent guidelines and data definitions. 3) The data set will include as a base, expenditures and revenues for health care services contained in the set of basic benefits generally included in health coverage programs. 4) The expenditure data base will be limited in the initial years but will evolve as additional sources of data are developed and submitted. 5) Data definitions and data collection techniques will be refined over time to ensure the collection of uniform and accurate data on health care spending and to assess the balance between the need for accurate data and the costs associated with collecting the data.

Statutory Sections Requiring Group Purchasers To Submit Data

The term "group purchaser" is defined in section 62J.03, as follows:

> "Subd. 6. **Group purchaser.** "Group purchaser" means a person or organization that purchases health care services on behalf of an identified group of persons, regardless of whether the cost of coverage or services is paid for by the purchaser or by the persons receiving coverage or services, as further defined in rules adopted by the commissioner. "Group purchaser" includes, but is not limited to, integrated service networks; community integrated service networks; health insurance companies, health maintenance organizations, nonprofit health service plan corporations, and other health plan companies; employee health plans offered by self-insured employers; trusts established in a collective bargaining agreement under the federal Labor-Management Relations Act of 1947, United States Code, title 29, section 141, et seq.; the Minnesota comprehensive health association; group health coverage offered by fraternal organizations, professional associations, or other organizations; state and federal health care programs; state and local public employee health plans; workers' compensation plans; and the medical component of automobile insurance coverage."

Group purchasers are required to collect and provide financial and statistical data to the Commissioner by Minnesota Statutes, section 62J.38, paragraphs (a) and (b), which state:

> **"62J.38 COST CONTAINMENT DATA FROM GROUP PURCHASERS.**
>
> (a) The commissioner shall require group purchasers to submit detailed data on total health care spending for each calendar year. Group purchasers shall submit data for the 1993 calendar year by April 1, 1994, and each April 1 thereafter shall submit data for the preceding calendar year.
>
> (b) The commissioner shall require each group purchaser to submit data on revenue, expenses, and member months, as applicable. Revenue data must distinguish between premium revenue and revenue from other sources and must also include information on the amount of revenue in reserves and changes in reserves. Expenditure data, including raw data from claims, may be provided separately for the following categories or for other categories required by the commissioner: physician services, dental services, other professional services, inpatient hospital services, outpatient hospital services, emergency, pharmacy services and other nondurable medical goods, mental health, and chemical dependency services, other expenditures, subscriber liability, and administrative costs. The commissioner may require each group purchaser to submit any other data, including data in unaggregated form, for the purposes of developing spending estimates, setting spending limits, and monitoring actual spending and costs." (Includes updates from the 1995 MinnesotaCare Act, Minnesota Laws 1995, chapter 234, article 5, section 11.)

Additional statutory authority for requiring group purchasers to collect and provide financial and statistical data to the Commissioner is found in Minnesota Statutes, section 62J.041, subdivisions 3 and 4, paragraph (a), which state:

> **"62J.041 INTERIM HEALTH PLAN COMPANY EXPENDITURE LIMITS.**
>
> Subd. 3. **Determination of expenditures.** Health plan companies shall submit to the commissioner of health, by April 1, 1994, for calendar year 1993; April 1, 1995, for calendar year 1994; April 1, 1996, for calendar year 1995; April 1, 1997, for calendar year 1996; and April 1, 1998, for calendar year 1997 all information the commissioner determines to be necessary to implement and enforce this section. The information must be submitted in the form specified by the commissioner. The information must include, but is not limited to, expenditures per member per month or cost per employee per month, and detailed information on revenues and reserves. The commissioner, to the extent possible, shall coordinate the submittal of the information required under this section with the submittal of the financial data required under chapter 62J, to minimize the administrative burden on health plan companies. The commissioner may adjust final expenditure figures for demographic changes, risk selection, changes in basic benefits, and legislative initiatives that materially change health care costs . . . .

Subd. 4. **Monitoring of reserves.** (a) The commissioners of health and commerce shall monitor health plan company reserves and net worth as established under chapters 60A, 62C, 62D, 62H, and 64B, with respect to the health plan companies that each commissioner respectively regulates to ensure that savings resulting from the establishment of expenditure limits are passed on to consumers in the form of lower premium rates." (Note: this statutory section had been section 62P.04 and was recoded as section 62J.041 by the 1995 MinnesotaCare Act, Minnesota Laws 1995, chapter 234, article 3, section 9. The 1995 MinnesotaCare Act made no changes in the language of these subdivisions.)

Other Statutory Sections Relating To The Collection Of Data From Group Purchasers

Under Minnesota Statutes, section 62J.04, subdivision 1a, paragraph (a), the Commissioner of Health is required to "report to the legislature by February 15 of each year on the implementation of the growth limits. This annual report shall describe the differences between the projected increase in health care expenditures, the actual expenditures based on data collected, and the impact and validity of growth limits within the overall health care reform strategy." (Includes updates from the 1995 MinnesotaCare Act, Minnesota Laws 1995, chapter 234, article 3, section 2.) To do the report required under this section, it is necessary for the Commissioner to collect data from group purchasers on actual expenditures.

Minnesota Statutes, sections 62J.301 and 62J.311, give the Commissioner directives regarding the collection and analysis of data from group purchasers. Sections 62J.301 and 62J.311 state in pertinent part:

**"62J.301 RESEARCH AND DATA INITIATIVES.**

. . . .

Subd. 3. **General duties.** The commissioner shall:

(1) collect and maintain data which enable population-based monitoring and trending of the access, utilization, quality, and cost of health care services within Minnesota;

(2) collect and maintain data for the purpose of estimating total Minnesota health care expenditures and trends;

(3) collect and maintain data for the purposes of setting limits under section 62J.04, and measuring growth limit compliance;

. . . .

(5) develop and implement data collection procedures to ensure a high level of cooperation from health care providers and health plan companies, as defined in section 62Q.01, subdivision 4;

(6) work closely with health plan companies and health care providers to promote improvements in health care efficiency and effectiveness; and

. . . .

**62J.311 ANALYSIS AND USE OF DATA.**

Subdivision 1. **Data analysis.** The commissioner shall analyze the data collected to:

(1) assist the state in developing and refining its health policy in the areas of access, utilization, quality, and cost;

(2) assist the state in promoting efficiency and effectiveness in the financing and delivery of health services;

(3) monitor and track accessibility, utilization, quality, and cost of health care services within the state;

(4) evaluate the impact of health care reform activities;

. . . .

(6) evaluate and determine the most appropriate methods for ongoing data collection.

Subd. 2. **Criteria for data and research initiatives.** (a) Data and research initiatives by the commissioner, pursuant to sections 62J.301 to 62J.42, must:

. . . .

(5) be structured to minimize the administrative burden on health plan companies, health care providers, and the health care delivery system, and minimize any privacy impact on individuals; and

. . . ."

(Sections 62J.301 and 62J.311 were first enacted in the 1995 MinnesotaCare Act, Minnesota Laws 1995, chapter 234, article 5, sections 6 and 7.)

Statutory Section Governing Privacy Of Data Collected From Group Purchasers

Minnesota Statutes, section 62J.321, subdivision 5, paragraph (a), governs the classification of data collected from group purchasers. It states:

"Subd. 5. **Data classification.** (a) Data collected to fulfill the data and research initiatives authorized by sections 62J.301 to 62J.42 that identify individual patients or providers are private data on individuals. Data not on individuals are nonpublic data. The commissioner shall establish procedures and safeguards to ensure that data released by the commissioner is in a form that does not identify specific patients, providers, employers, individual or group purchasers, or other specific individuals and organizations, except with the permission of the affected individual or organization, or as permitted elsewhere in this chapter." (Section 62J.321 was first enacted in the 1995 MinnesotaCare Act, Minnesota Laws 1995, chapter 234, article 5, section 8. Data classification provisions were formerly in section 62J.35, subdivision 3, which was repealed by Minnesota Laws 1995, chapter 234, article 5, section 24.)

Uses For Group Purchaser Data

The group purchaser data collected pursuant to these rules will assist analysts with public policy decisions and also will assist group purchasers in comparing their expenditures to aggregated data from all group purchasers. Ultimately the data collection should provide the information needed to monitor cost savings in the health care system. The financial and statistical data collected by the Department will serve the following purposes:

1) The aggregate group purchaser data is being used to form a total picture of the baseline levels of health care expenditures and will be used to monitor trends in how expenditures are changing over time.

Currently there are only rough estimates on all aspects of health care expenditures. Analysts are unable to quantify billing and collection costs, out-of-pocket costs, research and education costs, and other cost categories. Policy makers need accurate numbers to develop a total picture of health care spending as a basis to make informed public policy decisions. Once a complete picture of health care spending is developed, trends in spending can be monitored over time.

2) The aggregate group purchaser data will be used to monitor and enforce compliance with statutory growth limits. The data will also be used to help refine growth limit methodology and enforcement policy.

The Commissioner is directed by Minnesota Statutes, section 62J.041, subdivision 3, to monitor and enforce compliance with growth limits. The Commissioner is specifically directed to coordinate the collection of data for this purpose with the collection of data under other portions of Minnesota Statutes, chapter 62J. The data used for this purpose would include expenditures per member per month or cost per employee per month, and detailed information on revenues and reserves. The experience gained by the Department in monitoring and enforcing compliance with growth limits will be valuable in refining growth limit methodology and enforcement policy.

3) The aggregate group purchaser data will be used to study the impact of health care reform and to evaluate the success of reform in controlling health care spending. The data will also be used by policy makers to set the future direction of health care reform.

What effect will MinnesotaCare reforms have on expenditures? Which costs are increasing or decreasing or remaining the same? Researchers will use the information to monitor the trends in health care expenditures and evaluate the impact of health care reform on health care costs as reported in the survey. The data will also be monitored to identify areas where health care spending is of particular interest.

4) The aggregate group purchaser data will be used to monitor revenues and reserves and consumer cost sharing to ensure that savings resulting from growth limits are passed on to consumers in the form of lower premiums.

The Commissioner.is directed by Minnesota Statutes, section 62J.041, subdivision 4, to ensure that health plan companies' savings achieved due to complying with the state mandated growth limits are passed on to consumers in the form of lower premium rates. The data provided on trends in consumer cost-sharing including copayments and deductibles will also be monitored to ensure savings are passed on to consumers and that limits aren't met by shifting costs to consumers.

5) The aggregate group purchaser data will be used to measure and track spending associated with major administrative functions.

Minnesota Laws 1993, chapter 345, article 3, section 17, mandated that the Department "study costs and requirements incurred by health carriers, group purchasers, and health care providers that are related to the collection and submission of information to the state and federal government, insurers, and other third parties." The Department was also required to "evaluate and make recommendations related to cost-savings and efficiencies that may be achieved through streamlining and consolidating health care administrative, payment, and data collection systems." The Data Collection Advisory Committee which met during 1992-93 studied these issues and recommended that administrative costs data be collected in functional categories. Aggregate administrative costs data will be collected from group purchasers by functional areas where administrative dollars are spent. This will help identify areas where expenses are increasing or decreasing, and where opportunities exist for administrative savings.

6) The aggregate group purchaser data can be used in certain ways by group purchasers to enhance their business and the industry.

Note first that an individual group purchaser's data is considered private data and will not be available to other group purchasers or the public, except when aggregated with other group purchaser data. Individual group purchasers can use their own data to track their own costs over time. An individual group purchaser can also compare its own costs to aggregate costs for all group purchasers, and after taking into consideration its own unique characteristics, the group purchaser can identify areas where opportunities exist for savings. Group purchasers might even use the aggregate group purchaser data to identify areas where they might advocate for improvements to the health care system.

## Statutory Rulemaking Authority

The Commissioner's statutory authority for amending these rules is found in Minnesota Statutes, section 62J.321, subdivision 6, which states: "The commissioner may adopt rules to implement sections 62J.301 to 62J.452."

These rules were originally adopted under the authority of Minnesota Statutes, section 62J.35, which was repealed in the 1995 MinnesotaCare Act (Minnesota Laws 1995, section 234, article 5, section 24). Section 62J.321 was enacted in the 1995 MinnesotaCare Act to replace section 62J.35. As a transition from the former to the present statutory rulemaking authority, the 1995 MinnesotaCare Act contained the provision: "Notwithstanding Minnesota Statutes, section 14.05, subdivision 1, Minnesota Rules, chapters 4650, 4651, and 4652, shall continue in effect under the authority granted in Minnesota Statutes, section 62J.321, subdivision 6." (Minnesota Laws 1995, section 234, article 5, section 22).

## Solicitation Of Outside Opinions; Input Into The Rule Amendments

On May 15, 1995, the Department published in the State Register a Notice Of Solicitation Of Outside Information Or Opinions notifying the public of the Department's plans to amend these rules. On July 31, 1995, the Department published an Amended Solicitation to comply with new Solicitation requirements as set out in Minnesota Statutes, section 14.101. The Solicitations invited all interested persons to contact the Department. The Solicitation was also mailed to persons on the Department's rulemaking mailing list, to persons who had commented when these rules were adopted as emergency rules and as permanent rules, and to other persons identified by the Department as likely to be interested in the permanent rules.

As stated in the May 15, 1995, Solicitation, the Department formed a work group to advise on the development of amendments to these rules. The Department was able to accommodate all persons who wanted to participate on the work group. The first work group meeting was June 5. The work group met five times from June through August 1995. At the last work group meeting, work group members expressed satisfaction with the process and with their ability to give input to the Department.

Persons who participated in one or more group purchaser work group meetings were:

Roger Banks, Minneapolis Urban League
Sharon Berens, PreferredOne
Lynn A. Blewett, Minnesota Department of Health
Kevin Brandt, HealthPartners
Jennifer Breitinger, JWB Associates
Vicky Donaldson, Minnesota Department of Health
Dave Dziuk, HealthPartners
Mona Freeberg, Medica/Allina
Virginia Greenman, Consumer Member of MHCC
Michelle Hegarty, Medica/Allina Health Systems
Brenda Holden, Minnesota Department of Health
Michele Hostager, Prudential
Kathleen Kuha, Minnesota Department of Health
Mylene Landry, Minnesota Department of Health
Sally Mangina, State Farm Insurance
Mark Matthias, Mayo Health Plan
Gunnar Nelson, PreferedOne
Dave Orren, Minnesota Department of Health
Kathi Roelke, Minnesota Department of Health
Dan Rydel, Blue Cross and Blue Shield of Minnesota
Lisa Schoen, UCare Minnesota
Ann Marie Seward, Metropolitan Health Plan
Debra Stenseth, MN Department of Human Services
Alice Swan, College of St. Catherine
Beverly Turner, Insurance Federation of Minnesota
JoMarie Williamson, Prudential

## Small Business Considerations

Minnesota Statutes, section 14.115, requires the Department of Health to consider the effect on small businesses when it adopts rules. For purposes of this section, "small business" means a business entity, including farming and other agricultural operations and its affiliates, that (a) is independently owned and operated; (b) is not dominant in its field; and (c) employs fewer than 50 full-time employees or has gross annual sales of less than $4,000,000. For purposes of a specific rule, an agency may define small business to include more employees if necessary to adapt the rule to the needs and problems of small businesses.

The rules will have a direct effect on small businesses that meet the definition of group purchaser in part 4652.0100, subpart 12. These businesses are engaged in purchasing health care services on behalf of an identified group of persons. A list of the specific types of organizations that fit this definition is given in subpart 12.

Section 14.115, subdivision 2, states in part:

"When an agency proposes a new rule, or an amendment to an existing rule, which may affect small businesses ..., the agency shall consider each of the following methods for reducing the impact of the rule on small businesses:

(a) the establishment of less stringent compliance or reporting requirements for small businesses;

(b) the establishment of less stringent schedules or deadlines for compliance or reporting requirements for small businesses;

(c) the consolidation or simplification of compliance or reporting requirements for small businesses;

(d) the establishment of performance standards for small businesses to replace design or operational standards required in the rule; and

(e) the exemption of small businesses from any or all requirements of the rule."

Specific methods for reducing the impact of the rule amendments on small businesses have been considered. In general, the rules are drafted to impose as small a burden as possible on all businesses, including small businesses. The impact of the rules on small businesses has been reduced as follows:

a. Less stringent requirements. The work group process was designed to get input from the health care industry in an effort to make these rules more workable for the industry and to get the data needed by the Department without undue burden.

b. Less stringent schedules. The schedules for compliance with the rules were not amended at this time. However, it should be noted that the rules already include extensions of the filing deadline for reasonable cause. Also, the rules include the ability to correct a submission found to be incomplete, without this affecting the original filing date.

c. Consolidation or simplification of requirements. The work group process achieved significant clarification of definitions. This will simplify the process of completing the survey.

d. Performance standards. This is not applicable because there are no design or operational standards.

e. Exemption. The rule amendments do not exempt any group purchasers from compliance. However, it should be noted that the rules already contain a partial exemption for group purchasers with only a small amount of health care business in Minnesota. These group purchasers are exempted from completing the full survey. Instead, they just have to submit basic information on their Minnesota business.

## Departmental Charges Imposed By The Rules

Minnesota Statutes, section 16A.1285, does not apply because the rules do not establish or adjust charges for goods and services, licenses, or regulation.

## Fiscal Impact On Local Public Bodies

Minnesota Statutes, section 14.11, subdivision 1, does not apply because adoption of these rules will not result in additional spending by local public bodies in excess of $100,000 per year for the first two years following adoption of the rules.

## Agricultural Land Impact

Minnesota Statutes, section 14.11, subdivision 2, does not apply because adoption of these rules will not have an impact on agricultural land.

## Other Specific Statutory Requirements

Minnesota Statutes, section 62J.07, subdivision 3, requires the Commissioners of Health, Commerce, and Human Services to provide periodic reports to the Legislative Commission on Health Care Access on the progress of rulemaking that is authorized or required under the MinnesotaCare Law and to notify members of the Commission when a draft of proposed rules has been completed and scheduled for publication in the State Register. This will be done concurrently with submitting the rules and the Notice of Intent to Adopt to the State Register for publication.

## Other Statutory Requirements

Minnesota Statutes, sections 115.43, subdivision 1, and 116.07, subdivision 6, regarding pollution control and Minnesota Statutes, section 144A.29, subdivision 4, regarding nursing homes are not applicable to these rules.

## Witnesses

If these rules go to a public hearing, the witnesses listed below may testify on behalf of the Department in support of the need for and reasonableness of the rules. The witnesses will be available to answer questions about the development and the content of the rules.

- Barbara Nerness, Assistant Commissioner of Health.
- Dave Giese, Acting Director, Health Policy and Systems Compliance Division, Minnesota Department of Health.

- Lynn Blewett, Director, Health Economics Program, Health Policy and Systems Compliance Division, Minnesota Department of Health.
- Brenda Holden, Research Analysis Specialist, Health Policy and Systems Compliance Division, Minnesota Department of Health.
- Dave Orren, Rule Writer, Health Policy and Systems Compliance Division, Minnesota Department of Health.
- Any other employee of the Minnesota Department of Health.

## Rule-By-Rule Analysis

### 4652.0100 DEFINITIONS.

**Subpart 1a. Administrative services fee revenue.** The category "administrative service fee revenue" was reported last year, but there was no definition in the rules. In the collection of the data, we found that there were some inconsistencies in reporting, so it was necessary to define this term. Our general understanding of this term was that it was revenue related to administrative services contracts. With discussions and the advice of the work group, the term was defined so that it would be clearly understood and consistently applied by group purchasers.

**Subparts 4 and 19. Chemical dependency services expenses and mental health services expenses.** A question was raised late in the process during last year's rulemaking regarding the use of nationally recognized standardized reporting systems to capture costs for chemical dependency services and mental health services. The Department knows that many group purchasers, especially HMOs, use such standardized reporting systems for managing their business and that these systems provide valid data consistent with the Department's data reporting requirements. To complete last year's report, some group purchasers used such standardized reporting systems for capturing chemical dependency services and mental health services data. The Department was aware of this and accepted data submitted by these group purchasers. This subpart is amended to make explicit that this practice is acceptable to the Department as long as the group purchaser's system captures data consistent with the definitions.

There were inconsistencies in last year's report regarding the costs for prescription drugs and supplies administered as part of chemical dependency or mental health treatments. Some drugs and supplies for chemical dependency or mental health treatments are dispensed and billed directly through a hospital or health care provider. The inconsistencies arose because these drug and supply costs could have been reported under several expense categories. The work group recommendation was to report drug and supply costs where the billing occurs, namely, if a hospital or health care provider dispenses and bills for the drugs or supplies, the expense should be reported in the category under which they were billed. The Department agrees with this recommendation.

**Subpart 5. Claim processing expenses.** This was a minor clarification based on work group comments that "claim quality assurance" was an ambiguous term because "quality assurance" is used for both the financial and medical components of health care. For this category, we are

focusing on the financial component of health care. The work group advised us that the term "claim audit function" better described the costs we want to capture.

**Subpart 9. Durable medical goods expenses.** "Eyeglasses" was changed to "eyewear" to reflect the fact that group purchasers will in some cases pay for contacts and not just glasses.

**Subpart 10. Emergency services expenses.** There were inconsistencies in last year's report for physician services performed in an emergency room because some group purchasers were reporting these expenses under physician services expenses and some were reporting it under emergency services expenses. The work group told us that it would be easier for them to report all expenses for physician services under the physician services expenses category because of the way these services are billed. The Department will allow group purchasers to report these expenses this way in order to make it easier for group purchasers to report. This will also make the reporting of these expenses more consistent. In addition to this, we clarified what emergency services expenses should include. Basically this includes all services and supplies provided in the emergency room and billed by the facility, except for physician services.

**Subparts 13 and 14. Hospice care expenses as they relate to home health care expenses and inpatient hospital services expenses.** For last year's report, hospice care expenses were required to be reported under inpatient hospital services expenses. The work group told us that it was difficult or impossible to break out hospice care expenses from home health care expenses. Recognizing this difficulty, the Department is amending these subparts to require hospice care expenses to be reported for the location at which they are provided. This means that expenses for hospice care provided in the home will be captured in the home health care expenses category and expenses for hospice care provided in a hospital will be captured in the inpatient hospital services expenses category. This will eliminate any inconsistencies and will reduce the reporting burden on group purchasers.

**Subpart 19a. Minimum premium plan revenue.** The category "minimum premium plan revenue" was reported last year, but there was no definition in the rules. In the collection of the data, we found that there were some inconsistencies in reporting, so it was necessary to define this term. Department staff's general understanding of this term was that it was revenue related to minimum premium policies. With discussions and the advice of the work group, the term was defined so that it would be clearly understood and consistently applied by group purchasers.

**Subpart 20. MinnesotaCare tax expenses.** Presently, the rules define "MinnesotaCare tax expenses" to mean "all payments made for the MinnesotaCare tax under Minnesota Statutes, section 295.52." Section 295.52 refers to the 2% provider tax, which is paid by health care providers. Technically, group purchasers do not pay this. Our purpose in tracking this category is to get the amount of tax passed through from providers to the group purchaser. This was the understanding last year and was how group purchasers reported data. Section 295.582 contains pass-through language. We are amending the rule to refer to section 295.582 to make it more clear that we want the pass-through amount of tax paid for by the group purchasers.

**Subpart 24a. Patient services revenue.** This category was added to the list of revenue items collected under part 4652.0120. It is therefore necessary to define this term. This definition is very straightforward in that it applies only to those group purchasers who own clinics and the revenue is limited to the fee-for-service revenue from these clinics. Note that this does not apply to the revenue from members and subscribers of the group purchaser who obtain care at the clinics through a policy with the group purchaser, as this revenue would be reported under total premium revenue.

**Subpart 25. Pharmacy and other nondurable medical goods expenses.** This clarifies the Department's intent that this category capture drug and supply costs that are billed directly through a pharmacist or medical supply company. Pharmaceuticals and supplies that are administered or dispensed and billed directly through a hospital or health care provider should be reported where the billing occurs. This is consistent with the discussion under part 4652.0100, subparts 4 and 19, for chemical dependency services and mental health services.

**Subpart 26. Physician services expenses.** The term "ophthalmologists" was deleted because it was redundant; opthalmologists are licensed medical doctors.

Also, consistent with the discussion under part 4652.0100, subparts 4 and 19, for chemical dependency services and mental health services and part 4652.0100, subpart 25, pharmacy and other nondurable medical goods expenses, pharmaceuticals and supplies that are administered or dispensed and billed directly through a hospital or health care provider should be reported where the billing occurs

**Subpart 29. Quality assurance and utilization management expenses.** During a work group meeting the question came up as to where nurse triage expenses should be reported, as an argument could be made for reporting these expenses under several categories. Nurse triage refers to the service provided by many group purchasers where there is an experienced nurse available by phone to members and subscribers to educate and advise on routine health care matters, in particular whether health care physician or professional services are needed and where the most appropriate place for care would be. After work group discussions, we decided that nurse triage expenses should most appropriately be reported under the quality assurance and utilization management expenses category because a primary goal of this service is to make the most appropriate utilization decision.

**Subpart 30a. Reinsurance assumed revenue.** The category "reinsurance assumed revenue" was reported last year, but there was no definition in the rules. In the collection of the data, we found that there were some inconsistencies in reporting, so it was necessary to define this term. Our general understanding of this term was that it was revenue related to reinsurance plan policies. With discussions and the advice of the work group, the term was defined so that it would be clearly understood and consistently applied by group purchasers.

**Subpart 32. Skilled nursing facilities expenses.** During work group discussions, the question arose whether this category was supposed to just capture medical costs or whether it should also capture costs incidental to providing necessary medical care, namely room and board costs.

Since these costs are paid by the group purchaser, they should be reported by the group purchaser. It makes sense that these costs be reported in this category because it is difficult to separate the medical expenses from the custodial expenses for these facilities.

**Subpart 33. Subscriber.** There were some minor inconsistencies and questions in reporting data on subscribers in last year's report. This definition was clarified to make sure that there would be no confusion between subscribers and members. The work group reviewed this language and felt that it was clear and would help eliminate confusion.

**Subpart 34. Total premium revenue.** If the same revenues are reported in more than one category, the revenues would be double counted when the data are analyzed. This double counting would make it appear that Minnesota's health care costs are higher than they actually are. This term was amended because we wanted to make sure that revenue reported under other categories would not also be reported under this category.

**Subpart 34a. Utilization review fee revenue.** The category "utilization review fee revenue" was reported last year, but there was no definition in the rules. In the collection of the data, we found that there were some inconsistencies in reporting, so it was necessary to define this term. Our general understanding of this term was that it was revenue related to utilization review products. With discussions and the advice of the work group, the term was defined so that it would be clearly understood and consistently applied by group purchasers.

**4652.0110 GROUP PURCHASER REPORTING.**

**Subpart 1. Group purchasers must report; exceptions.** This subpart is amended to allow the submission of the report in computer format. The Department wants to collect its data in this format for ease of entering and processing the data. This will reduce the burden on most group purchasers because they compile the data in computer format and, in the past, have printed it out on paper to submit to the Department. Then the Department would have to enter the data. Getting the data on computer format will eliminate several steps and is likely to reduce data entry errors, reduce the amount of paper, and minimize data privacy concerns with paper copies.

**Subpart 1, item A. Reporting amount of premium on short report.** This item is amended to require a group purchaser that is filing the short report to state the dollar amount of total health care premiums for Minnesota residents. Previously, the group purchaser would have just stated that it was under the threshold amount of $3,000,000. Knowing the dollar amount of total health care premiums for Minnesota residents will help the Department to better tie the number of lives covered to the premium amount. Also, the Department plans to inform group purchasers close to the $3,000,000 threshhold about the requirements of the long form so that these group purchasers can prepare to compile their data according to the long form requirements if they believe they will exceed the $3,000,000 threshhold. This should present no additional burden on the group purchaser because to know whether they are under the threshhold, they would have to know the amount of premium.

## 4652.0120 CONTENTS OF REPORT.

**Item A. Patient services revenue.** "Patient services revenue" was added as a category of "other revenue" because in the work group meetings, Department staff learned that fee-for-service revenue received by clinics owned by a group purchaser did not fit into the existing categories. This revenue was overlooked when these rules were first adopted last year because most group purchasers do not own clinics.

**Item A. Revenue categories separated by type of policy.** Each revenue category must be separated by type of health care policy. The rule was amended to require separation by commercial, Medicare, Medicare supplement, and other public programs. The existing rule required separation by Medicare and non-Medicare amounts. The revenues from these types of policies are important information for the Legislature and other policy makers in developing and monitoring health care reform initiatives. One health care reform initiative in particular for which this separation is essential is the monitoring of growth limits because the growth limits apply only to commercial and Medicare supplement policies. This is reasonable because group purchasers are able to separate these categories without undue burden.

**Item B. Expenditure categories separated by type of policy.** Each expenditure category must be separated by type of health care policy. The rule is amended to require separation by commercial, self-insured, Medicare, Medicare supplement, and other public programs. The existing rule required separation by insured business, self-insured business, Medicare, medical assistance, and general assistance. Using the term "commercial" instead of "insured business" makes this consistent throughout the reports and is a term commonly used by group purchasers for this type of policy. This change of terms does not change any of the reporting requirements for group purchasers. The term "self-insured business" was changed to "self-insured" to be consistent throughout the reports. This change of terms also does not change any of the reporting requirements for group purchasers. The terms "medical assistance" and "general assistance" were replaced by "other public programs" because our analysis of these types of policies was combined and because we wanted to include all of the other public programs, such as MinnesotaCare, Head Start, Indian Health Program, and others. Combining these two categories into one category will likely reduce the reporting burden on group purchasers.

**Item B. Report member liability for each policy category.** The rule is amended to require reporting of member liability for each policy category. Out-of-pocket expenses are of great interest to the Legislature and other policy makers. Member liability is an important component of out-of-pocket expenses. Tracking member liability will help the Department track out-of-pocket expenses for that segment of the population who have health coverage. It will also help the Department answer questions on cost shifting and other consumer direct cost issues related to health care reform.

**Item C. Medicare supplement broken down by expenditure category, where applicable.** When the rules were first adopted in 1994, it was the Department's understanding that Medicare supplement coverages could not be broken down by expenditure category. During work group meetings on the development of these rule amendments, Department staff learned that, in many

cases, Medicare supplement coverage can be broken down by expenditure categories. Therefore, the rule was amended to delete the reference to Medicare supplement coverages in the provision that allows for listing total expenses for coverages where expense categories cannot be itemized. If a group purchaser is unable to break down its Medicare supplement coverages, the group purchaser may still list this under total expenses.

**Item F. Categories itemized by type of policy.** Item F requires reporting the total number of members and subscribers by type of policy, including family policies and individual policies and member months, and to report separately for medical and dental contracts. The rule is amended to require that each of these categories be further itemized by commercial, self-insured, Medicare, Medicare supplement, and other public programs. This itemization is important to the Legislature and other policy makers to determine how many Minnesotans have health and dental coverage, the types of coverage, and the amount of time during the year they are covered. This information is readily available to some group purchasers. For those group purchasers where this information is not readily available, the rules allow actuarial estimates. Therefore the group purchasers can supply this information without undue burden.

**4652.0140 VARIANCES.**

**Subpart 1. Data from other sources.** Under this subpart, the Commissioner of Health will determine whether to use data from other sources if these data duplicate data collected under the rules. This determination would be triggered either by a request from a group purchaser or by the Commissioner's own initiative. To make this determination, the Commissioner would have to consider whether the data are duplicative, the data are available at reasonable cost, the Department has the resources available to use the data, and the data will meet all statutory data collection, analysis, and privacy requirements. The Department is aware of data that are similar, and possibly duplicative, to data required under the rules. This subpart gives the Department the flexibility to reduce the reporting burden on group purchasers if these data are in fact duplicative or if a data source is developed in the future which duplicates data required under the rules. The Department's interest is in obtaining these data for analysis, not in making all group purchasers give the data directly to the Department. The criteria for the Commissioner to consider ensure that the Department's data collection efforts will not be compromised by using data from other sources.

**Subpart 2. Aggregate reporting for systems.** This subpart will allow an organization operating a group purchaser which is part of a system of group purchasers, hospitals, or clinics to report all components of the system as an aggregate. This subpart was included in an attempt to give the Department the flexibility to deal with health care systems in whatever form they may take in the future. Driven in part by health care reform and in part by forces in the health care marketplace, health care will be delivered in some cases by systems consisting of group purchasers, hospitals, and health care providers. The Department cannot predict exactly what forms these systems will take, but wants to leave open the possibility in the rules of collecting data at the system level. While allowing system level reporting, the Department will still have to comply with statutory requirements so it is reasonable that this subpart only allows system-level reporting if statutory requirements are met. This subpart contemplates that a system and the

Commissioner would have to meet and work out the details of the data submission so that the Department can use the data to meet all statutory requirements.

## Conclusion

Based on the foregoing, the Department's proposed rules are both necessary and reasonable.

10/18/95
Date

for Christine D. Rice Deputy Commissioner
Anne M. Barry, Commissioner
Department of Health

## Appendix

Items in the Appendix are included as part of the official rulemaking record. Copies of Appendix items are available upon request from Brenda Holden, Minnesota Department of Health, Health Care Delivery Systems Policy Division, P.O. Box 64975, 121 East Seventh Place, Suite 400, St. Paul, Minnesota 55164-0975, 612/282-6323. TDD users may call the Minnesota Department of Health at 612/623-5522.

A. Minutes of work group meetings. Note that minutes are included for the purpose of documenting the work group's input, and do not necessarily represent the Department's position.

B. Draft of data collection report form based upon the proposed rule amendments.

**Minutes for the Work Group on Chapter 4652**
Aggregate Data from Commercial Insurers and HMOs
June 5, 1995, 10:00 - 12:00 a.m.
State Office Building Room 300S, St. Paul, Minnesota

**Persons attending the meeting:**

Virginia Greenman, MHCC
Mark Matthias, Mayo Health Plan
Gunnar Nelson, PreferredOne
Lisa Schoen, UCare Minnesota
Debra Stenseth, MN Department of Human Services
Sally Mangina, State Farm Insurance Companies
JoMarie Williamson, Prudential
Michele Hostager, Prudential
Ann Marie Seward, Metropolitan Health Plan
Michelle Hegarty, Medica/Allina
Mona Freeberg, Medica/Allina
Dave Orren, Minnesota Department of Health
Brenda Holden, Minnesota Department of Health
Mylene Landry, Minnesota Department of Health

The next two meeting dates are scheduled for June 28, 1995 at 1:00 p.m. and July 12, 1995 at 9:00 a.m. Future meetings will be held on Wednesday mornings in room 300S of the State Office Building.

Brenda Holden began by reviewing the current list of issues relating to the Group Purchaser Financial & Statistical Report. The group agreed that all issues are worth re-examination. Two additional issues were added to the list. With respect to Report #4, "Indirect Health Care Expenses", the existing category breakdowns must be re-examined. With respect to Report #2, the group agreed that better definitions are needed. Items #5, 6, & 9 from the issue list will be discussed as one issue.

On June 28, 1995 the group should be prepared to discuss item #6 from the revised issue list. The group will work to redefine and clarify the definitions for Financial & Statistical Report #2.

**Department of Health Contacts**
**Brenda Holden: 282-6323**
**Mylene Landry: 282-6351**

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**Department of Health Contacts**
**Brenda Holden: 282-6323**
**Mylene Landry: 282-6351**

# Minnesota Department of Health
# Group Purchasers Work Group - Chapter 4652
# Meeting Summary for June 28, 1995

Group Purchasers Rules Work Group Members and Interested Persons signed in:

Dave Dziuk, HealthPartners
Virginia Greenman, Consumer Member of MHCC
Michelle Hegarty, Medica/Allina Health System
Michelle Hostager, Prudential Ins., Group Underwriting
Kathleen Kuha, MDH/HCDP
Mylene Landry, MDH/HCDP
Mark Matthias, Mayo Health Plan
Gunnar Nelson, PreferedOne
Dave Orren, MDH/HCDP
Dan Rydel, BCBSM
Lisa Schoen, UCare of Minnesota
Ann Marie Seward, Metropolitan Health Plan
Alice Swan, College of St. Catherine
Jennifer Breitinger, JWB Associates
Beverly Turner, Insurance Federation of MN

1. The meeting opened with a discussion on definitions for "members" and "subscribers". Gunnar Nelson of PreferredOne asked whether or not we should count members and subscribers even if the group purchaser is the secondary insurer. There was some concern over the possibility of double counting. The groups concensus was that this would be difficult to count, however, and not worth the additional administrative burdens.

2. The work group suggested that all the definitions for Report #2 need work and need to be included in the rules. Specifically, we need to determine if reinsurance means gross or net and determine whether and/or what part of group purchaser premiums should go to Utilization Review.

3. The group requested that Lynn Blewett, Director of the Health Economics Program attend the July 12th meeting to address issues relating to the use of the data. Specifically, why the group purchasers have to split their revenue sources in these five categories and how the Department is using that data.

4. The Department needs to improve the definition for "non-expense incurred expense" or perhaps find a more descriptive term for expenses that cannot be attributed or allocated to the specific expense categories

5. The banners/headers need to be more consistent across all reports.

6. The group discussed the possibility of consolidating Department of Health reporting requirements for group purchasers.

7. Dave Dziuk headed a discussion on whether HEDIS codes should be used for mental health and chemical dependency. There was some concern over whether or not it is worth the effort to "micromanage" this. The group did not reach a conclusion.

8. The question was raised over where the capitated amounts should go. Dave Orren stated that based on his memory of last year's work group discussion, if specific expense categories can be identified, they should be put in that specific category. Likewise, if the expense cannot be identified, it should go in the non-expense incurred category.

## Issues list from Rules 4652 meeting 6/28/95

| Issue | Discussion | Conclusion |
|---|---|---|
| MA, GAMC included on 1993 data, not on 1994 | Was wrong report completed? Did we decide to collect from DHS instead? | MDH found that MA, GAMC are included on the HMO form. They are not, however on the commercial insurer's form. |
| Count of members and subscribers | Many indemnity carriers do not have a definite number. Is there a standard method for estimating members from subscribers (e.g. 2.4 members per subscriber)? Should MDH request the methodology used to determine? | (No comments) |
| How much of a month to be a subscriber? | Is it necessary or useful to count subscribers by part of months (e.g. late sign-on)? | No, this should not have to be done. Bookkeeping headache and probably balances out anyway w/ Oct open enroll. |
| Do secondary insurance policies create double counting of members? | E.g. someone who appears on both Plan A's member 'roster' and on Plan B's (as a dependent) may inflate the numbers. | Do not try to count. Not much inflation, situation fairly rare; also, would create huge bookkeeping problem for the plans. |
| Matching the rules to the report form | | Form appears to be mostly acceptable |

| Issue | Discussion | Conclusion |
|---|---|---|
| Report #2, revenues; 'self-insured' does not appear as a column category | Self-insureds generate some revenues to plans (even though medical claims are paid by the self-ins company), as UR or other services. If these revenues are added to 'commercial' or somewhere, then the proportion of admin expenses to medical expenses appears to rise. (Medical exp from self-ins are reported separately on Rpt 3) | Self-insured should have a column on Rpt 2 the same as on Rpt 3, so admin revs from self-ins may be removed from general admin revs. This ties in with a common adjustment method for the growth limits. |
| "Reinsurance revenue" definition | Seems like a category to be completed only if plan wrote reinsurance. Does not sound like a payment to a plan who had made a reinsurance claim. Several definitions are self-reflecting (e.g. see charitable contributions expenses) | Definitions should be re-written. Are there standard definitions available, e.g. from insurance underwriting textbooks? Can the work group assist with finding them? |
| Consistency between all reports that payers file with the State. | Many reports are filed, some calling for this number, others that. Definitions vary. HMOs file extensive reports with MDH. | This is a critical issue. MDH should look into the other reports and cooperate with those depts, both to coordinate definitions and requests, and to reduce redundant requests. Begin with OSC and the HMO reports. Can work group members give us the list of other reports? |
| UR revenue which is paid as part of premium vs UR which is paid as a fee | | Address this along with other definitions |
| Why have minimum premium plan revenues reported separately? | 1) "MPP revenues" needs a definition. 2) Is there a reason to report it separately from commercial | Lynn will address why MPP was separated last year. |

| Issue | Discussion | Conclusion |
|---|---|---|
| What is the line between self-insured and commercial? | One plan reported all its business as self-ins because all its members are its employees, except its MA business. Most plans do not have trouble distinguishing between self/comm. | No change suggested. |
| The headers on Rpt 3 are wrong. | They make 'self-insured' look like part of commercial. | Header should be removed so this Rpt 3 looks like Rpt 1. |
| Excluding non-MN residents? | 1) MDH's business is only with MN residents, and so should not be given more info than needed. 2) Can it be done? (Very difficult). | No. Most plans present have very few non-MN residents enrolled; the effort required to separate them would not be worth it. If it causes a growth limit problem, then affected plan could adjust for it in their methodology. |
| Exclude taxes and assessments more accurately or consistently? | Taxes and assessments are not under plan's control, so they are reported separately to aid in calculating growth limits. However, doing so makes tie-out to other reports less clear. How detailed should tax/assessment category be? (E.g. list each tax: MnCare, HMO tax, state, federal, surcharges...) | No change. Leave taxes and assessments reported separately (like lines 13 & 14 on Rpt 4). Also, HMO tax coming in next year which should get its own entry? Unresolved how detailed the 'lines 13 & 14 list' should be. |
| The provider 2% tax | Do plans estimate how much of 2% provider tax is paid as a pass-through part of medical claim expenses? Should they list it separately (some plans can do this) or leave it in as part of the medical claims expense line? Note: Any estimates of how much provider tax was paid as a pass-through will be estimates only. | Need a decision: either it should be a line item in expenses or it should go into claims. Some on work group favor leaving in claims, others separate. |

| Issue | Discussion | Conclusion |
|---|---|---|
| What is a "non-expense incurred expense"? | A technical term used by plans who write checks for "lumped" payments e.g. to a Medicare Supplement subscriber who gets a lump sum or is paid for a consolidated batch of bills. No detail is available on whether MD or hosp bills. | Renamed "non-itemized" expense. |
| Whether to use HEDIS or other kind of definition to categorize Rpt 3 medical expense claims into (e.g) physician services, other HP services, IP hosp services, etc? | What systems are available? What are their faults? Is it worth redefining the form? | (No clear conclusion) |
| Where are capitated payment being put?<br>If capitation is "the future", would it be good to start measuring how much capitation occurs in both HMO and indemnity plans as a baseline? | Most plans put all physician services (capitated or FFS) into physician, hosp into hosp, etc. Most plans agree that it is easy enough to place the dollars into Rpt 3 categories because when they capitate, they know in general what they are capitating for. If the provider subcapitates, it's not the plan's business. | Relatively easy to measure capitated or non-capitated (end-of-period settlements present some difficulties). Need decision: should they be reported separately? Work group favors separate. |
| | | |

**Minnesota Department of Health**
**Group Purchaser Rules Work Group - Chapter 4652**
Minutes for the Meeting on July 12, 1995, 9:00 to 11:00 a.m.
Held at Medica/Allina Health Systems, Minnetonka, Minnesota

**Persons attending the meeting:**

Roger Banks, Minneapolis Urban League
Lynn A. Blewett, Minnesota Department of Health
Kevin Brandt, HealthPartners
Michelle Hegarty, Medica/Allina
Brenda Holden, Minnesota Department of Health
Michele Hostager, Prudential
Kathy Kuha, Minnesota Department of Health
Mylene Landry, Minnesota Department of Health
Mark Matthias, Mayo Health Plan
Dave Orren, Minnesota Department of Health
Dan Rydel, BCBSM
Lisa Schoen, UCare Minnesota
Ann Marie Seward, Metropolitan Health Plan
Debra Stenseth, MN Department of Human Services
Alice Swan, College of St. Catherine
Beverly Turner, Insurance Federation of Minnesota

1. Lynn A. Blewett, Ph.D., Director of the Health Economics Program, gave a presentation on Minnesota Health Care Spending and Trends. A discussion followed which addressed the work group's concerns over how the Department is using the information.

2. The work group agreed to leave the definitions for "members" and "subscribers". Instead, changes will be made to the report form leaving it up to the group purchasers to define by methodology, members covered if that number is different than subscribers covered or if the actual number of members is unknown. There are no other issues with report #1.

3. The work group did not take issue with the Department's suggestion to have a single report form for HMOs and commercial insurers, rather than having two separate, but very similar report forms.

4. The combined report #2 will include a column titled "other public programs". This category will capture medical assistance, GAMC, and the subsidized MinnesotaCare health insurance program administrated through the Department of Human Services. In addition, a line for "**patient service revenue**" was added. The group suggested the following definition for patient service revenue: "Revenue for providing patient services". This will also be a separate category from "total premium revenue".

5. The group agreed to the proposed definition for "**total premium revenue**" with the addition of patient services revenue as described above.

6. The proposed definitions for "**minimum premium plan revenue**" and "**utilization review fee revenue**" were accepted without modification.

7. The proposed definition for "**administrative services fee revenue**" was accepted with the following modifications: That "insurer be replaced with the term "group purchaser" and "certain services" be replaced with "claims administration and other services".

8. Similarly, the proposed definition for "**reinsurance assumed revenue**" was accepted provided that "insurer" be replaced with "group purchaser".

9. There are no other issues concerning Report #2.

10. The meeting than shifted to a discussion of Report #3. Line 13 of Report #3 was renamed "Expenses not itemized above". This would include fixed indemnity, capitated, and Medicare supplement payments that cannot be itemized.

11. The Department will look into whether the MinnesotaCare 2% tax can be included in the expense categories so that it reconciles with the group purchaser statutory filings.

12. The July 26th meeting (location Medica/Allina) will concentrate on report #3. Specifically how the expenditure categories should be reported. (HEDIS issue).

**Minnesota Department of Health**
**Group Purchaser Rules Work Group - Chapter 4652**
Minutes for the Meeting on July 26, 1995, 9:00 to 11:00 a.m.
Held at Medica/Allina Health Systems, Minnetonka, Minnesota

**Persons attending the meeting:**

Jennifer Breitinger, JWB Associates
Michelle Hegarty, Medica/Allina
Brenda Holden, Minnesota Department of Health
Michele Hostager, Prudential
Kathleen Kuha, Minnesota Department of Health
Sally Mangina, State Farm Insurance
Mark Matthias, Mayo Health Plan
Dave Orren, Minnesota Department of Health
Dan Rydel, BCBSM
Lisa Schoen, UCare Minnesota
Ann Marie Seward, Metropolitan Health Plan
Beverly Turner, Insurance Federation of Minnesota

1. An Amended Solicitation of Comments was distributed along with a letter from Commissioner Barry. This was similar to the Solicitation issued in May 1995 and was done because the Legislature changed the requirements for seeking public input when doing rules.

2. The Department of Health will no longer require group purchasers to subtract out the MinnesotaCare 2% tax from the expense categories (report #3). Methodology will be adjusted for the 2% tax difference between years. This adjustment must reconcile with the amount stated on report #4, item 13, MinnesotaCare Tax category listed under the tax and assessments portion.

3. An additional column, "Other Public Programs" was added to report #3. " Other Public Programs" includes MA, GAMC, MinnesotaCare Health Plan, etc. The MinnesotaCare Health Plan referenced here is defined as the subsidized health care program administered by the Department of Human Services.

4. The group then went through the definitions for report #3. The **physician services category** along with other categories has not been reported consistently. To clarify, drugs and supplies administered or dispensed in an office setting are to be expenses for that category and not to be itemized for placement in the pharmacy, durable or nondurable categories. The term ophthalmologist was dropped from the definition since ophthalmologists are licensed medical doctors.

5. **Skilled nursing facilities** was further defined to include room and board due to inconsistencies in reporting.

6. **Pharmacy and other nondurable medical goods** was also clarified so that drugs and supplies administered or dispensed in an office or hospital setting are to be in the respective office or hospital expenses category and not to be in the pharmacy category.

7. **Durable medical goods** definition changed eye glasses to eyewear.

8. **Emergency Services** was clarified for consistent reporting. Emergency services includes costs for medical care provided in the emergency room of a hospital. This includes the room, board and any services such as x-ray and laboratory services billed by the facility. Does not include expenditures for physician services.

9. **Chemical dependency services and mental health services expenses**. The HEDIS issue was discussed and while many group purchasers are satisfied with the existing definition, the group noted that not all group purchasers have the same reporting base. Therefore, the group recommended to retain the existing definition. The group was not opposed to adding in the definition that group purchasers may use a nationally recognized, standardized reporting system which captures chemical dependency and mental health inpatient, outpatient, and other professional services. Another clarification to the definition was again drugs and supplies administered or dispensed in an office sitting are to be expenses for that category and not to be itemized for placement in the pharmacy, durable or nondurable categories.

10. An unresolved issue was where to report expenditures for hospice care. By definition hospice care should be included in the **inpatient hospital services** category. However, some in the group have been reporting it under the **home health care** category. It is impossible to separate home health and hospice care. The group agreed to research how it was now being reported by their companies and would come with recommendations to the next meeting on how to report hospice care.

11. It was agreed that the categories for report #4 were fine. The group went over the definitions. There were only a few minor changes. In the **claims processing** category, claim quality assurance was changed to claims audit function. Nurse triage services was added to the **quality assurance and utilization management** category.

12. **MinnesotaCare tax** category was changed to clarify payments paid to provider.

13. The August 9th meeting will be hosted by BCBSM at the RiverPark in Eagan. The group will discuss the hospice issue and review the updated Group Purchaser Financial and Statistical Report. This will include report forms #1 - #4 as well as the instructions.

**Minnesota Department of Health**
**Group Purchaser Rules Work Group - Chapter 4652**
Minutes for the Meeting on August 9, 1995 from 9:00 to 11:00 a.m.
Held at Blue Cross and Blue Shield of Minnesota, Eagan

**Persons attending the meeting:**

Jennifer Breitinger, JWB Associates
Vicky Donaldson, Minnesota Department of Health
Dave Dziuk, HealthPartners
Michelle Hegarty, Medica/Allina Health Systems
Brenda Holden, Minnesota Department of Health
Kathleen Kuha, Minnesota Department of Health
Sally Mangina, State Farm Insurance
Sharon Berens for Gunnar Nelson, PreferredOne
Dave Orren, Minnesota Department of Health
Kathi Roelke, Minnesota Department of Health
Dan Rydel, Blue Cross and Blue Shield of Minnesota
Lisa Schoen, UCare Minnesota
Ann Marie Seward, Metropolitan Health Plan
Beverly Turner, Insurance Federation of Minnesota

1. The group discussed the Hospice care issue. (Report # 3) In the past hospice care expenditures were to be reported under inpatient hospital services. However, many group purchasers cannot separate hospice care that is not inpatient hospital services from home health care expenditures. For consistency, the group recommended that hospice care expenditures received as inpatient hospital services should be reported under the inpatient hospital services category. Hospice care expenditures other than inpatient hospital should be reported in the home health care category.

2. In the past, the codes used when one was unable to complete a category were numeric (-1, -2, -3). The group would prefer the use of alpha codes instead of numeric. It was decided that "NR" would be used for items not reported, "NA" for items not applicable, and "RE" for items reported elsewhere.

3. Discussed next was the use of a short form for group purchasers that collected less than $3 million in premiums for Minnesota residents. The group recommended that a short form along with the complete group purchaser financial and statistical report be sent to the smaller group purchasers. This would give the smaller group purchasers a chance to see what information they might need to collect in the future. The short form would consist of Report #1 (persons covered) with an addition of a total premium revenue line. (Note: we are rethinking whether the short form should be as detailed as Report #1, or whether we only need the total health premiums amount and total number of members and subscribers.)

4. Alternative ways of submitting the report were discussed. When the report is sent out, information will be included on software packages the department can accept and may include information on requesting a formatted disk from the department.

5. The Report forms and definitions were discussed and the following changes were recommended:

a. Report # 1 - no changes.

b. Report # 2 - definition for Patient Services Revenue was added. Patient Services Revenue includes fee for service revenue received for medical and dental services delivered to patients by clinics that are owned by the group purchaser. The definition for Administrative Services Fee Revenue added "/ includes self-insured" after third party, for additional clarity. There was discussion whether or not to add a self-insured column. The group consensus was that this was not necessary because this would likely be reported as part of Administrative Services Fee Revenue.

c. Report # 3 - The instructions will include a statement to include the MinnesotaCare 2% tax in these categories. This statement will also be reflected in the cover letter. Inpatient hospital services expenses will include inpatient hospice care. Home health care expenses will include non-inpatient hospice care expenditures. The Medicare Supplement column will no longer be shaded since some group purchasers are able to break Medicare Supplement payments into the expenditure categories. After discussion, we clarified that the directions already state that long term care coverages are not reported in this report.

d. Report # 4 - no changes.

6. The issue of how to report the upcoming (1/1/96) 1% gross premium on non-profits and HMOs was brought up to look at in the future.

7. Dialog occurred between the work group members and Vicky Donaldson and Kathi Roelke from the Minnesota Department of Health's HMO unit.

8. The work group completed discussion of all issues. Hence, the August 23rd meeting is canceled and no future meetings are planned. Please review the Report form and instructions/definitions (dated 8/10/95) one more time. If there are any problems or changes please contact me. I will send the rules out as soon as they are finished.

MINNESOTA DEPARTMENT OF HEALTH For period: 1/1/95 to 12/31/95
GROUP PURCHASER FINANCIAL AND STATISTICAL REPORT #1

**The information provided in this report is classified as non-public. (MN Stat. 62J.321, Subd. 5.)**

| | |
|---|---|
| Company Name: | |
| Address: | *DRAFT 8/10/95* |
| NAIC Code: | Group Code: |
| Name and title of person completing form: | Phone Number: ( ) |

| Covered Persons as of Dec. 31, 1995 | Commercial | Self-Insured | Medicare | Medicare Supplement | Other Public Programs |
|---|---|---|---|---|---|
| TOTAL NUMBER OF SUBSCRIBERS COVERED - Medical | | | | | |
| TOTAL NUMBER OF SUBSCRIBERS COVERED - Dental | | | | | |
| Individual Plan - Medical | | | | | |
| Individual Plan - Dental | | | | | |
| Family Plan - Medical | | | | | |
| Family Plan - Dental | | | | | |

***If the number of members covered is KNOWN, check here _____.

***If members covered is NOT KNOWN place the multiple used to calculate members covered in this space _____.

| | | | | | |
|---|---|---|---|---|---|
| TOTAL NUMBER OF MEMBERS COVERED - Medical*** | | | | | |
| TOTAL NUMBER OF MEMBERS COVERED - Dental*** | | | | | |
| TOTAL MEMBER MONTHS - Medical | | | | | |
| TOTAL MEMBER MONTHS - Dental | | | | | |

I have completed these reports (1 through 4). I am available to answer questions regarding the completion of these reports from the Minnesota Department of Health.

_____ _____
(Name) (Date)

**Please Return Reports 1 through 4 By April 1, 1996 to:**

**Minnesota Department of Health**
**Health Economics Program**
**P.O. Box 64975**
**St. Paul, MN 55164-0975**
**Tel: (612) 282-6312 Fax: (612) 282-5628**

## MINNESOTA DEPARTMENT OF HEALTH

**For period:** 1/1/95 to 12/31/95

**GROUP PURCHASER FINANCIAL AND STATISTICAL REPORT # 2**

**HEALTH CARRIER REVENUE SOURCES**

**The information provided in this report is classified as non-public. (MN Stat. 62J.321, Subd. 5.)**

| Revenue Sources | Commercial | Medicare | Medicare Supplement | Other Public Programs |
|---|---|---|---|---|
| Total Premium Revenue | | | | |
| Minimum Premium Plan Revenue | | | | |
| Administrative Services Fee Revenue | | | | |
| Utilization Review Fee Revenue | | | | |
| Reinsurance Assumed Revenue | | | | |
| Patient Services Revenue | | | | |

***DRAFT 8/10/95***

MINNESOTA DEPARTMENT OF HEALTH For period: 1/1/95 to 12/31/95
GROUP PURCHASER FINANCIAL AND STATISTICAL REPORT # 4
INDIRECT HEALTH CARE EXPENSES

**The information provided on this report is classified as non-public. (MN Stat. 62J.321 Subd. 5.)**
**The information required by this report may be estimated from existing accounting methods with allocation to specific categories. This information is intended to detail types of indirect health care expenses. It is not intended for company to company comparisons and will be used at an industry-wide aggregate level only.**

| CATEGORY | TOTAL |
|---|---|
| 1. BILLING AND ENROLLMENT | |
| 2. CLAIM PROCESSING | |
| 3. CUSTOMER SERVICE | |
| 4. PRODUCT MANAGEMENT AND MARKETING | |
| 5. REGULATORY COMPLIANCE AND GOVERNMENT RELATIONS | |
| 6. PROVIDER RELATIONS AND CONTRACTING | |
| 7. QUALITY ASSURANCE AND UTILIZATION MANAGEMENT | |
| 8. WELLNESS AND HEALTH EDUCATION | |
| 9. RESEARCH AND PRODUCT DEVELOPMENT | |
| 10. CHARITABLE CONTRIBUTIONS | |
| 11. GENERAL ADMINISTRATION | |
| 12. TOTAL INDIRECT HEALTH CARE EXPENSES | |

***DRAFT 8/10/95***

**Please provide information on the following taxes and assessments.**
**Do not include the following taxes and assessments in the total on line 12.**

| | |
|---|---|
| 13. MINNESOTACARE TAX | |
| 14. OTHER TAXES AND ASSESSMENTS | |