

Minnesota Attorney General: Administrative Rules Proceedings

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STATE OF MINNESOTA

DEPARTMENT ATTORNEY GENERAL - HEALTH

Office Memorandum

TO : Michael Miller
Special Assistant
Attorney General
Administration - Room208

DATE: Sept. 30, 1976

FROM : John A. Breviu
Special Assistant
Attorney General

SUBJECT: HMO Copayment Rules

Enclosed for your review please find three copies of the record regarding rules adopted by the Board of Health dealing with Health Maintenance Organizations. I don't believe that there are any problems with these rules. If you have any questions, please do not hesitate to contact me.

Thank you.

JAB:ss
enclosures

MINNESOTA DEPARTMENT OF HEALTH RULES
CHAPTER TWENTY-EIGHT

Amendments to Rules for
Health Maintenance Organizations

Section 1. MHD 369(c)(3) is amended as follows:

(3) Copayments, Limitations, Exclusions and Restrictions on Service. In addition to the limitations and exclusions allowed in MHD 369(c)(2), a health maintenance organization may impose copayments for services or goods provided and may impose certain restrictions on services~~,~~. ~~such as on frequency or length of time a health maintenance service is provided. Provided, however that all copayments, limitations and exclusions must be reasonable. The express policy of the Board is to favor limitations rather than exclusions, and the Board may limit the extent of limitations and/or exclusions which may be included in any health care plan to ensure that comprehensive health care services are reasonably available to enrollees. The standard of reasonableness shall be applied in full consideration of the general concept that a health maintenance organization must provide comprehensive health maintenance services in exchange for a single, prepaid sum.~~ Any such provisions must clearly be stated in the evidence of coverage in compliance with Minn. Stat. §62D.07, Subd. 3(b)~~.~~ and comply with the following standards:

(aa) Limitations and Exclusions. There may be no limitations or exclusions other than those allowed by the statutes or in rules promulgated pursuant to Minn. Stat. §62D.20. Where exclusions are allowed, it is the express policy of the Board to favor limitations rather than exclusions and the Board may limit the extent of limitations and/or exclusions which may be included in any health care plan to ensure that comprehensive health care services are reasonably available to enrollees. The standard of reasonableness shall be applied in full consideration of the general concept that a health maintenance organization must provide comprehensive health maintenance services in exchange for a single prepaid sum.

(bb) Restrictions. Reasonable restrictions other than limitations, exclusions and copayments are permissible. These include, but are not limited to restrictions on the frequency or length of time a health maintenance service is provided (example: repeated, frequent physical exams), or the denial of a service that is not reasonably required to maintain the enrollees in good health (example: physical exams requested only for the protection or convenience of third parties). The standard of reasonableness shall be applied in full consideration of the general concept that a health maintenance organization must provide comprehensive health maintenance services in exchange for a single, prepaid sum.

(cc) Copayments. Reasonable copayments, as defined in Minn. Rule MHD 376(k), are allowed. Any amount or form of copayment shall be deemed reasonable when imposed on services which, pursuant to MHD 369, may be excluded completely, provided that the copayment is not greater than the cost or charge of that particular service. Furthermore, copayments, either on specific services or in the aggregate, may be imposed on out-of-area services and emergency care by providers who do not have arrangements with the health maintenance organization in the form of a reasonable "deductible," plus a twenty-five percent (25%) "coinsurance" feature, plus all charges which exceed a specified annual aggregate amount not less than $25,000.00.

The standard of reasonableness, in all circumstances, shall be applied in full consideration of the general concept that a health maintenance organization must provide comprehensive health maintenance services in exchange for a single, prepaid sum.

No copayment may be imposed on preventive health care services as defined in MHD 367(e)(5), including administration of immunization, well-baby care, periodic screening and prenatal care, provided that this prohibition shall not be construed to prevent a copayment on maternity services in general, which may include prenatal care.

Copayments may not exceed twenty-five percent (25%) of the costs or charges for a particular service, except those copayments imposed upon services which may be excluded completely, out-of-area and emergency care described previously in this section, preventive health care services, and prescription drug benefits.*

*Copayments imposed upon prescription drug benefits shall be reasonable under the general provisions described in this section.

Sec. 2. MHD 369(g) is amended as follows:

(g) Effective date of Operating Requirements. When changes are required in existing evidences of coverage or health maintenance contracts in order to implement the provisions of these rules, such changes shall be implemented upon the renewal date of such documents commencing with the first renewal after 60 180 days after the effective date of these rules. New contracts or evidences of coverage to be implemented after 60 180 days after the effective date of these rules must be in compliance with these rules upon implementation.

Sec. 3. MHD 371 is amended as follows:

Annual Reports. In addition to all other information specified in the Act, every health maintenance organization shall include in its annual report to the Board the following:

(a) The results of any and all elections conducted during the preceding calendar year relative to consumer representation on the health maintenance organization's governing body.

(b) A copy of the health maintenance organization's most recent information summary provided to its enrollees in accordance with Section 62D.09 of the Act.

(c) A description of the method and results of the system to evaluate the quality of health services. Such evaluation shall include, but not necessarily be limited to, study of the quality of care for at least one disease condition or age group.

(d) A schedule of prepayment charges made to enrollees during the preceding year and any changes which have been implemented or approved up to the reporting date.

Sec. 4. MHD 372(a) is amended as follows:

(a) Termination of Coverage

(1) Justification. In addition to those reasons specified in Section 62D.12, Subdivision 2 of the Act, a health maintenance organization may, upon thirty (30) days notice, cancel or fail to renew the coverage of an enrollee if such enrollee:

(aa) Knowingly gives false, material information at the time of enrollment relative to his health status, provided such cancellation or non-renewal is made six (6) months of the date of enrollment.

(bb) Moves out of the geographic service area filed with the Board, provided such cancellation or non-renewal is made within one (1) year following the date the health maintenance organization was provided written notification of the address change.

Sec. 5. MHD 374 is amended as follows:

MHD 374 Periodic Filings

~~(a) Filing Requirements. Any filings that are required by Minn. Stat. §§62D.07, and 62D.08, Subd. 1, and this rule must be filed with the Department of Health no later than ten days prior to the second Thursday of each month, which is the regular meeting date of the Board, unless there is an important and unexpected circumstance which requires filing on a different date. If such circumstance exists, the filing must include a statement describing the circumstances and the urgency of the Board's attention to the filing.~~

(a) Filing Requirements. Required filings will be acted upon at the next official meeting of the Board of Health following the filing date, provided the filing date is at least fifteen (15) days before said meeting. Exceptions to the requirement for filing fifteen (15) days in advance of a meeting will be made upon the filing of a statement of urgency and the circumstances involved.

(b) Provider Agreements. The provisions of Minn. Stat. §62D.08, Subd. 1 shall apply to any substantive modification in any agreement with providers as described and required for filing in MHD 368(e).

(c) The filing of any contracts or evidences of coverage pursuant to Minn. Stat. §62D.07 or §62D.08, Subd. 1, shall be accompanied by sufficient evidence on cost of services on which copayments are being imposed so as to allow the Board to determine the impact and reasonableness of the copayment provisions.

(d) Service Area. The filing of amendments to an H.M.O.'s geographic service area pursuant to Minn. Stat. §62D.08, Subdivision 1, and §62D.03, Subdivision 4(i) must contain sufficient supporting documentation of service area, facility and personnel availability and accessibility to allow a determination of compliance with MHD 369(d).

(e) Upon receipt of any filing under Minn. Stat. §62D.07, 62D.08, Subd. 1 or MHD 374, the Board may request such additional data as is reasonably necessary to determine legal propriety of the filed material. Failure of a health maintenance organization to provide such data as required by MHD 374 or requested by the Board pursuant to this rule shall result in disapproval of the filing.

Sec. 6. MHD 375 is amended as follows:

MHD 375. Improper Practices

(a) It shall be an improper practice for a health maintenance organization to advertise or market its operation by making qualitative judgment or statements concerning any health professional who provides services for a health maintenance organization.

(b) A health maintenance organization shall not enroll a person who resides outside the health maintenance organization's defined service area, unless the health maintenance organization provides the enrollee with written notice of the consequences of his special enrollment.

APPROVED AS TO FORM AND LEGALITY
OCT 27 1976 19
WARREN SPANNAUS, ATTORNEY GENERAL
BY Michael B. Miller
SPECIAL ASSISTANT ATTORNEY GENERAL

STATE OF MINNESOTA
DEPARTMENT OF STATE
FILED
OCT 27 1976 - 2:30 pm
Joan Anderson Growe
Secretary of State

MINNESOTA DEPARTMENT OF HEALTH RULES
CHAPTER TWENTY-EIGHT

Proposed Amendments to Rules for
Health Maintenance Organizations

Section 1. MHD 369(c)(3) is amended as follows:

(3) Copayments, Limitations, Exclusions and Restrictions on Service. In addition to the limitations and exclusions allowed in MHD 369(c)(2), a health maintenance organization may impose copayments for services or goods provided and may impose certain restrictions on services~~,~~. ~~such as on frequency or length of time a health maintenance service is provided.--Provided,-however-that all copayments,-limitations-and-exclusions-must-be-reasonable. The-express-policy-of-the-Board-is-to-favor-limitations-rather-than exclusions,-and-the-Board-may-limit-the-extent-of-limitations and/or-exclusions-which-may-be-included-in-any-health-care-plan to-ensure-that-comprehensive-health-care-services-are-reasonably available-to-enrollees.--The-standard-of-reasonableness-shall-be applied-in-full-consideration-of-the-general-concept-that-a-health maintenance-organization-must-provide-comprehensive-health-maintenance-services-in-exchange-for-a-single,-prepaid-sum.~~ Any such provisions must clearly be stated in the evidence of coverage in compliance with Minn. Stat. §62D.07, Subd. 3(b)~~.~~ and comply with the following standards:

(aa) Limitations and Exclusions. There may be no limitations or exclusions other than those allowed by the statutes or in rules promulgated pursuant to Minn. Stat. §62D.20. Where exclusions are allowed, it is the express policy of the Board to favor limitations rather than exclusions and the Board may limit the extent of limitations and/or exclusions which may be included in any health care plan to ensure that comprehensive health care services are reasonably available to enrollees. The standard of reasonableness shall be applied in full consideration of the general concept that a health maintenance organization must provide comprehensive health maintenance services in exchange for a single, prepaid sum.

(bb) Restrictions. Reasonable restrictions other than limitations, exclusions and copayments are permissible. These include, but are not limited to restrictions on the frequency or length of time a health maintenance service is provided (example: repeated, frequent physical exams), or the denial of a service that is not reasonably required to maintain the enrollees in good health (example: physical exams requested only for the protection or convenience of third parties). The standard of reasonableness shall be applied in full consideration of the general concept that a health maintenance

organization must provide comprehensive health maintenance services in exchange for a single, prepaid sum.

(cc) Copayments. Reasonable copayments as defined in Minn. Reg. MHD 367(k), are allowed. The standard of reasonableness shall be applied in full consideration of the general concept that a health maintenance organization must provide comprehensive health maintenance services in exchange for a single, prepaid sum. Based on this measure of reasonableness, copayments shall be deemed reasonable and shall be approved by the Board upon the proper filing of a contract and evidence of coverage containing copayment provisions which comply with the following:

(i) Any amount or form of copayment may be imposed on services that, pursuant to MHD 369, may be excluded completely;

(ii) Copayments, other than those imposed pursuant to MHD 369(c)(3)(cc)(i) above and other than those for drug benefits, emergency care and out-of-area services, may not exceed twenty-five percent (25%) of the costs or charges for a particular service. In the case of emergency care by providers who do not have an arrangement with the health maintenance organization, and in the case of out-of-area services, copayments may be imposed, either on specific services or in the aggregate, in the form of a reasonable "deductible," plus a twenty-five percent (25%) "coinsurance" feature, plus all charges which exceed a specified annual aggregate amount not less than $25,000.00. In the case of drug benefits, a health maintenance organization may impose reasonable copayments as approved by the Board upon filing of the contract provision.

(iii) There may be no copayment imposed on preventive health care services as defined in MHD 367(e)(5) including, but not limited to, the administration of immunizations, well baby care, periodic screenings and prenatal care, provided that this prohibition against copayments on prenatal care shall not be construed to prohibit a copayment on maternity services in general, which may include prenatal care.

Sec. 2. MHD 369(g) is amended as follows:

(g) Effective date of Operating Requirements. When changes are required in existing evidences of coverage or health maintenance contracts in order to implement the provisions of these rules, such changes shall be implemented upon the renewal date of

such documents commencing with the first renewal after 60 180 days after the effective date of these rules. New contracts or evidences of coverage to be implemented after 60 180 days after the effective date of these rules must be in compliance with these rules upon implementation.

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Annual Reports. In addition to all other information specified in the Act, every health maintenance organization shall include in its annual report to the Board the following:

(a) The results of any and all elections conducted during the preceding calendar year relative to consumer representation on the health maintenance organization's governing body.

(b) A copy of the health maintenance organization's most recent information summary provided to its enrollees in accordance with Section 62D.09 of the Act.

(c) A description of the method and results of the system to evaluate the quality of health services. Such evaluation shall include, but not necessarily be limited to, study of the quality of care for at least one disease condition or age group.

(d) A schedule of prepayment charges made to enrollees during the preceding year and any changes which have been implemented or approved up to the reporting date.

Sec. 4. MHD 372(a) is amended as follows:

(a) Termination of Coverage

(1) Justification. In addition to those reasons specified in Section 62D.12, Subdivision 2 of the Act, a health maintenance organization may, upon thirty (30) days notice, cancel or fail to renew the coverage of an enrollee if such enrollee:

(aa) Knowingly gives false, material information at the time of enrollment relative to his health status, provided such cancellation or non-renewal is made within six (6) months of the date of enrollment.

(bb) Moves out of the geographic service area filed with the Board, provided such cancellation or non-renewal is made within one (1)

year following the date the health maintenance organization was provided written notification of the address change.

Sec. 5. MHD 374 is amended as follows:

MHD 374 Periodic Filings

~~(a)--Filing-Requirements.--Any-filings-that-are-required-by-Minn.-Stat.-§§62D.07,-and-62D.08,-Subd.-1,-and this-rule-must-be-filed-with-the-Department-of-Health-no later-than-ten-days-prior-to-the-second-Thursday-of-each month,-which-is-the-regular-meeting-date-of-the-Board, unless-there-is-an-important-and-unexpected-circumstance which-requires-filing-on-a-different-date.--If-such-circumstance-exists,-the-filing-must-include-a-statement describing-the-circumstances-and-the-urgency-of-the-Board's attention-to-the-filing.~~

(a) Filing Requirements. Required filings will be acted upon at the next official meeting of the Board of Health following the filing date, provided the filing date is at least fifteen (15) days before said meeting. Exceptions to the requirement for filing fifteen (15) days in advance of a meeting will be made upon the filing of a statement of urgency and the circumstances involved.

(b) Provider Agreements. The provisions of Minn. Stat. §62D.08, Subd. 1 shall apply to any substantive modification in any agreement with providers as described and required for filing in MHD 368(e).

(c) The filing of any contracts or evidences of coverage pursuant to Minn. Stat. §62D.07 or §62D.08, Subd. 1, shall be accompanied by sufficient evidence on cost of services on which copayments are being imposed so as to allow the Board to determine the impact and reasonableness of the copayment provisions.

(d) Service Area. The filing of amendments to an H.M.O.'s geographic service area pursuant to Minn. Stat. §62D.08, Subdivision 1, and §62D.03, Subdivision 4(i) must contain sufficient supporting documentation of service area, facility and personnel availability and accessibility and existing community standards in receiving health care in other health care delivery systems so as to allow a determination of compliance with MHD 369(d).

(e) Upon receipt of any filing under Minn. Stat. §62D.07, §62D.08, Subd. 1 or MHD 374, the Board may request such additional data as is reasonably necessary to determine legal propriety of the filed material. Failure of a health maintenance organization to provide such data as required by MHD 374 or requested by the Board pursuant to this rule shall result in disapproval of the filing.

Sec. 6. MHD 375 is amended as follows:

MHD 375. Improper Practices

(a) It shall be an improper practice for a health maintenance organization to advertise or market its operation by making qualitative judgment or statements concerning any health professional who provides services for a health maintenance organization.

(b) A health maintenance organization shall not enroll a person who resides outside the health maintenance organization's defined service area, unless the health maintenance organization and prospective enrollee sign a statement of understanding. Such statement of understanding shall summarize the terms and conditions for provision of comprehensive health maintenance services and list the locations at which such services may be obtained.

STATE OF MINNESOTA
OFFICE OF HEARING EXAMINERS

FOR THE MINNESOTA STATE BOARD OF HEALTH

IN THE MATTER OF PROPOSED AMENDMENTS RELATING TO HEALTH MAINTENANCE ORGANIZATIONS.

REPORT OF THE ACTING CHIEF HEARING EXAMINER

WHEREAS, a hearing was held on May 7, 1976, before Steve M. Mihalchick, a Hearing Examiner of the State Office of Hearing Examiners, on the abcve-entitled matter in compliance with Minn. Stat. §15.0412, Subd. 4; and

WHEREAS, the Report of Hearing Examiner made pursuant to Minn. Stat. §15.052, Subd. 3, was issued to the State Board of Health on June 25, 1976; and

WHEREAS, the State Board of Health has now determined to adopt rules pursuant to Minn. Stat. §15.0412, Subd. 4; and

WHEREAS, the State Board of Health has submitted said rules to the Acting Chief Hearing Examiner for review pursuant to Minn. Stat. §15.052, Subd. 4, and Rule HE 107; and

WHEREAS, the Acting Chief Hearing Examiner finds that there are no substantial changes in said rules as originally proposed.

NOW, THEREFORE, upon receipt of this Report, the State Board of Health has the responsibility of submitting the complete hearing record and the rules as adopted by the Board to the Attorney General and to publish in the State Register, all pursuant to Minn. Stat. §15.0412, Subd. 4.

Dated this 22nd day of September, 1976.

Duane R. Harves

DUANE R. HARVES
Acting Chief Hearing Examiner

BEFORE THE OFFICE OF HEARING EXAMINERS

OF THE STATE OF MINNESOTA

IN THE MATTER OF PROPOSED AMENDMENTS RELATING TO HEALTH MAINTENANCE ORGANIZATIONS.	H.E. DOCKET NO. HLTH-76-013-SM

Board Room
Minnesota Health Department
Building
717 Delaware Street S.E.
Minneapolis, Minnesota
Friday, May 7, 1976

Met, pursuant to notice, at 1:30 o'clock in the afternoon.

BEFORE:

STEVE M. MIHALCHICK, Hearing Examiner

APPEARANCES:

JOHN A. BREVIU, Special Assistant Attorney General, appearing on behalf of the Minnesota Department of Health.

KENT PETERSON, appearing on behalf of the Minnesota Department of Health, HMO Unit.

I N D E X

STATEMENTS	PAGE
Doug Shaw	14
Doug Westervelt	26
Robert Ditmore	33

E X H I B I T S

NUMBER	MARKED	RECEIVED
Exhibits A thru J, inclusive	(Previously marked)	7
Hearing Exhibit No. 1	7	7
Hearing Exhibit No. 2	7	8
Hearing Exhibit No. 3	7	8
Hearing Exhibit No. 4	7	8
Hearing Exhibit No. 5	14	15

P R O C E E D I N G S

EXAM. MIHALCHICK: This hearing will come to order. My name is Steve M. Mihalchick, and I'm a Hearing Examiner from the Office of Hearing Examiners, State of Minnesota.

Available at the front of the room, as you came in, were the agenda and guidelines for the conduct of this hearing. I'll review those briefly, and we will follow that agenda today.

Has everyone signed the register?

First I'll ask the panel to introduce themselves.

MR. BREVIU: My name is Jack Breviu, I'm with the Attorney General's Office, and I represent the Department of Health.

MR. PETERSON: My name is Kent Peterson, I'm with the Department of Health, HMO Unit.

EXAM. MIHALCHICK: I'll briefly go through the agenda. Following this explanation, we will receive the jurisdictional documents, and then Mr. Peterson and Mr. Breviu will make the agency presentation; we will then take questions and statements from the interested people present, and then I'll close the hearing.

Everyone here is required to sign the register,

and everyone has indicated that they have done so.

The purpose of this hearing is to consider whether the proposed rules should be adopted and given the force of law as if adopted by the legislature itself.

The agency must document its specific statutory authority to take the proposed action; show that it has fulfilled all the relative and substantive procedural requirements of law or rule, and demonstrate the need for and reasonableness of its proposed action.

All persons present will have a chance to express their views.

I should explain the procedure for adoption of the rules in the state now. Of course, the rules have been drafted. Subsequent to this hearing the record will remain open for 20 days and during that period anyone may submit written comments to me -- my address is shown on the back of the agenda sheet -- and those must be received at my office by May 27th at 4:30. After that I will issue a report to the agency, taking note of how well they did and whether they did affirmatively demonstrate their authority, the reasonableness of the rule, and the need for the rule. The agency will then decide, and to adopt the

rule either as proposed or as amended; they will return it to the Office of Hearing Examiners where the Chief Hearing Examiner checks it to make sure that there are no substantive changes from the proposed rules. If there are, he may require that a separate hearing be held on those substantive changes. The rules are then submitted to the Attorney General who makes a final determination as to the legality of the rule, and then it's submitted to the Secretary of State, at which time it's effective. Unless that's after July 1st, in which time it has to be filed in the State Register, and it won't be effective for 20 days after that.

Have all the people that have come in registered?

VOICE: No, I haven't.

EXAM. MIHALCHICK: There is a register on the table right behind you: if you would sign in, please.

On April 12th the Board filed with me the documents required, and they have been available for inspection at my office since April 12th. I would note that nobody has inspected them. They include the following exhibits:

Exhibit A, which is the order for hearing,

signed by Dr. Lawson; Exhibit B is the notice of hearing which was mailed to interested persons; Exhibit C is the affidavit that a representative of the Department received a list of names from the Secretary of State of interested persons; Exhibit D is the affidavit that the notice was mailed to those persons who indicated their interest on the Secretary of State's list; Exhibit D-1 is an amended affidavit of mailing stating the same thing -- the original affidavit had stated that the Secretary of State's list was attached and it was not, and it was amended; Exhibit E is the statement of need required under the rules of Hearing Examiner; Exhibit F is an affidavit of mailing that on the 10th of December, 1975 a notice of intent to obtain information on proposed rules was mailed to interested persons; Exhibit G is the copies of the materials received in response to that notice; includes a letter from Med Center Health Plan; a letter from Target Stores, Incorporated; a letter from Northwestern National Life Insurance Company, and a letter from Group Health Plan, Incorporated. Exhibit H is a statement of the agency personnel who will appear, which is also required by Hearing Examiner rules, and Exhibit I was a summary of evidence or

justification for the proposed rules.

One other document or set of documents was filed prior to the hearing, and that was the -- is Exhibit J which are the preliminary filings requesting a hearing by the Office of Hearing Examiners.

Mr. Breviu, would you offer those in evidence or so move?

MR. BREVIU: I would offer Exhibits A through J into evidence at this time, Mr. Hearing Officer.

EXAM. MIHALCHICK: They will be received.

(Exhibits A through J inclusive received in evidence.)

(Hearing Exhibits Nos. 1, 2, 3 and 4 marked for identification.)

EXAM. MIHALCHICK: I have had marked Exhibit 1 which is a copy of the agenda and guidelines, and that will be received in evidence.

(Hearing Exhibit No. 1 received in evidence.)

EXAM. MIHALCHICK: Mr. Breviu has also had marked the original copy of the notice of hearing, that's Exhibit 2; a certificate from the Secretary of State verifying the list of names that was given on March 18, 1976 is Exhibit 3, and

Exhibit 4 is the certificate of the Board's Authorizing Resolution.

MR. BREVIU: Mr. Hearing Officer, I would request that Exhibits 1 through 4 be accepted into evidence at this time.

EXAM. MIHALCHICK: Exhibit No. 1 has been received. Exhibits 2, 3, and 4 are received in evidence.

(Hearing Exhibits Nos. 2, 3, and 4 received in evidence.)

EXAM. MIHALCHICK: We will now move into the real part of this hearing, and Mr. Peterson will present the agency's rationale and justification for adopting these rules. He's indicated to me that he wishes to take them section by section. Anybody who wants to ask a question may interrupt at any time, or if you wish to wait until the end of a section, you may do that. If you do wish to ask a question, I'd ask that you state your name so that we may get it on the record.

Mr. Peterson.

MR. PETERSON: Mr. Hearing Officer, the proposed amendments to the HMO rules, which we are considering today, are organized in six sections.

The first section has to do with the

standards relating to HMO copayments, limitations, exclusions, and restrictions on services. The existing section of rules is reorganized and there is additional clarification and more specific lanaguage used in the proposed amendments. The section on limitations and exclusions, which is item (aa) on Page 1 of the proposed amendments, is a restatement and clarification of what is -- is in the rules as -- at this time. We also restate and clarify restrictions which is item (bb) on Page 1. The copayment section, which is small (cc) on Page 2 has substantially different language than the previous rule. This new rule proposes three standards for acceptance of reasonable copayments. The first standard is that when the copayment is being imposed on services that are not required under Minnesota laws or rules, there shall be -- the reasonableness shall be considered without the 25 percent standard which is stated later in the rules. For services which are required under the statute and rules, other than drug benefits, emergency care, and out-of-area services, the standard of reasonableness shall be 25 percent of the cost or the charges for the particular service. Also excluded from this section

are services which shall be deemed to be preventive health care services as identified in the law and rules. These amendments are considered to be necessary to provide a simpler method for Minnesota HMO's to develop service contracts. The existing law does not provide sufficient explanations so that HMO's may develop a contract with the potential purchaser, and we feel that it is fair that they have additional definition.

The justification, which is being presented today in written form, and which I shall not read completely, does mention the literature which does not show any detrimental effect on the health status of enrollees when copayments are imposed on the services which are mentioned in the rules. We do feel that there would be potential detriment to the health status of individuals, and it would not be consistent with the intent of the law to have copayments imposed upon preventive health care services.

The literature which is presented in the justification explains this objection to copayments on preventive health care services.

That is the summary of the section one on

copayments, and I would ask that the entire justification be entered into the record.

EXAM. MIHALCHICK: The justification has already been received into the record and is part of the record.

Are there any comments or questions, either pro or con, on the proposed amendment to Rule 369(c)(3)?

(No Response)

EXAM. MIHALCHICK: I see none. Why don't you continue to section two.

MR. PETERSON: Section two identifies a longer length of time for the effective date of operating requirements. The previous rule stated that new contracts or evidence of coverages shall be implemented within 60 days after the effective date of rules. This new proposal is for the effective date to be 180 days after the rules are adopted.

EXAM. MIHALCHICK: Are there any comments on this proposed change to Rule 369(g)?

(No Response)

EXAM. MIHALCHICK: I see none.

MR. PETERSON: Section three adds a new item which is needed by the Board in annual reports. The new item is the schedule of prepayment charges

and the Board feels that this information is needed for the Board's examination of financial stability and on costs information for the Board to properly regulate Minnesota HMO's.

EXAM. MIHALCHICK: Are there any comments on Rule 371, the proposed amendment?

(No Response)

EXAM. MIHALCHICK: I see none.

MR. PETERSON: Section four of the amended rule amends MHD 372 (a) and adds the additional justification for termination of coverage. We state that the HMO may only terminate an enrollee for moving out of the service area within one year after the HMO was notified of the address change.

We feel that this additional grounds for termination is necessary so that individuals would not be carried with -- on HMO enrollment and only dropped for grounds other than moving out of the service area. There would be possible discrimination against people with high utilization if this rule were not enacted.

EXAM. MIHALCHICK: Are there any comments on the proposed change in 372(a)?

(No Response)

EXAM. MIHALCHICK: Seeing none, proceed with the next section.

MR. PETERSON: Section five amends MHD 374 and requires certain other information to be filed with the Board of Health at times of filing of contracts or geographic service area or other filings. The Board feels that it's necessary to have full information and documentation of required filings so that the judgment may be made with full knowledge of the effect of filings.

EXAM. MIHALCHICK: Are there any comments on the proposed amendments to Rule 374?

(No Response)

EXAM. MIHALCHICK: Seeing none, let's move to the last section.

MR. PETERSON: The last section is amendment to MHD 375 and adds another standard of improper practice. This is a clarification of existing interpretation of the law, and states clearly that no HMO may enroll a person who lives outside of the geographic service area of the HMO unless a statement of understanding has been reached by the individual and the HMO, and such signed document is kept by the HMO.

EXAM. MIHALCHICK: Are there any comments on Rule 375?

(No Response)

EXAM. MIHALCHICK: Are there any comments on any of the rules or the rules in general?

VOICE: May I sit up here?

EXAM. MIHALCHICK: Sure. Would you state your name and any person or agency you represent, if so.

MR. SHAW: My name is Doug Shaw, I'm Executive Director of the Physicians Health Plan of Greater Minneapolis, and I am presenting testimony this afternoon on not only on behalf of my own organization, but also on behalf of the MedCenter, Nicollet-Eitel, Ramsey and Share Health Plans. I have signed written testimony that I'd like to -- to leave with you this afternoon also.

EXAM. MIHALCHICK: Are you going to summarize that for us?

MR. SHAW: If I could, please.

EXAM. MIHALCHICK: Let me first have the Reporter mark that, please, as an exhibit.

(Hearing Exhibit No. 5 marked for identification.)

EXAM. MIHALCHICK: Exhibit 5 is received.

(Hearing Exhibit No. 5 received in evidence.)

EXAM. MIHALCHICK: Mr. Shaw, could you give us an oral summary of that?

MR. SHAW: All right. If you'll bear with me, I would like to read the letter, and I think it presents a carefully prepared and complete statement of some of our concerns about the proposed regulations. I will then paraphrase and summarize comments of ours concerning the regulations as they are actually proposed.

"In general, it is our position that the proposed rules are unnecessary. While we recognize the need to clarify existing rules and regulations, we believe that the proposed new rules merely add further to the confusion which has existed since the passage of the HMO Act in 1973 and serve to unnecessarily complicate the ability of HMO's to deliver quality health care to citizens of Minnesota.

"Our first concern is that the legislative intent as described in 62D.01 subdivisions 2(a), 2(b), and 2(c) is not being fulfilled by the regulatory posture which has been adopted by the Board. It is our understanding that the purpose of the regulations is to carry out the intent of the legislature as stated

in the aforementioned subdivisions. We take these passages to mean that it is the policy of the State of Minnesota to (a) 'remove the barriers to the formation, promotion, and expansion of health maintenance organizations,' (b) 'to provide for their regulation by the State Board of Health,' (c) 'to exempt them from the operation of the insurance and non-profit health services plan corporation laws of the state...' and (d) '...to closely monitor the development of health maintenance organizations in order to assess their impact on the cost of health care to consumers, the accessibility of health care to consumers, and the quality of health care provided to consumers.'

"If the goal of the legislation is to make HMO's available to the people of Minnesota, then the goals of the regulations must be to allow HMO's to develop without encumbering them with strict requirements as to permissible organizational formats or the benefits they must offer.

"We feel that the Board can better carry out the expressed policy of the legislation by concerning itself more with assuring that HMO's do not misrepresent themselves to their enrollees or to

potential enrollees. We believe it is imperative to remember that no one is forced to join an HMO. Rather, each person has the right to choose between or among an indemnity insurance plan, a Blues plan, and one or a number of HMO's. Therefore, it should be the Board's primary concern to make sure that each potential enrollee is presented with a clear and concise statement of what the HMO proposes to offer in order that the enrollee may make an intelligent and rational decision. To that end, it should be the Board's policy to be flexible in dealing with HMO's, allowing them to set benefits within very broad parameters so long as they are well defined to prospective buyers.

"It is also important to remember that it was envisioned by those sponsoring the HMO legislation that HMO's--as organized health care systems--would compete in the marketplace. We feel that the Board must set broad parameters because strict regulation will frustrate one of the most important principles behind the development of HMO's, that of market competition.

"Finally, one of the effects of strict regulation is to fail to recognize the different

wants and/or needs of the various enrollee populations to which HMO's must appeal. For instance, while some copays may act as a barrier to care for certain enrolled groups, the high premium cost of an HMO without copayments may, in fact, act as a barrier to a larger group of enrollees who wish to join an HMO.

"A second general concern relates to the overall approach that the Board has taken in the past and in the proposed regulations. The burden of proof has been with an HMO to show that what the HMO proposes to do is not illegal. Furthermore, the Board has adopted the position that in the absence of a specific rule allowing an action, such action is assumed to be per se illegal. We believe that such a system denies the HMO due process. Worse yet, this approach stifles the opportunity for HMO's to be innovative. It is impossible for the Board to anticipate every public need and proactively promulgate a rule which permits HMO's to be responsive to existing and emerging public needs. Instead of concentrating on how to meet the requirements of our various publics, HMO's unfortunately now have to ask 'what is permissible under the rules.'

"It is our belief that an HMO's filing should be accepted unless the Board can demonstrate in a clear and concise manner that what the HMO proposes is contrary to public law. Therefore, we propose that regulations be changed to require that, in the event that an HMO's filing is not accepted, the Board must provide written statement describing the grounds on which the denial was made.

"Finally, to the extent that regulations are deemed necessary, the Board has an obligation to make them clear and concise. To that end, statements which appear in both the existing and proposed regulations such as 'the Board may request additional data as is reasonably necessary to determine,' or 'preventative health care services...including, but not limited to,' must be replaced with clear and concise descriptions and/or definitions of what these terms mean and require. It is imperative that as businesses we know more definitely the boundaries within which we must live. Vagueness or ambiguities in the regulations only serve to make the task of complying with regulations more difficult and unnecessarily raise the cost of health care, which consumers ultimately bear. In addition, such variations and/or vagueness foster inconsistent

regulation on the part of the Board when considering one HMO's contract versus the same contract or concept at a later date. And finally, variations and/or ambiguities in the regulations cause a great deal of uncertainty when we are in the marketplace attempting to serve the specific needs of our buyers."

What I would like to do now for you is to present proposed comments of our own or recommendations concerning the regulations that are proposed for promulgation, to identify how these might differ from those as presented in the written statement that we've been given, and to present our rationale briefly concerning each of the areas.

First, in regard to Section 1, MHD 369(c)(3), this section concerns copayments, limitations, exclusions, and restrictions on service, I would like to read this as we would propose it be passed. "In addition to the limitations and exclusions allowed in MHD 369(c)(2), a health maintenance organization may impose copayments for services or goods provided and may impose certain restrictions on services, such as on frequency or length of time a health maintenance service is provided. However, any such copayment, limitation or exclusion must

be clearly stated in the evidence of coverage in compliance with Minnesota Statutes 62D.07, Subdivision 3(b)."

What we have done is to take a portion of the regulation as it now exists in the first sentence to suggest that the word "such as on frequency or length of time a health maintenance service is provided" remain in the regulations, and then we've suggested and are recommending that the new proposed subsections (aa), (bb), and (cc) be eliminated and not included with the regulation. We -- it is our position that the new subsections to this rule are unnecessary and introduce inefficiencies of regulatory pricing in place of market-determined prices. By not allowing HMO's the full flexibility of pricing in response to the spectrum of market demands, the Board assures that invariably some segment of society will be underserved.

In regard to Section 3, MHD 371(d), we are recommending that the second half of that sentence be deleted, so that the new proposed rule (d) now would read as we recommend: "(d) A schedule of prepayment charges made to enrollees during the preceding year."

We are concerned that references in the regulation concerning presentations of scheduled prepayment charges might eventually lead to or be a prelude to premium regulation, and in this sense we are most definitely concerned. In the same instance we understand the concern of the Board for information concerning our prepayment charges and do not oppose the intent of the law as we understand it, but would recommend it with the change as we have indicated here.

Under Section 4, MHD 378--excuse me--372(a), we are recommending also the addition of a new regulation, (cc), which would read: "Abuses of the delivery system by repeated failing to keep scheduled appointments, or refusing to accept prescribed treatment provided that the enrollee is given three-month notification of the intent to cancel or not renew coverage if such negligence continues."

This proposed regulation concerns termination of coverage and represents again our concern that as health maintenance organizations and organized delivery systems, our enrollees have certain obligations to the HMO concerning the manner in which they seek and utilize services under our program,

and we feel very strongly that such a regulation is desirable.

In regard to -- excuse me -- in place of Section 6, MHD 375(b), as it's now stated, we have replaced this with a proposed regulation that would read: "Upon receipt of a signed application, at its discretion an HMO may enroll a person living outside its service area."

It's our feeling that prospective enrollees contemplating participation in health maintenance organizations in fact do receive various extensive notifications of benefits provided under these programs, and especially location of facilities. We feel that the rule as proposed presents some unnecessary duplication and very definitely would be administratively burdensome and costly to carry out. This also -- this rule also as proposed by us is consistent with our feeling that HMO enrollees make the decision to participate in a plan based on factual definitive information that they're provided.

This is the end of my testimony. I would be glad to answer questions, or we have representatives of each of the organizations present that I'm sure could comment also.

EXAM. MIHALCHICK: Before I have Mr. Peterson or anyone else comment, I would like to point out that such changes as you recommend, if they are substantive changes, for example, the additional provision on -- to Rule 372, the abuses of the system, that I think is a substantive change or something that's not in the proposed rules. As such, that would require a separate hearing. Even if Mr. Peterson, say, were to agree with that and would want to adopt it as part of these rules, I think something like that would be a -- would require a separate hearing.

With that in mind, Mr. Peterson, would you comment, or do you care to comment?

MR. PETERSON: Yes. In regard to your first recommendation on copayments, I think that I'd like to remind you that the law does state that the Board shall review filings for reasonableness of copayments. Now, there would be no definition of reasonableness in your proposed wording. Reasonableness would then refer -- would go back to the statute and we would have no standards for determining what is reasonable and what is not unreasonable. Would you like to comment on how the Board should determine reasonableness?

MR. SHAW: It's our feeling, in regard to copayments, that the factor of reasonableness is one that's determined by the potential group purchasing health maintenance organization programs or potential enrollees; that each individual enrollee prospective, based on information provided to them by the HMO, which describes benefits, exclusions, limitations, and copayment charges, can make a determination on their own behalf as to whether they want to enter into a relationship with that HMO in consideration of these factors.

We feel very strongly that the rule of reasonableness is not one that can be put into formulas as proposed -- under the proposed regulations.

MR. BREVIU: Excuse me, if I could follow up on that. Are you suggesting that the Board of Health has no role to play in determining whether a proposed contract contains reasonable copayment provisions?

VOICE: I'd like to comment on that as well, to follow up on your question.

EXAM. MIHALCHICK: You want to come up right now?

VOICE: Sure.

EXAM. MIHALCHICK: Maybe bring up another chair, if you would like, and identify yourself.

MR. WESTERVELT: My name is Doug Westervelt, I'm Executive Director of the Nicollet-Eitel Family Health Plan.

EXAM. MIHALCHICK: How do you spell your last name?

MR. WESTERVELT: W-e-s-t-e-r-v-e-l-t.

EXAM. MIHALCHICK: You wish to respond to Mr. Breviu's question?

MR. WESTERVELT: Yes. As I understand it, the law provided no provision for the Board to regulate rates, meaning the capitation charges, and I would like to remind you and the Board that -- of some of the factors of realities of running a health maintenance organization, as relates to this specific topic, that is, that revenue, which we as organizations take in, is really a function of price times the quantity or the units which we deliver. Prices are composed of two elements: one is our capitation rates and the other element is copayments.

EXAM. MIHALCHICK: Excuse me, what is capitation?

MR. WESTERVELT: That is the prepaid charges

which we charge for delivering services.

MR. BREVIU: The monthly sum.

MR. WESTERVELT: Right, the monthly sum.

MR. BREVIU: Charged enrollees.

MR. WESTERVELT: Right. So what I'm saying to you is that our total revenue is a function both of copayments and capitation rates.

In the long run for a health maintenance organization or any organization, business organization to exist, revenue is going to have to equal expenses. It's an accounting -- it's a fact of life, it's an accounting truism.

If you regulate copayments, you also in effect directly regulate rates, because as it must, as the equation must balance, it's a basic accounting equation, if you impose limitations on what we can do with respect to copayments, the only other way that we can adjust for that is in the capitation rates -- you directly affect capitation rates.

So I think, in answer to your question, that I think there is a role, the law provides a role for the State Board of Health to, in fact, review or -- copayments for standards for reasonableness, but the market really suggests what reasonableness is,

and unless we are substantially out of line with what the market is -- and, after all, there are fairly sophisticated buyers, not only just to consumers, but employee benefits managers looking at these things as well, and I think that except for some very extreme cases that the specific regulations which have been proposed, and we're having testimony on today, would in fact inhibit the operation of market -- of the market, in effect to attempt to substitute inefficient regulatory pricing, pricing in the full sense, pricing not only with respect to reviewing copayments, but pricing with respect to, in effect, setting capitation rates, and I think that is improper, as the law did not provide for the Board to set capitation rates.

MR. PETERSON: Mr. Shaw, do you have any comment?

MR. SHAW: I didn't have a chance to see the specific articles that you referred to, and I think in support of the copayment concept.

In my personal review of the literature, I think there are as many articles that I've seen that would suggest barriers to people seeking care because of the presence of a copayment as those that

have not -- have failed to show that relationship existing.

I think it is not clearly demonstrated in the literature that copayments necessarily are a barrier to care, people seeking care. I think the only thing that's been definitively proven in the literature is the fact, that Mr. Westervelt referred to, and that is there is a direct relationship between sharing in the cost of a product and the total price of that product as it's presented to groups.

MR. WESTERVELT: I would also like to point out that if we are attempting to -- if the Board is attempting to get at the standard of reasonableness, what is reasonable for one market or one of our publics, and, after all, if HMO's are going to fulfill the visions for which they were enacted, they are going to have to serve many different publics, and what is reasonable for one particular group, as we point out in our covering letter, might be unreasonable for a different public, and to uniformly establish point type or a -- point types of rules saying 25 percent is reasonable, assures that invariably the Board will -- invariably

assure that some public is, in fact, underserved. The only way that we can effectively assure that the public is served, and that, in fact, we will have reasonable rates for all different publics which we must serve, is to allow the market to play that role.

MR. BREVIU: You indicated earlier, though, did you not, that the Board does have some role to play with regard to the review of reasonable copayment provisions as opposed to and distinguished from capitation amounts?

MR. WESTERVELT: I said the law, as I understand it, the law provides for that, that's right.

I'm saying that within very broad guidelines that, unless there is something brought to the attention of the Board where it's a very unusual circumstance, that it seems to me that the real, the standards of reasonableness would be set in the marketplace rather than by trying to substitute regulatory pricing for market pricing.

MR. SHAW: We've had a somewhat unique situation in the State of Minnesota, too, in that the minimum required benefits which must be offered

by HMO's are probably as extensive as you would see anywhere in the country. They, in fact, in many instances, far exceed the requirements as stated in the federal HMO laws. An example of that is our requirement that Minnesota HMO's must provide coverage for the outpatient prescription medication. The fact that the minimum benefit levels have been set at this extensive rate again gets back to the point that these things are, in fact, prepaid benefits; the overall cost of the HMO plans then float beyond which you might normally find with regular forms of group health insurance, or Blue Cross, Blue Shield, and we again, I think, feel very strongly these benefits are appropriate, but at the same sense we need flexibility as organizations, as marketing and business organizations, to be able to utilize various types of rating and other financial strategy to present a price to our potential buyers that is, in fact, competitive with other segments of the market, group health insurance in particular.

EXAM. MIHALCHICK: You have any comments on any of the other provisions that he raised?

MR. PETERSON: No, I have no other questions.

MR. BREVIU: One point I'd just like to

clarify for the record. In your cover letter on Page 2, referring to the fourth and fifth paragraphs, are you not actually addressing general problems of regulation in dealing with the Board of Health as opposed to the specific rules that we are concerned with right now at this hearing?

MR. SHAW: Yes, I think we are.

EXAM. MIHALCHICK: Mr. Shaw, I take it that you have no argument with the changing of 60 to 180.

MR. SHAW: No.

MR. PETERSON: I think I have one other question. Have you in the past found that there's been a lack of clarity in the law and the rules in regard to copayments?

MR. SHAW: I'm going to have to address personally on this. I think, yes. I think each -- well, we in particular, and I suspect other HMO's in Minnesota, have found instances where, because of the way a copayment was stated as permissible in the regulations or not addressed at all, that we found ourselves in a position of potential -- let's see --

VOICE: Mr. Chairman, may I join this group

and offer some testimony?

EXAM. MIHALCHICK: All right. What is your name?

MR. DITMORE: My name is Bob Ditmore, I'm president of the Share Health Plan.

On the issue of reasonableness, Mr. Peterson, I think that, and also Mr. Breviu, I think on the issue of the test of reasonableness, I'd like to point out that, and remind the Board, that this is an infant industry. I think the intent of the legislation was to try to let HMO's develop and prosper in the state. I think the point that we are trying to make here is that they can not develop and prosper as an infant industry, particularly new companies, new organizations within that infant industry, if they're going to be constrained by very strict rules.

You mention -- you raise the question about what test of reasonableness can the State Board of Health apply to the issue of copayments, and that's an excellent question. I think it's something that's going to have to develop over a period of time, and I would suggest that what the State Board of Health do at a minimum is look at the experience in the rest of the industry, both within the state and particularly

outside of the state. There is a tremendous body of evidence that indicates the copayments have been used for 25 years with the major HMO's in the business -- Kaiser, the Harvard Plan, Group Health in St. Paul, and group health associations around the country. There is absolutely no evidence to indicate that co-payments are a barrier to health -- excuse me, are a barrier to the quality of health care. There is absolutely no evidence.

We studied this, we've done a study of the literature, and I would defy anybody to come up with any conclusive evidence that copayments affect the quality of health care. There is plenty of evidence that copayments are used frequently in the industry, and I would suggest that the State Board of Health attempt to educate itself, and it is an education process, both on our part and I think on the part of the State Board of Health. But to impose rigid regulations, such as what have been proposed, is really the wrong approach.

The other point I would like to make to demonstrate this is the -- the major issue, I think, we're talking about here are copayments on office visits. Now, the Share Health Plan has the only

approved contract in the State of Minnesota that has a copayment on office visits -- it's a three-dollar copayment -- and that applies to one of our major groups, the Teamsters, which represents approximately 60 percent of our total membership -- it's approximately 6000 enrollees out of a total of 10,000, and the experience that we've had with that one group is that the utilization of the plan is almost identical to the balance of the patient population which has no copayments.

EXAM. MIHALCHICK: Mr. Peterson.

MR. PETERSON: I have no comment.

MR. BREVIU: Are you suggesting that that copayment provision would not have been approved by the Board of Health under the current rules that are proposed?

MR. DITMORE: Yes, I would have, and the reason I suggest that is that the three-dollar copayment was approved by the State Board of Health because of other factors in the contract. It included, for example, a very comprehensive dental program, a very comprehensive optical program, which went above and beyond the scope of most contracts. They approved the three-dollar copayment in the con-

text of these other additional benefits as being reasonable. My -- I suggest that that three-dollar copayment would not have been approved had these other benefits not been a part of the contract.

MR. BREVIU: Can you point -- I mean, is there any specific rule that's being proposed today that would prohibit the use of such copayment provision?

MR. DITMORE: I don't -- I can't forecast with any accuracy what the State Board of Health would do in any particular case.

To be specific as I can, however, I think the one objection that I have in the 25 percent role is that it excludes "service for preventive health care."

The question is how do you define preventive health care. It's almost impossible to administer within an HMO when a person comes up to the front desk,and a copayment is applicable generally to a physician visit or an office encounter, it's an administrative impossibility for a clerk to determine whether that particular visit is going to be for preventive service. It's an impossibility.

MR. PETERSON: Mr. Ditmore, would you say that three dollars is less than 25 percent of the

average total cost of an outpatient physician visit?

MR. DITMORE: Yes, it is.

EXAM. MIHALCHICK: Are there any further comments?

(No Response)

EXAM. MIHALCHICK: Are there any comments from any other members of the audience on any of the proposed rules or the rules in general?

(No Response)

EXAM. MIHALCHICK: I'd like to remind you that I will receive written documents within 20 days; they must be received within 20 days, which would be May 27th, and must be received at my office, and that is listed on the agenda.

You are also advised that under Minnesota Statutes, Section 10A.01, Subdivision 11, any individual representing persons or associations attempting to influence administrative action, such as the promulgation of these rules, must register with the State Ethics Commission as a lobbyist within five days of the commencement of such activity. If you have any questions on your status as a lobbyist, I would refer you to the Ethics Commission in the State Office Building.

Are there any further comments from any members of the panel?

MR. PETERSON: No.

EXAM. MIHALCHICK: Any members of the audience?

VOICE: Yes. I just have a question about the procedure from this point forward.

EXAM. MIHALCHICK: What's your name, please?

MR. HOEFS: John Hoefs, H-o-e-f-s, Minnesota Health Maintenance Network Plan.

EXAM. MIHALCHICK: What's your question?

MR. HOEFS: My question is one of procedure as to hence this meeting where -- where does the discussion go from here.

EXAM. MIHALCHICK: Okay. For 20 days the record will remain open. At the end of that period I will make a report in which I must determine whether each of the proposed rules, whether the agency has demonstrated that each of the proposed rules has statutory authority for its adoption, whether it's necessary, and whether it's reasonable. I then make a report back to this agency, and they must wait at least 10 days, and during that time my report will be available to anyone who's indicated with a

"yes" or a check mark on the registration sheet. My secretary will notify you when it's ready. After waiting 10 days, the Department can then or the agency will then adopt the rule; they may amend them, consistent with the testimony that comes in, and then there's two steps before they're finally approved. First, they return to the Office of Hearing Examiners where the Chief Hearing Examiner determines whether there's been a substantial change between the rule as adopted or as proposed. If there is, he will reject that part of the rule and require another hearing. Assuming it's approved there, it's submitted to the Attorney General who, within 20 days, has to approve it as being legal.

Public input can be received at any of those points.

After my report is issued, you can address letters to the agency; after they decide to adopt, you can then address information to the Attorney General if you don't believe the rules are legal as adopted. Once the Attorney General approves them, he files them with the Secretary of State, and then they're adopted.

MR. HOEFS: And when are they to be effec-

tive?

EXAM. MIHALCHICK: Okay. They will be effective immediately, if that happens before July 1st. After July 1st they have to be published in the State Register, which begins publication July 1st, and in which case they won't be effective for 20 days until after publication.

The whole purpose of all these rules now is to get the public input, and to make sure that the rules are fulfilling the legislative intent. My job is one step of that, and this hearing is one step of that. So I would like your input either now or within 20 days in writing.

Are there any further comments or questions?

(No Response)

This hearing will be adjourned.

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(Whereupon, the hearing was concluded at approximately 2:45 o'clock in the afternoon.)

RECEIVED
APR 12 1976
OFFICE OF HEARING EXAMINERS

RECEIVED
MAR 26 1976
OFFICE OF HEARING EXAMINERS

STATE OF MINNESOTA

COUNTY OF HENNEPIN

BEFORE THE MINNESOTA

STATE BOARD OF HEALTH

In the Matter of Proposed Amendments Relating to Health Maintenance Organizations

ORDER FOR HEARING

To effectively implement Minn. Stat. ch. 62D (1974) the Minnesota State Board of Health deems it necessary to consider adoption of the proposed amendments captioned above pursuant to the authority vested in it by Minn. Stat. § 62D.20 (1974).

NOW, THEREFORE, IT IS ORDERED this 23rd day of March, 1976, that a public hearing on the proposed rules captioned above be held in the Board Room, Minnesota Health Department Building, 717 Delaware Street S.E., Minneapolis, Minnesota, on May 7, 1976, commencing at 1:30 p.m., and continuing until all representatives of associations or other interested groups or persons have had an opportunity to be heard.

IT IS FURTHER ORDERED, that notice of said hearing be given to all representatives of associations or other interested groups or persons who have registered their names with the Secretary of State for that purpose and all persons who are presently members of the Minnesota Legislature.

STATE OF MINNESOTA

BOARD OF HEALTH

WARREN R. LAWSON, M.D.
Secretary and Executive Officer

Exhibit No. 4

File No. HEHM-76-0015-5

Date

STATE OF MINNESOTA

COUNTY OF HENNEPIN

BEFORE THE MINNESOTA

STATE BOARD OF HEALTH

In the Matter of Proposed Amendments Relating to Health Maintenance Organizations

NOTICE OF HEARING

Notice is hereby given that a public hearing will be held pursuant to Minn. Stat. §15.0412 Subd. 4 (1974), as amended by Minn. Laws 1975, ch. 380, in the above-entitled matter, in the Board Room, Minnesota Department of Health Building, 717 Delaware Street S.E., Minneapolis, Minnesota, on Friday, May 7, 1976, commencing at 1:30 P.M., and continuing until all representatives or other interested groups of persons have had an opportunity to be heard concerning adoption of the proposed rules captioned above by submitting either oral or written data, statements, or arguments. Statements or briefs may be submitted without appearing at the hearing.

Under Minn. Stat. §10A.01 Subd. 11 (1974) any individual engaged for pay or other consideration for the purpose of representing persons or associations attempting to influence administrative action, such as the promulgation of these proposed rules, must register with the State Ethics Commission as a lobbyist within five days of the commencement of such activity by the individual. The State Ethics Commission is located at 410 State Office Building, St. Paul, Minnesota 55155.

Pursuant to authority granted by Minn. Stat. §62D.20 (1974) the Minnesota State Board of Health proposes to adopt amendments to existing rules relating to the following matters:

(a) Amendment of MHD 369(c)(3) to establish more complete standards relating to H.M.O. copayments.

(b) Amendment of MHD 369(g) to change the effective date of these operating requirements from 60 to 180 days after the effective date of these rules.

(c) Amendment of MHD 371 to require an additional item of information in the annual report of an H.M.O.

(d) Amendment of MHD 372(a) relating to the termination of enrollees who move out of the area served by an H.M.O.

Exhibit No. B

File No. HLTH-76-013-SM

Date

(e) Amend MHD 374 to provide additional time for the board to consider H.M.O. matters upon which it will act at a monthly board meeting and to insure sufficient documentation of matters submitted for consideration.

(f) Amendment of MHD 375 relating to areas an H.M.O. may serve.

A copy of the amendments proposed by the Minnesota State Board of Health is attached and made a part hereof.

Copies of the proposed rules are now available and may be obtained by writing to Mr. Kent Peterson of the Minnesota Department of Health, 717 Delaware Street S.E., Minneapolis, Minnesota 55440. Additional copies will be available at the door on the date of hearing.

Testimony or other evidence to be submitted for consideration should be pertinent to the matter at hand and may be presented either orally or in writing at the public hearing or by mailing a statement to the Secretary and Executive Officer of the Board at the Department of Health Building, address above. If the person submitting a statement cannot be present to read his statement at the time of the hearing, the statement will be entered into the record. For those wishing to submit written statements or exhibits, it is requested that at least three (3) copies of such statement, exhibit or summary be furnished at the hearing. The record will remain open for receipt of briefs or other written material relative to the proposed rules for twenty (20) days subsequent to the public hearing.

It is suggested that to save time and avoid duplication, those organizations or associations having a common viewpoint or interest in these proceedings join together where possible and present a single statement in behalf of such interests.

Dated: March 23, 1976

STATE OF MINNESOTA

BOARD OF HEALTH

/s/ Warren R. Lawson, M.D.
WARREN R. LAWSON, M.D.
Secretary and Executive Officer

MINNESOTA DEPARTMENT OF HEALTH RULES
CHAPTER TWENTY-EIGHT

Proposed Amendments to Rules for
Health Maintenance Organizations

Section 1. MHD 369(c)(3) is amended as follows:

(3) Copayments, Limitations, Exclusions and Restrictions on Service. In addition to the limitations and exclusions allowed in MHD 369(c)(2), a health maintenance organization may impose copayments for services or goods provided and may impose certain restrictions on services~~,~~. ~~such-as-on-frequency-or-length-of-time a-health-maintenance-service-is-provided.--Provided,-however-that all-copayments,-limitations-and-exclusions-must-be-reasonable. The-express-policy-of-the-Board-is-to-favor-limitations-rather-than exclusions,-and-the-Board-may-limit-the-extent-of-limitations and/or-exclusions-which-may-be-included-in-any-health-care-plan to-ensure-that-comprehensive-health-care-services-are-reasonably available-to-enrollees.--The-standard-of-reasonableness-shall-be applied-in-full-consideration-of-the-general-concept-that-a-health maintenance-organization-must-provide-comprehensive-health-maintenance-services-in-exchange-for-a-single,-prepaid-sum.~~ Any such provisions must clearly be stated in the evidence of coverage in compliance with Minn. Stat. §62D.07, Subd. 3(b)~~.~~ and comply with the following standards:

(aa) Limitations and Exclusions. There may be no limitations or exclusions other than those allowed by the statutes or in rules promulgated pursuant to Minn. Stat. §62D.20. Where exclusions are allowed, it is the express policy of the Board to favor limitations rather than exclusions and the Board may limit the extent of limitations and/or exclusions which may be included in any health care plan to ensure that comprehensive health care services are reasonably available to enrollees. The standard of reasonableness shall be applied in full consideration of the general concept that a health maintenance organization must provide comprehensive health maintenance services in exchange for a single, prepaid sum.

(bb) Restrictions. Reasonable restrictions other than limitations, exclusions and copayments are permissible. These include, but are not limited to restrictions on the frequency or length of time a health maintenance service is provided (example: repeated, frequent physical exams), or the denial of a service that is not reasonably required to maintain the enrollees in good health (example: physical exams requested only for the protection or convenience of third parties). The standard of reasonableness shall be applied in full consideration of the general concept that a health maintenance

organization must provide comprehensive health maintenance services in exchange for a single, prepaid sum.

(cc) Copayments. Reasonable copayments as defined in Minn. Reg. MHD 367(k), are allowed. The standard of reasonableness shall be applied in full consideration of the general concept that a health maintenance organization must provide comprehensive health maintenance services in exchange for a single, prepaid sum. Based on this measure of reasonableness, copayments shall be deemed reasonable and shall be approved by the Board upon the proper filing of a contract and evidence of coverage containing copayment provisions which comply with the following:

(i) Any amount or form of copayment may be imposed on services that, pursuant to MHD 369, may be excluded completely;

(ii) Copayments, other than those imposed pursuant to MHD 369(c)(3)(cc)(i) above and other than those for drug benefits, emergency care and out-of-area services, may not exceed twenty-five percent (25%) of the costs or charges for a particular service. In the case of emergency care by providers who do not have an arrangement with the health maintenance organization, and in the case of out-of-area services, copayments may be imposed, either on specific services or in the aggregate, in the form of a reasonable "deductible," plus a twenty-five percent (25%) "coinsurance" feature, plus all charges which exceed a specified annual aggregate amount not less than $25,000.00. In the case of drug benefits, a health maintenance organization may impose reasonable copayments as approved by the Board upon filing of the contract provision.

(iii) There may be no copayment imposed on preventive health care services as defined in MHD 367(e)(5) including, but not limited to, the administration of immunizations, well baby care, periodic screenings and prenatal care, provided that this prohibition against copayments on prenatal care shall not be construed to prohibit a copayment on maternity services in general, which may include prenatal care.

Sec. 2. MHD 369(g) is amended as follows:

(g) Effective date of Operating Requirements. When changes are required in existing evidences of coverage or health maintenance contracts in order to implement the provisions of these rules, such changes shall be implemented upon the renewal date of

such documents commencing with the first renewal after 60 180 days after the effective date of these rules. New contracts or evidences of coverage to be implemented after 60 180 days after the effective date of these rules must be in compliance with these rules upon implementation.

Sec. 3. MHD 371 is amended as follows:

Annual Reports. In addition to all other information specified in the Act, every health maintenance organization shall include in its annual report to the Board the following:

(a) The results of any and all elections conducted during the preceding calendar year relative to consumer representation on the health maintenance organization's governing body.

(b) A copy of the health maintenance organization's most recent information summary provided to its enrollees in accordance with Section 62D.09 of the Act.

(c) A description of the method and results of the system to evaluate the quality of health services. Such evaluation shall include, but not necessarily be limited to, study of the quality of care for at least one disease condition or age group.

(d) A schedule of prepayment charges made to enrollees during the preceding year and any changes which have been implemented or approved up to the reporting date.

Sec. 4. MHD 372(a) is amended as follows:

(a) Termination of Coverage

(1) Justification. In addition to those reasons specified in Section 62D.12, Subdivision 2 of the Act, a health maintenance organization may, upon thirty (30) days notice, cancel or fail to renew the coverage of an enrollee if such enrollee:

(aa) Knowingly gives false, material information at the time of enrollment relative to his health status, provided such cancellation or non-renewal is made within six (6) months of the date of enrollment.

(bb) Moves out of the geographic service area filed with the Board, provided such cancellation or non-renewal is made within one (1)

year following the date the health maintenance organization was provided written notification of the address change.

Sec. 5. MHD 374 is amended as follows:

MHD 374 Periodic Filings

~~(a)--Filing-Requirements.--Any-filings-that-are-required-by-Minn.-Stat.-§§62D.07,-and-62D.08,-Subd.-1,-and this-rule-must-be-filed-with-the-Department-of-Health-no later-than-ten-days-prior-to-the-second-Thursday-of-each month,-which-is-the-regular-meeting-date-of-the-Board, unless-there-is-an-important-and-unexpected-circumstance which-requires-filing-on-a-different-date.--If-such-circumstance-exists,-the-filing-must-include-a-statement describing-the-circumstances-and-the-urgency-of-the-Board's attention-to-the-filing.~~

(a) Filing Requirements. Required filings will be acted upon at the next official meeting of the Board of Health following the filing date, provided the filing date is at least fifteen (15) days before said meeting. Exceptions to the requirement for filing fifteen (15) days in advance of a meeting will be made upon the filing of a statement of urgency and the circumstances involved.

(b) Provider Agreements. The provisions of Minn. Stat. §62D.08, Subd. 1 shall apply to any substantive modification in any agreement with providers as described and required for filing in MHD 368(e).

(c) The filing of any contracts or evidences of coverage pursuant to Minn. Stat. §62D.07 or §62D.08, Subd. 1, shall be accompanied by sufficient evidence on cost of services on which copayments are being imposed so as to allow the Board to determine the impact and reasonableness of the copayment provisions.

(d) Service Area. The filing of amendments to an H.M.O.'s geographic service area pursuant to Minn. Stat. §62D.08, Subdivision 1, and §62D.03, Subdivision 4(i) must contain sufficient supporting documentation of service area, facility and personnel availability and accessibility and existing community standards in receiving health care in other health care delivery systems so as to allow a determination of compliance with MHD 369(d).

(e) Upon receipt of any filing under Minn. Stat. §62D.07, §62D.08, Subd. 1 or MHD 374, the Board may request such additional data as is reasonably necessary to determine legal propriety of the filed material. Failure of a health maintenance organization to provide such data as required by MHD 374 or requested by the Board pursuant to this rule shall result in disapproval of the filing.

Sec. 6. MHD 375 is amended as follows:

MHD 375. Improper Practices

(a) It shall be an improper practice for a health maintenance organization to advertise or market its operation by making qualitative judgment or statements concerning any health professional who provides services for a health maintenance organization.

(b) A health maintenance organization shall not enroll a person who resides outside the health maintenance organization's defined service area, unless the health maintenance organization and prospective enrollee sign a statement of understanding. Such statement of understanding shall summarize the terms and conditions for provision of comprehensive health maintenance services and list the locations at which such services may be obtained.

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STATE OF MINNESOTA

COUNTY OF RAMSEY

In the Matter of the Proposed Amendments Relating to Health Maintenance Organizations

AFFIDAVIT OF RECEIPT OF SECRETARY OF STATE'S LIST OF INTERESTED PERSONS

WILLIAM G. MOORE, being first duly sworn, deposes and says:

That on the 18th day of March, 1976, at the City of St. Paul, County of Ramsey, State of Minnesota, he received from the Minnesota Secretary of State's office a complete list of persons, associations, and other interested groups who as of March 18, 1976, at 11:00 o'clock A.M., had requested pursuant to Minn. Stat. § 15.0412 subd. 4 (1974) that their names be placed on file with the Secretary of State for the purpose of receiving notice of public hearing on proposed rules on the subject captioned above.

William G Moore
William G. Moore

Subscribed and sworn to before me this 23rd day of March, 1976

Mildreth Olson

MILDRETH OLSON
Notary Public, Ramsey Co. Minn.
MY COMMISSION EXPIRES
October 31, 1980

Exhibit No. 2
File No. HE-76-012-5
Date

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STATE OF MINNESOTA

COUNTY OF HENNEPIN

In the Matter of the Proposed Amendments Relating to Health Maintenance Organizations.

AFFIDAVIT OF MAILING

KATHERINE TEKSTEN, being first duly sworn, deposes and says:

That on the 2nd day of April, 1976, at the City of Minneapolis, County of Hennepin, State of Minnesota, she served the attached Notice of Hearing by depositing in the United States mail at said City of Minneapolis, a true and correct copy thereof, properly enveloped, with postage prepaid, to all persons and associations at the addresses listed on the Certificate of the Secretary of State attached and made a part hereof as Exhibit A, to all persons and associations at the addresses listed on Exhibit B, attached and made a part hereof, as well as to all members of the Minnesota Legislature as of the date of mailing.

Katherine Teksten
Katherine Teksten

Subscribed and sworn to before me this 2nd day of April, 1976.

Wilbert Olson

Exhibit No. D
File No. HLTH-76-013-5M
Date

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STATE OF MINNESOTA

COUNTY OF HENNEPIN

In the Matter of the Proposed Amendments Relating to Health Maintenance Organizations.

AFFIDAVIT OF MAILING

KATHERINE TEKSTEN, being first duly sworn, deposes and says:

That on the 2nd day of April, 1976, at the City of Minneapolis, County of Hennepin, State of Minnesota, she served the attached Notice of Hearing by depositing in the United States mail at said City of Minneapolis, a true and correct copy thereof, properly enveloped, with postage prepaid, to all persons and associations at the addresses listed on the Certificate of the Secretary of State, to all persons and associations at the addresses listed on the Health Department list attached and made a part hereof as Exhibit A, as well as to all members of the Minnesota Legislature as of the date of mailing.

Katherine Teksten
Katherine Teksten

Subscribed and sworn to before me this 15th day of April, 1976.

Notary Public, Hennepin Co., Minn.
My Commission Expires October 31, 1980

Exhibit No. D-1
File No. HLTH-76-013-SM
Date

HEALTH

Exhibit A

Abrahamson, Dr. Dean E., 243 Space Science Center, Mpls 55455
Benson, John W., Pharmacy Dept., St.Lukes Div., United Hospitals, 300 Pleasant Ave., St.Paul, Mn. 55102
Booth, Cold Storage Co., St. Peter & Kellogg, St. Paul

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Branson, Lindley S., 300 Roanoke Bldg., Mpls 55402

Bush, John T., Box 611, Mayo Bldg., U of M Mpls 55455

Cassell, Dr. Carl V.E., MN State Dental Ass'n, 2236 Marshall Ave, St. Paul 55101

Damon Corp., Att: B.G. Goodman, 115 4th Ave., Needham Heights, Man. 02194
Deephaven, Montessori School, Inc. 188 S Circle A Dr., Wayzata 55391
Elston, Elaine, Box 44, Cottonwood, Mn. 56229

Environment Reporter, 1231 25th St, N.W., Washington D.C.

40 Club, Aitkin 56431
Fox, Howard, 244 Dayton Ave., St.Paul, Mn. 55102 (CEMETERIES ONLY)

Hawley, Lyle, Graco, P.O. Box 1441, Mpls 55440

Higgins, J.C., Brotherhood Rwy. Clerks, 2317 W. 7th St., Duluth

Houghton, Charles, Vendo, 7246 Troost Ave, Kansas City, MO 64131

Janke, John R., Burger Chef Systems, Inc., 250 N St., White Plains, New York 106
Jankowski, Mrs.JoAnne,22-27th Ave. S.E.,Mpls. 55414-King Care Centers, Inc.

Kurtz, Mrs.Kirsten, MN Nurses Ass'n, 1821 Univ Ave, St. Paul 55104

Markham, B.B., 2250 IDS Center, 80 S 8th St, Mpls 55402

Merck & Co, Inc., Rahway, N.J., Att: Off of Gen Counsel

Mpls & Henn County Mental Health Clinic, 619 S 5th St, Mpls 55415

MN Nurses Ass'n, Att: Geraldine Wedel, 1821 Univ Ave,Rm 152, St. Paul 55104

MN State Pharmaceutical Ass'n, 2388 Univ Ave, St. Paul 55104
Mitchell, Malcolm, Met.Health Bd., 300 Metro Sq.Bldg.,7th&Robert, St.Paul,Mn.
Moore, Roger, 115 Forestview Lane, No., Mpls, Mn. 55441

Parke, Davis & Company, P.O. Box 118, Detroit Michigan 48120,Attn: Dennis Gibson

Patrick, Peter, 101 Central Ave, S.E., Mpls 55414

Perso, E.R., 4411 Branson St, Mpls 55424

Pihlaja, Jerome A. Bureau Criminal App.Lab., 1246 University Ave.,St.Paul 55104

Planning and Advisory Comm. of Crow Wing County, Court House, Brainerd 56401

Roesler, Immanuel F., 6700 Portland Ave S., Richfield 55423

Roos, Roger Dr., Univ Health Serv, U of M, Mpls 55455

Schneider, Dorothy, St. Paul Bur Health, 555 Cedar St, St. Paul 55101
Schroeder, Roger D., 7729 Groveland Road, Mpls., Mn. 55432
Sigmeth, Gary F., 8415 Isle Ave.So.,Cottage Grove,Minn. 55016

Usher, Janice, Isanti Co.Public Health Nursing Serv.,237 SW 2nd, Cambridge 55008

Wahl, Jack, Inver Hills Comm College, Inver Grove Heights 55075

Walgreen, J.E. Krahulec, 4300 Peterson, Ave, Chicago Ill 60646

DIV. OF ENVIRONMENTAL SANITATION

U.S. Soil Conservation Serv., 517 Red Courts Bldg, St. Paul (Swimming pools)

HOTELS, RESORTS, RESTAURANTS

U.S. Soil Conservation Serv., 517 Red Courts Bldg, St. Paul (trailer parks, etc)

MINN PLUMBING CODE ONLY

Hendricks, Manley, & Tyler Pipe Industries, Box 2027, Tyler, Texas 50701

Higgins, Robert G., Rm 300B, 1409 Willow St, Mpls 55403

Sharp, Richard H. 964 W. Cecil St., Neenah, Wisc 54956

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OFFICE OF HEARING EXAMINERS

STATE OF MINNESOTA
COUNTY OF HENNEPIN

BEFORE THE MINNESOTA
STATE BOARD OF HEALTH

In the Matter of Proposed
Amendments Relating to Health
Maintenance Organizations

STATEMENT OF NEED

The above-captioned rules are amendments to existing rules of the State Board of Health. The last time the above-captioned rules were amended was September 6, 1974 (date of order adopting rules).

The need to adopt each section of these rules is set forth below:

SECTION 1: Amendment to MHD 369(c)(3)

Additional experience with H.M.O. contracts has shown the current regulation which provides guidelines for co-payments and restrictions, MHD 369(c)(3) to be too general. These regulations establish more complete standards relating to co-payments. These standards set forth guidelines to be followed in determining if a co-payment is reasonable.

SECTION 2: Amendment to MHD 369(g)

Changes the effective date of these operating requirements from 60 to 180 days after the effective date of these rules. This additional time is necessary to draft new contracts, arrange the services under the different rules and to coordinate the administrative procedures to perform the services.

SECTION 3: Amendment to MHD 371

Provides that an additional item of information be provided on the annual report each H.M.O. must file. This item,

Exhibit No. E
File No. HCH-76-015-SR
Date

a schedule of prepayment charges made to enrollees during the preceding year, is necessary for the Board to assess the financial stability of H.M.O.s as required by Minn. Stat. § 62D.04 subd. 1(e)(1) (1974).

SECTION 4: Amendment to MHD 372(a)

This amendment is necessary to clarify the situation where an enrollee may be terminated for moving out of the area served by an H.M.O. Moving out of the service area is a permissible ground for termination pursuant to Minn. Stat. § 62D.12 (1974). This rule is needed to establish a reasonable time frame in which the H.M.O. must make its decision to terminate.

SECTION 5: Amendment to MHD 374

This amendment is necessary for two reasons:

1. The Board needs additional time in which to consider matters upon which it will act at its monthly meeting.

2. Since the Board must approve every filing before it can become effective, sufficient documentation is required for the Board to make an informed decision. This amendment requires H.M.O.s to document the need for approval of a filing.

SECTION 6: Amendment to MHD 375

This amendment relating to areas an H.M.O. may serve is necessary to comply with the statutory provisions on service areas while still allowing for enrollment of an individual under exceptional circumstances.

STATE OF MINNESOTA

BOARD OF HEALTH

WARREN R. LAWSON, M.D.
Secretary and Executive Officer

RECEIVED
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STATE OF MINNESOTA

COUNTY OF HENNEPIN

In the Matter of the Proposed Adoption, Amendment, or Revision of the Rules of the Minnesota State Board of Health

AFFIDAVIT OF MAILING

Charlotte D. Sommers, being first duly sworn, deposes and says:

That on the 10th day of December, 1975, at the City of Minneapolis, County of Hennepin, State of Minnesota, she served the attached Notice of Irtent to Obtain Information on Proposed Rules from Non-Agency Sources by depositing in the United States mail at said City of Minneapolis, a true and correct copy thereof, properly enveloped, with postage prepaid, to all persons and associations at the addresses listed on the Certificate of the Secretary of State attached and made a part hereof as Exhibit A as well as to all members of the Minnesota Legislature as of the date of mailing.

Charlotte D. Sommers

Subscribed and sworn to before me this 10th day of December, 1975.

Frank J. Bigham

FRANK J. BIGHAM
Notary Public, Ramsey Co. Mn.
MY COMMISSION EXPIRES
May 16, 1980

Exhibit No. F
File No. HETH-76-013-SM
Date

STATE OF MINNESOTA

COUNTY OF HENNEPIN

BEFORE THE MINNESOTA

STATE BOARD OF HEALTH

In the Matter of the Proposed Adoption, Amendment or Revision of the Rules of the Minnesota State Board of Health.

NOTICE OF INTENT TO OBTAIN INFORMATION ON PROPOSED RULES FROM NON-AGENCY SOURCES

NOTICE IS HEREBY GIVEN, pursuant to the provisions of Minnesota Laws 1975, Chapter 380, section 2, subdivision 6, that the Minnesota State Board of Health is considering to propose the adoption of new rules on the subjects noted below (items A through L) and the amendment and revision of the existing rules noted below (items M through R).

All interested parties desiring to submit data or views relating to the proposed adoption, amendment or revision of the rules noted below should address their comments (either written or oral) to the Minnesota Department of Health (717 Delaware Street S.E., Minneapolis, Minnesota 55440) by writing or calling the persons designated. Any evidence submitted for consideration should be pertinent to the matter at hand. Any written material received by the Department will become part of the hearing record.

A. Rules relating to the award of grants to include but not be limited to:

1. Public health grants (general program)

   Contact: Division of Community Services Development
   Attn. : Ernest Kramer
   Phone : (612) 296-5471

2. Emergency medical services grants

   Contact: Division of Health Facilities Emergency Medical Services
   Attn. : Bernard Webber
   Phone : (612) 296-5281

B. Rule relating to the regulation with respect to sanitary conditions of mass gatherings.

Contact: Division of Environmental Health, Section of Hotels, Resorts and Restaurants
Attn. : Charles Schneider
Phone : (612) 296-5335

C. Rules relating to standards for early and periodic screening for children 0-13 years.

Contact: Division of Personal Health Services
Maternal and Child Health
Attn. : Sheila Swaiman
Phone : (612) 296-5286

D. Rules relating to guidelines for perinatal regionalization plan.

Contact: Division of Personal Health Services
Maternal and Child Health
Attn. : Marilyn Wilfong
Phone : (612) 296-5293

E. Rules relating to the "reasonable volume of uncompensated care" and the "community services" requirements of the hospital survey and construction (Hill-Burton) program.

Contact: Division of Health Facilities
Section of Planning and Program Operations
Attn. : Robert Manske
Phone : (612) 296-5442

F. Rules relating to educational programs for:

1. Medication administration for unlicensed personnel in nursing home and intermediate care facilities for the mentally retarded.

2. Food service supervisors (90 hour course).

Contact: Division of Health Facilities
Technical Consultation and Training Section
Attn. : Robert Hamilton
Phone : (612) 296-5487

G. Rule relating to standards for the Minnesota Programs of Projects:

1. Children and Youth
2. Maternal and Infant Care
3. Dental Health
4. Infant Intensive Care
5. Family Planning

Contact: Division of Personal Health Services
Attn. : Dr. Ronald Campbell
Phone : (612) 296-5265

H. Rule relating to application procedures and eligibility for crippled children services including but not limited to the new cystic fibrosis program for persons over 21.

Contact: Division of Personal Health Services
Crippled Children Services
Attn. : Dr. Mildred Norval
Phone : (612) 296-5389

I. Rules relating to the establishment of credentials for those categories of allied health manpower as such are determined by the Board of Health to constitute a useful new category of health care responsibility and important to regulate in the public interest pursuant to the Allied Health Manpower Act, Minn. Stat. §§ 145.861 to 145.866, such rules to include but not limited to the credentialing requirement; scope of practice authorized, supervision required, continuing education; career progression; disciplinary procedures; and the development, administration, and grading of examinations to verify the qualifications of applicants. Categories of allied health manpower presently seeking a credentialing requirement and on which public input is being received which might lead to the promulgation of rules include chemical dependency professionals, speech pathologists and audiologists, emergency medical technicians, sanitarians, contact lens technicians, and x-ray technologists.

Contact: Allied Health Manpower Section
Attn. : Corrine Larson
Phone : (612) 296-5393

J. Rules relating to implementing the Minnesota Health Manpower Information System.

Contact: Allied Health Manpower Section
Attn. : Paul Gunderson
Phone : (612) 296-5393

K. Rules relating to the nature and requirements of all general formal and informal procedures (as distinguished from procedures for specific programs which will be promulgated as separate rules) related to the administration of official duties of the State Board of Health which directly affect the rights of or procedures available to the public.

Contact: Executive Office
Attn. : David Giese
Phone : (612) 296-5463

L. Rules relating to the nature and requirements of all general formal and informal procedures (as distinguished from procedures for specific programs which will be promulgated as separate rules) related to the administration of official duties of the State Department of Health which directly affect the rights of or procedures available to the public.

Contact: Executive Office
Attn. : David Giese
Phone : (612) 296-5463

M. Amendments of MHD 391-410, Supervised Living Facilities, will include but not be limited to adding detoxification centers as a facility covered by these rules.

Contact: Division of Health Facilities
Attn. : Hans Larsen
Phone : (612) 296-5451

N. Amendment of MHD 139, Plumbing, will include standards and qualifications for examination and licensing of journeyman and master plumbers.

Contact: Division of Environmental Health Plumbing Section
Attn. : Charles Settle
Phone : (612) 296-5325

O. Amendment of MHD 151-160, Lodging Establishments, and MHD 161-170, Food and Beverage Establishments will update standards.

Contact: Division of Environmental Health, Section of Hotels, Resorts and Restaurants
Attn. : Charles Schneider
Phone : (612) 296-5335

P. Amendment of MHD 366-390, Rules for the Certification and Regulation of Health Maintenance Organizations, to include but not be limited to certification criteria and standards, standards for determining the reasonableness of co-payments with respect to health maintenance organization benefits, and standards for determining the propriety of the geographic service area of health maintenance organizations.

Contact: Division of Health Facilities HMO Unit
Attn. : Kent Peterson
Phone : (612) 296-5365

Q. Amendment to MHD 36-43, Hospital Administrators, will update standards.

Contact: Hospital Administrator Registration Program
Attn. : Collin Eid
Phone : (612) 296-5393

R. Amendment to MHD 44-71, Rules relating to nursing homes with respect to the establishment of levels of assessments for violations of the rules pursuant to Minn. Laws 1975, ch. 310 § 7.

Contact: Division of Health Facilities
Attn. : H. Michael Tripple
Phone : (612) 296-5418

Any materials submitted shall be reviewed and considered by the Department of Health during the preparation of the proposed rules. Notice of the public hearing on the proposed rules shall be given to all interested parties in accordance with the provisions of the Administrative Procedure Act.

Under the provisions of Minn. Stat. § 10A.01 subd. 11 (1974), any individual representing persons or associations attempting to influence administrative action, such as the promulgation of these proposed rules, must register with the State Ethics Commission as a lobbyist

within five days of the commencement of such activity by the individual. The State Ethics Commission is located at Room 401, State Office Building, Saint Paul, Minnesota 55155.

Dated: December 8, 1975.

STATE OF MINNESOTA

BOARD OF HEALTH

WARREN R. LAWSON, M.D.
Secretary and Executive Officer

Exhibit A

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APR 12 1976
OFFICE OF HEARING EXAMINERS

STATE OF MINNESOTA

COUNTY OF RAMSEY

In the Matter of the Proposed Adoption, Amendment or Revision of the Rules of the Minnesota State Board of Health

CERTIFICATE

I hereby certify that the 447 general labels and 3 page list for the Minnesota State Health Department all of which are attached and made a part hereof, constitute the complete lists of persons, associations, and other interested groups who as of 8:30 o'clock A.M., this 5th day of December, 1975, have requested pursuant to Minn. Stat. § 15.0412 subd. 4 (1974) as amended by Minn. Laws 1975, ch. 380 § 2 subd. 4 that their names be placed on file with the Secretary of State for the purpose of receiving notice of public hearing on proposed rules.

Joan Anderson Growe
SECRETARY OF STATE

JOAN ANDERSON GROWE

By Neil Dion

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STATE OF MINNESOTA

COUNTY OF HENNEPIN

BEFORE THE MINNESOTA

STATE BOARD OF HEALTH

In the Matter of Proposed Amendments Relating to Health Maintenance Organizations

MATERIALS RECEIVED FOLLOWING NOTICE PURSUANT TO MINN. STAT. § 15.0412 (Supp. 1975)

The following material was received following notice issued on December 10, 1975 (which notice is herewith filed with the Office of Hearing Examiners) pursuant to Minn. Stat. § 15.0412 subd. 6 (Supp. 1975) seeking information or opinions on the above-captioned matter:

1. Letter from Med Center Health Plan.
2. Letter from Target Stores Incorporated.
3. Letter from Northwestern National Life Insurance Co.
4. Letter from Group Health Plan, Inc.

STATE OF MINNESOTA

BOARD OF HEALTH

WARREN R. LAWSON, M.D.
Secretary and Executive Officer

Exhibit No. 6

File No. MHO-76-013-50

Date

med center health plan
5000 west 39th street • st. louis park, minnesota 55416 • (612) 927-3185

office of the director

RECEIVED
JAN 28 1976
HMO Unit
Minn. Dept. of Health

January 26, 1976

Mr. Kent Peterson
HMO Unit Minnesota
Department of Health
7717 S. E. Delaware Street
Minneapolis, Minnesota 55440

RE: Proposed Rules for HMO Copayment Requirements

Dear Kent:

I have received and reviewed December bulletin (1975-11) regarding the proposed changes in copayment for HMOs. The purpose of this letter is to express my general support for these proposed changes. I believe that if adopted these new rules will be of great assistance to HMOs in Minnesota and will serve to make HMO coverage available to many more persons by allowing HMOs greater flexibility in structuring their benefit packages inorder that they may be affordable to more people.

I am concerned, however, about proposed rules MHD 374 (c) and (d). While I am sympathetic to and can understand the information needs of the Board of Health, I am concerned that as worded these sections are too vague and could infact be used as a tool to prevent HMOs from implementing the copayments which the proposed rules intend to allow. Presently written these rules could allow the Board to require that HMOs collect and supply the Board with information which they do not presently collect nor do they feel appropriate to collect. Further the potential for the need to collect Board required information could lead to higher administrative expenses. Since MCHP understands the need the Board may have for this information, we are not suggesting that all reference to the informational needs be deleted from the proposed rules. However, we urge that before being adopted these rules be rewritten to provide greater specificity as to the types of information that HMOs will be required to provide the Board. Once this change is made I believe our organization will be prepared to support you and the Board completely in its attempt to adopt these rules.

I look forward to discussing this matter with you in greater detail at your convenience. Should you have any questions regarding this matter please do not hesitate to contact me at 927-3185.

Sincerely,

Stephen K. Goldstone
Executive Director

SKG/alc

cc: L.N. Vorlicky, M.D.
A.C. Bredesen

File - New Rules

Target Stores Incorporated
755 53rd Avenue N.E.
Fridley, Minnesota 55421
Telephone 612/788 9351

January 20, 1976

Kent Peterson
717 Delaware St. S. E.
Minneapolis, Minn. 55400

RECEIVED
JAN 26 1976
HMO Unit
Minn. Dept. of Health

Dear Sir:

My letter is in reference to our conversation today on the telephone. I work at Target pharmacy and am being denied the opportunity to join the H.M.O. at work because I live outside the boundary of its licensed treatment area. It is not the fault of Target nor the H.M.O but probably of its charter. I believe a person who lives outside the treatment area of a H.M.O. should be given the opportunity to join provided that he signs a statement acknowledging that he must go to the H.M.O. for all care save emergency.

I live in Isanti county, about 2 miles north of the Anoka county line and we have been using the Robbinsdale Clinic up to now. The MedCenter Plan has a satelite facility in the Coon Rapids Clinic which is only about 20 minutes from our home and Mercy Hospital can be no farther. I believe that the rule concerning the boundaries should not be hard and fast. The client, assuming he is intelligent, should be able to make up his mind if he wants to drive 10-20 miles to his doctor. This should not be legislated. If you would like me to testify concerning this matter, I would be happy to do so. Thank you for your consideration.

Sincerely,

William A. Soderlund
Pharmacy Manager

RECEIVED
JAN 6 1976
HMO Unit
Minn. Dept. of Health

NORTHWESTERN NATIONAL LIFE INSURANCE COMPANY

A. CHARLES BREDESEN III
DIRECTOR, GROUP HEALTH SERVICES

612 • 372 5328

January 5, 1976

Mr. Kent E. Peterson
HMO Unit
Minnesota Department of Health
717 S. E. Delaware Street
Minneapolis, MN 55440

Re: Proposed Rules for HMO Copayment Requirements

Dear Kent,

I received December Bulletin (1975-11) regarding proposed changes in copayment availability for HMOs. This letter is intended to express my support for these proposed changes. If adopted, these new rules will be of great assistance to the HMOs in Minnesota and will serve to make HMO coverage available to many more persons.

I am concerned somewhat, however, about proposed Rules MHD 374 (c) and (d). I am sympathetic to the information needs the Board will have in implementing these rules, but I find these two sections to be too vague. Instead, I think the rules should specify exactly what type of documentation an HMO would have to provide for consideration of its copayments by the Board. As the proposed rules now stand, the Board could require information the HMO had not collected and/or was unable to collect. By identifying in the rules exactly what information would be required by the Board, the HMO could prepare its data collection systems to be able to supply this information. And, the HMOs would also have a clearer idea of the type of considerations the Board will make in assessing any proposed copayments.

I will look forward to hearing from you when the date for the hearing is set. Thank you for keeping me informed of matters in this area. If there is some way I could be of assistance to you, please let me know.

Sincerely,

A. Charles Bredesen III
Director, Group Health Services

ACB:dp

OUP HEALTH PLAN, INC.
2500 Como Avenue
Saint Paul, Minnesota 55108

January 5, 1976

Mr. Kent E. Peterson
H M O Unit
Minnesota Department of Health
717 S.E. Delaware Street
Minneapolis, Minnesota 55440

Dear Kent:

Please consider this a semi-official reaction to your proposed rules on co-payments, et al. I say "semi-official" because none of my suggestions is substantive and some are merely mechanical.

I have no heartburn about any of the proposed rules - can live with all of them - and am pleased to observe that our Minnesota State Board of Health approved contract appears to comply fully.

Enclosed is a copy of your proposed rules. Suggested amendments have been made in red ink and numbered for easy reference. The following numbers correspond and are followed by the rationale for the suggested change:

1. The expunged clause is considered to be pleonastic; it is a gratuitous irrelevancy. So what, if the Board prefers limitations to exclusions? They're either allowed or they're not allowed. Why not begin to state the Board's position, as indicated in red ink, at the point where it is objectively meaningful and without being prefaced by a negating subjectivity?

2. Spelling

3. Spelling

4. "Should" is considered better than "must" because there will be many filings where data are obviously not necessary. The issue will speak for itself; for instance, where the co-payment is a percentage. Furthermore, the Board is completely protected by the next paragraph which says, in effect, that if a filing is missing data the Board would like to have it may ask for it.

5. "A valid" is another pleonasm. Adjectives of this nature serve no purpose but to consume ink.

One more thing should be added. It is assumed that where specific criteria are set forth (such as "may not exceed 25%") the actuarial equivalent is acceptable. Is this correct? If so, perhaps it would be wise to say so in the Rules. To do this 369 (c) (3) (cc) (ii) should be amended as follows:

Remove the period after the last word (service)
in the first sentence and add
"or their actuarial equivalent."

Remove the period after the last word ($25,000)
in the second sentence and add
"or the actuarial equivalent."

Regarding Rules on Service Area we cannot take a position without seeing what is proposed. But we do feel that this is an area for treading lightly. Involved in the issue is strong individual human preference that transcends any allegedly unassailable moat around a point of service. If an area boundary runs down the center of a road, why can't the people across the street be members? If the boundary takes in both sides of the road, why can't the people across the alley join? As I stated once before in a letter to John Diehl (November 5, 1975), service areas should be amorphous. Human preference should be allowed to function; especially if the consequences of distance between clinic and residence are fully explained. Furthermore, the factor of human mobility creates many problems in H M O's. To address these in Rules is to address as many situations as there are moves outside a specifically defined area. People move outside a service area and simply cannot get other coverage. If they are willing to have accident coverage why not let them? We shall watch with much interest your efforts to unravel this dilemma. We feel that the issue should not be fettered by Rules but instead allowed to operate with "reasonableness" and allowed to be plyed by human preference.

Sincerely,

John Thames

John Thames
Assistant to the General Manager
Group Health Plan, Inc.

JT:mz
Encl.

MINNESOTA DEPARTMENT OF HEALTH RULES
CHAPTER TWENTY-EIGHT

Proposed Rules for
Health Maintenance Organization
Copayment Requirements

DRAFT PRESENTED TO STATE BOARD OF HEALTH
DECEMBER 11, 1975

MHD 369 (c)(3) is amended as follows:

(3) Copayments, Limitations, Exclusions and Restrictions on Service. In addition to the limitations and exclusions allowed in MHD 369 (c)(2), a health maintenance organization may impose copayments for services or goods provided and may impose certain restrictions on services, ~~such as on frequency or length of time a health maintenance service is provided. Provided, however that all copayments, limitations and exclusions must be reasonable. The express policy of the Board is to favor limitations rather than exclusions, and the Board may limit the extent of limitations and/or exclusions which may be included in any health care plan to ensure that comprehensive health care services are reasonably available to enrollees. The standard of reasonableness shall be applied in full consideration of the general concept that a health maintenance organization must provide comprehensive health maintenance services in exchange for a single prepaid sum.~~ Any such provisions must clearly be stated in the evidence of coverage in compliance with Minn. Stat. §62D.07, Subd. 3(b), and comply with the following standards:

(aa) Limitations and Exclusions. There may be no limitations or exclusions other than those allowed by the statutes or in rules promulgated pursuant to Minn. Stat. §62D.20. ~~There exclusions are allowed, it is the express policy of the Board to favor limitations rather than exclusions and~~ The Board may limit the extent of limitations and/or exclusions which may be included in any health care plan to ensure that comprehensive health care services are reasonably available to enrollees. The standard of reasonableness shall be applied in full consideration of the general concept that a health maintenance organization must provide comprehensive health maintenance services in exchange for a single prepaid sum.

(1)

of time a health maintenance organization must provide (Example: Repeated, frequent physical exams), or the denial of a service that is not reasonably required to maintain the enrollees good health (Example: Physical exams requested only for the protection or convenience of third parties). The standard of reasonableness shall be applied in full consideration of the general concept that a health maintenance organization must provide comprehensive health maintenance services in exchange for a single, prepaid sum.

(cc) Copayments. Reasonable copayments as defined in Minn. Reg. MHD 367(R), are allowed. The standard of reasonableness shall be applied in full consideration of the general concept that a health maintenance organization must provide comprehensive health maintenance services in exchange for a single prepaid sum. Based on this measure of reasonableness, copayments shall be deemed reasonable and shall be approved by the Board upon the proper filing of a contract and evidence of coverage containing copayment provisions which comply with the following:

(i) Any amount or form of copayment may be imposed on services that, pursuant to MHD 369, may be excluded completely;

(ii) Copayments, other than those imposed pursuant to MHD 369(c)(3)(cc)(i) above and other than those for drug benefits, emergency care and out-of-area services, may not exceed twenty-five percent (25%) of the costs or charges for a particular service. In the case of emergency care by providers who do not have an arrangement with the health maintenance organization, and in the case of out-of-area services, copayments may be imposed, either on specific services or in the aggregate, in the form of a reasonable "deductible," plus a twenty-five percent (25%) "coinsurance" feature, plus all charges which exceed a specified annual aggregate amount not less than $25,000.00. In the case of drug benefits, a health maintenance organization may impose reasonable copayments as approved by the Board upon filing of the contract provision.

(iii) There may be no copayment imposed on preventive health care services as defined in MHD 367(e)(5) including, but not limited to, the administration of immunizations, well baby care, periodic screenings and prenatal care, provided that this prohibition against copayments on prenatal care shall not be construed to prohibit a copayment on maternity services in general, which may include prenatal care.

MHD 369(g) is amended, as follows: (C.

(g) Effective date of Operating Requirements. When changes are required in existing evidences of coverage or health maintenance contracts in order to implement the provisions of these rules, such changes shall be implemented upon the renewal date of such documents commencing with the first renewal after 60 180 days after the effective date of these rules. New contracts or evidences of coverage to be implemented after 60 180 days after the effective date of these rules must be in compliance with these rules upon implementation.

MHD 374 is amended, as follows:

MHD 374 Periodic Filings

~~(a) Filing Requirements. Any filings that are required by Minn. Stat. §§62D.07, and 62D.08, Subd. 1, and this rule must be filed with the Department of Health no later than ten days prior to the second Thursday of each month, which is the regular meeting date of the Board, unless there is an important and unexpected circumstance which requires filing on a different date. If such circumstance exists, the filing must include a statement describing the circumstances and the urgency of the Board's attention to the filing.~~

(a) Filing Requirements. Required filings will be acted upon at the next official meeting of the Board of Health following the filing date, provided the filing date is at least ten days before said meeting. Exceptions to the requirement for filing ten days in advance of a meeting will be made upon the filing of a statement of urgency and the circumstances involved.

(b) Provider Agreements. The provisions of Minn. Stat. §62D.08, Subd. 1 shall apply to any substantive modification in any agreement with providers as described and required for filing in MHD 368(e).

(c) The filing of any amendments to contracts or evidences of coverage or a filing of any new contract or evidence of coverage pursuant to Minn. Stat. §§62D.07 or 62D.08, Subd. 1, which filing contains any copayment provisions, should be accompanied by documented cost data on the services on which copayments are being imposed sufficient to allow the Board to determine the impact and reasonableness of the copayment provisions.

(d) Upon receipt of any filing under Minn. Stat. §62D.07 or §62D.08, Subd. 1, or any data filed in support of a filing pursuant to those sections, the board may request such additional explanatory or supporting data as is reasonably calculated to determine the need for, or reasonableness or impact of the filed material. The failure of a health maintenance organization to provide such explanatory or supporting data as required by this rule or requested by the Board pursuant to this rule is ~~a valid~~ basis for disapproval of the filing.

RECEIVED
APR 12 1976
OFFICE OF HEARING
EXAMINERS

STATE OF MINNESOTA

COUNTY OF HENNEPIN

BEFORE THE MINNESOTA

STATE BOARD OF HEALTH

In the Matter of Proposed
Amendments Relating to
Health Maintenance Organizations

STATEMENT OF AGENCY
PERSONNEL WHO WILL
REPRESENT THE AGENCY
AT THE HEARING AND
WITNESSES WHO WILL
APPEAR ON BEHALF
OF THE AGENCY

The Minnesota Department of Health will be represented by Kent Peterson and John A. Breviu, Special Assistant Attorney General, in the above-captioned matter. Mr. Peterson is the only person expected to offer testimony on behalf of the agency.

STATE OF MINNESOTA

BOARD OF HEALTH

WARREN R. LAWSON, M.D.
Secretary and Executive Officer

Exhibit No. H
File No. MHTA 74-013-SA
Date

RECEIVED
APR 12 1976
OFFICE OF HEARING
EXAMINERS

STATE OF MINNESOTA

COUNTY OF HENNEPIN

BEFORE THE MINNESOTA

STATE BOARD OF HEALTH

In the Matter of
Proposed Rules for
Health Maintenance
Organizations.

SUMMARY OF EVIDENCE

In compliance with Minn. Rule HE 104(i), the Minnesota State Board of Health hereby submits the attached Justification. The Justification will be submitted into the record at the public hearing in support of the proposed rules.

STATE OF MINNESOTA

BOARD OF HEALTH

for Ellen Fiper

WARREN R. LAWSON
Secretary and Executive Officer

Exhibit No. I

File No. HEALTH-76-013-SM

STATE OF MINNESOTA

COUNTY OF HENNEPIN

BEFORE THE MINNESOTA

STATE BOARD OF HEALTH

In the Matter of Proposed
Rules for Health Maintenance
Organizations

JUSTIFICATION

RECEIVED
APR 12 1976
OFFICE OF HEARING
EXAMINERS

Section 1. Amendment to MHD 369(c)(3)

As stated in Minn. Stat. §62D.02, Subd. 8, the definition of "health maintenance contract," indicates that the contract may provide for "reasonable" copayment provisions. Furthermore, Minn. Stat. §62D.07, Subd. 3(b)(4) requires that a copayment be specified in the evidence of coverage and thus, implicitly, copayments are permitted. Further authorization for the State Board of Health to promulgate this rule is found in Minn. Stat. §62D.20. This statute states that the State Board of Health may promulgate such reasonable rules and regulations as necessary or proper to carry out the provisions of §62D.01 to §62D.29.

The term "copayment" is defined by existing rules. Specifically, MHD 367(k) provides as follows:

> "(k) 'Enrollee copayment provisions' means those contract clauses requiring charges to enrollees in addition to fixed, prepaid sums, to supplement the cost of providing covered comprehensive health maintenance services; 'enrollee copayment provisions' also mean the difference between an indemnity benefit and the charge of a provider for health services rendered."

The need for further rules in this area relates to the need to develop standards to determine "reasonableness" of copayments charged by H.M.O.s. To meet this need, MHD 369(c)(3), MHD 369(g) and MHD 374 are being changed.

The current Minn. Rule MHD 369(c)(3) states the guidelines on copayments, limitations, exclusions and restrictions on service. These current rules are quite general and the result has been that the State Board of Health has not had available as complete a written standard for acceptance of copayments as is desirable. As a result of acquiring additional experience in H.M.O. contracts and with the goal of establishing more complete standards for interpretation of "reasonableness," these amendments to Minn. Rule MHD 369(c)(3) are being proposed.

The general need, therefore, is to develop a set of guidelines or standards that give the Board better guidance in carrying out its duty of approving or disapproving H.M.O. contracts, and which will allow H.M.O.s to determine whether a contract is in compliance with Board rules before the contract is submitted and passed upon by the Board.

First of all, the proposal strikes a substantial part of existing rule MHD 369(c)(3). This deletion is necessary because the existing rule treats copayments, limitations, exclusions and other restrictions the same, while the need discussed above, requires that each of these items be separated out and dealt with individually (if not differently).

The proposed rule MHD 369(c)(3)(aa) reorganizes the existing language in the rule under the subdivision "Limitations and Exclusions." This paragraph also references the fact that no limitations or exclusions other than those allowed by the statute or rules shall be permitted. There is no change in the standards or requirements under this paragraph.

In regard to the next paragraph, Minn. Rule MHD 369(c)(3)(bb), the concept of reasonable restrictions is explained in more detail than the previous rule. Two factors in determining reasonableness of restrictions are described. These are: (1) restrictions on the frequency or length of time a health maintenance service is provided and, (2) the denial of a service that is not reasonably required to maintain the enrollee in good health.

The first of these factors is necessary so that repeated, frequent physical examinations or other similar procedures would not be required of H.M.O.s. This factor is authorized under Minn. Stat. §62D.02, Subd. 7, which mandates only services which are "reasonably" required to maintain a person in good health. The "reasonableness" may be a factor of frequency or length of time.

The second factor is specifically authorized in Minn. Stat. §62D.02, Subd. 7, which defines "comprehensive health maintenance services" to include only those services which "enrollees might reasonably require to be maintained in good health. . . ." Pursuant to that statute, the Board of Health has allowed H.M.O.s to refrain from rendering services in certain circumstances or to refrain from providing certain kinds of services when the circumstance or the kind of service went beyond the scope of service defined in the statute. This addition to the rules would categorize that type of "exclusion" from the covered services and subject it to the reasonableness standard as is the case with all other limitations, exclusions and copayments.

More complete standards for copayments are listed in proposed new rule MHD 369(c)(3)(cc). To begin with, the proposed rule reiterates the existing standard, that reasonableness is determined in full consideration of the general concept that an H.M.O. must provide comprehensive health maintenance services in exchange for

a single, prepaid sum. However, this standard by itself created confusion and uncertainty in the management and operation of H.M.O.s and in development and negotiation of H.M.O. contracts. In turn, this tended to dampen the expansion of H.M.O.s and was, therefore, contrary to the general philosophy articulated in Minn. Stat. §62D.01. It is, therefore, necessary to develop more precise standards and to remove impairments.

The first standard is that any amount or form of copayment may be imposed upon a service which the law and rules permit as an exclusion. This rule is necessary to specifically authorize such copayments and it is clearly logical that the statute had intended that these excluded services may be covered in part for certain H.M.O.s. It would be "unreasonable" to not permit a co-payment on these services when the entire service may be excluded.

The second standard is that copayments on services, other than those listed otherwise, may not exceed twenty-five percent of the cost or charges for that particular service. This fixed, mechanical formula may be applied to all services of the health maintenance organization other than those specifically listed. It is felt by the Board that this is reasonable and necessary to provide the flexibility in the operating standards of health maintenance organizations to permit competitive pricing of the health maintenance organizations' contracts with the dual option health insurance contracts and contracts of nonprofit health service plans.

Emergency care and out-of-area services are not provided through arrangements by the health maintenance organization and, therefore, it is quite reasonable that other payment mechanisms may be used for these services. The rule permits deductibles or coinsurance features to be used in these situations where the plan organized system is not used and the service is controlled by other factors of the health care delivery system. It is necessary for certain H.M.O.s to control these "unarranged" services in a more stringent fashion and, thereby, the additional copayment flexibility is reasonable and necessary.

Drug benefits are much less frequently found in health insurance and nonprofit health service plan contracts and, therefore, the health maintenance organization has difficulty competing with these other plans. While the Board feels that drug benefits are necessary to maintain a person in good health, it is quite reasonable that the copayment on these drug benefits may need to be higher than twenty-five percent of the cost for the particular service when the dual option indemnity plan has no drug benefits. Therefore, the drug benefit copayment is left more flexible than the twenty-five percent standard and generally accepted considerations of reasonableness will be applied to this provision.

Proposed Minn. Rule MHD 369(c)(3)(cc)(iii) completely prohibits copayments on those services which are defined to be preventive health care services. The Board feels that imposition of a copayment on preventive services may present a barrier to people

achieving a maintenance level of health. To achieve greater efficiency and economy in providing health care services (as stated in Minn. Stat. §62D.01, Subd. 2(a)) preventive services should in no way be discouraged.

Detailed research by the Department of Health indicates that the presence of a copayment on a particular service has virtually no deterrent effect on people who are actually sick receiving necessary care. The research indicates that, in low-income groups, the presence of a copayment may be a deterrent to people receiving what might be considered to be preventive services; however, no similar deterrent was found among employed populations. The information also indicates that the financial management and the financial stability of an H.M.O. is affected substantially by the natural or actuarial affinity of high-risk persons to an H.M.O. program. This effect dramatically increases the more the H.M.O. charges for its services compared to the fee-for-service alternative that is available to a given person. In other words, in order to carry out the State's responsibility to assure financial stability of an H.M.O., the regulatory system needs to allow the H.M.O. to deal with this problem and, short of cutting back services (which is unacceptable under other statutes and rules), the only cost containment device that is available is through the implementation of copayments.

MHD 369(c)(3)(cc)(ii), as proposed, would require an H.M.O. to include within the prepaid amount at least seventy-five percent of the cost or charges for the covered services and allows a maximum copayment up to twenty-five percent of the cost or charges. This standard establishes a reasonable, maximum copayment, which is in line with the practice of the Board of Health in the past, when considering other standards for reasonableness previously adopted and maintained by these rules. The practice of allowing the twenty-five percent maximum copayment in addition to a deductible feature is further justified on those limited types of services where it is allowed in the proposed rules, because those particular types of services have been demonstrated to be subject to abuse by enrollees such that the service is used inappropriately beyond the control of the H.M.O. management. With reasonable copayments, the enrollee has viable alternatives within the plan which would not impair or threaten the enrollee's health. Accordingly, the additional incentives, which would still have to be approved individually by the Board of Health, are justified and appropriate.

Proposed rule MHD 369(c)(3)(cc)(iii) is clearly justified by the findings as to low-income groups which is discussed above. While the presence of a copayment might not be a deterrent to receiving service in an affluent segment of the population, we are taking note that almost all H.M.O. enrollment is developed through employment groups and it is a practical impossibility to have different terms of coverage for different employees within a single group, depending upon the income level or other measures of financial ability of the employee. Accordingly, this is justified

as the only workable means of protecting low-income enrollees from a deterrent against needed preventive services.

As a general point, relative to all of the proposed substantive changes, it should be noted that, although there is literature and other resources available relative to the effects of copayments on the utilization of service, there is no good study which discusses the effect of copayments on the health status of enrolled individuals. Nevertheless, in the absence of any empirical data which would indicate that copayments will be a detriment to the health status of enrollees, these proposals which would protect the interests of the enrollees regardless of their income status, are justified as the proper execution of the regulatory authority to achieve greater availability of health care services to citizens of Minnesota, as articulated in Minn. Stat. Chapter 62D.

Section 2. MHD 369(g)

The proposed amendment to Minn. Reg. MHD 369(g) changes the effective date of these operating requirements from sixty to 180 days after the effective date of these rules. This additional time is necessary to develop the administrative capability to implement the rule changes. In consideration of the time necessary to draft new contracts, arrange the services under the different rules and to coordinate the administrative procedures to perform the services, 180 days rather than sixty days, is reasonable and necessary.

Section 3. Proposed Minn. Rule MHD 371

Minn. Stat. §62D.08, requires that each certified H.M.O. submit an annual report on or before April 1 relating to the preceding calendar year. This report is to contain certain items which are listed in that section of the statute and subdivision 3(e) of that section of the statute provides that the Board may require such other information as is necessary to assess the duties under the law. This amendment in Minn. Rule MHD 371 specifies one additional item of information that must be submitted in addition to the items required by statute and the items previously listed in this rule.

Information on the current schedule of enrollee charges is necessary for the Board to assess the financial stability of H.M.O.s as required in Minn. Stat. §62D.04, Subd. 1(e)(1) and to enable the State Board of Health to "assess the general reasonableness of charges" under Minn. Stat. §62D.19. Additionally, the State Board of Health is obliged to report to the Legislature the impact of H.M.O.s on the cost of health care to consumers (Minn. Stat. §62D.25). It is, therefore, reasonable and within the scope of the authority of the

State Board of Health to require the schedule of prepayment charges to be submitted in the annual report by H.M.O.s.

Section 4. Proposed MHD 372(a)

This proposed rule relates to termination of coverage based upon Minn. Stat. §62D.12, Subd. 2 which prohibits cancellation or failure to renew coverage on the part of an enrollee except in six specific situations and other situations which may be designated pursuant to rules promulgated by the Board of Health. "Enrollee moving out of the area served" is one of the permissible grounds for termination; however, this new rule clarifies the grounds for termination by stating that such termination must occur within one year following the date that the H.M.O. has been provided written notification of the address change. This rule is necessary to prevent an H.M.O. from terminating an enrollee at a late date on the grounds that the enrollee has moved outside of the service area; but, the actual situation for the termination at a late date may be some other reason such as the enrollee becoming afflicted with a chronic disease and, thereby, anticipating high utilization of services. This rule protects the enrollee from unjust termination following moving outside of the service area. Minn. Stat. §62D.12, Subd. 2 states the health maintenance organization "may" use moving out of the geographic service area as a grounds for termination. This rule clarifies the situation in which such termination may take place.

Section 5. Proposed Minn. Rule MHD 374

Minn. Stat. §62D.08 states that health maintenance organizations shall file notice with the Board prior to any modifications of certain operations or documents listed in the statutes. This proposed rule modifies the procedure in which such filings shall be submitted and creates an orderly process for handling of these filings. Since the State Board of Health meets once per month and the process for distribution of the Board's agenda and background material takes at least one week, it is reasonable and necessary that the materials to be submitted to the Board for its review shall be sent to the H.M.O. Unit's office at least fifteen days prior to the meeting of the full State Board of Health. The current practice of requiring the filings ten days prior to the meeting is insufficient time. For situations of urgency, this proposed rule permits H.M.O.s to file periodic changes less than fifteen days in advance of the meeting; however, the circumstances involved must be explained to the Board at that time.

Proposed MHD 374(c) relates to the documentation that must be submitted with filings of any contracts or evidences of coverage which contain copayment provisions. As stated under Section 1 of these proposed amendments to the H.M.O. rules, the Board must determine the impact and reasonableness of copayment provisions; therefore, sufficient evidence of the cost of the services on which

copayments are being proposed is necessary to make full determination of the percentage of such copayments and/or other determinations of proper copayments.

Analogous to the copayment filings, filings on amendments to service areas shall contain sufficient supporting documentation for the Board's determination of eligibility of that periodic filing. This rule is reasonable and necessary to reference the specific type of data necessary in making this determination. The types of data which the Board considers necessary is the proposed facility, the proposed personnel and the existing community standards for receiving health care. On the basis of that information, the Board will be able to determine compliance with the current MHD 379(d).

Proposed MHD 374(e) states that the Board will request additional data when it is necessary to determine the legal propriety of the filing. Such additional data may be necessary to fully explain the scope, nature or extent of the filed material. It is proper that the Board should request such additional data and failure to submit such data may quite likely place the Board in the situation where it lacks sufficient information to make an affirmative finding on the matter.

Section 6. MHD 375

Minn. Stat. §62D.03, Subd. 4(i) requires health maintenance organizations to describe their service areas at the time they apply for a certificate of authority from the Board. Likewise, an H.M.O. must file an amendment to its service area with the Board prior to implementing such change. Minn. Stat. §62D.15, Subd. 1(a) grants the Board the authority to suspend or revoke a certificate of authority of any H.M.O. which is operating contrary to the information submitted to it under Minn. Stat. §62D.03. This information does definitely include the H.M.O.'s service area. Therefore, it is implicit that the service area established by an H.M.O. is intended to be the primary area of new enrollment. Since the law clearly permits the Board to initiate disciplinary proceedings if an H.M.O. is operating beyond its service area, the Board does have authority to regulate this area of operation.

To allow for exceptions and mitigating circumstances whereby a person may be residing very close to the service area or the person may, for example, be expecting to move within the service area in the extremely near future, a system for enrollment of the specific individuals is provided. The statement of understanding must be signed by the prospective enrollee and the health maintenance organization and, therefore, this document will serve as the evidence that there was exclamation of the terms and conditions of enrollment and that both parties understand the limitations which the special enrollment has established.

RULES AMENDMENTS RELATING TO HMO's 5/7/76

RULES HEARING AGENDA AND GUIDELINES

This hearing is being conducted by an objective Hearing Examiner appointed and employed by the State Office of Hearing Examiners. He is not an employee of the agency proposing to promulgate these rules and has not discussed the merits of any questions involved with either the agency or with any other interested parties. He will strive to conduct an impartial, even-handed hearing in a fair and expeditious fashion. After the hearing he will weigh the evidence and arguments without any predisposition to either accept or reject the proposed rules in preparing Findings of Fact, Conclusions and Recommendations to the agency. The agency will then make its decision as to whether to adopt, modify or reject the proposed rules after waiting at least ten days, during which time the Findings of Fact and Recommendations will be available to affected persons. If you desire to be notified when these Findings are available, please so indicate on the register and be sure to include your phone number.

I. AGENDA

1. Hearing Convened by Hearing Examiner
2. Introduction of Agency Panel
3. Explanation of Procedure by Hearing Examiner
4. Introduction of Jurisdictional Documents
5. Presentation by Agency
6. Questions and Statements from Attorneys
7. Questions and Statements from Other Interested Persons
8. Hearing Closed by Hearing Examiner

If any person is peculiarly inconvenienced by the above agenda, such as having to get back to his employment or whatever, he should indicate this to the Hearing Examiner who will consider suspending the agenda to accommodate such special circumstances.

II. GUIDELINES

1. Everyone attending the hearing is required to sign the register as you enter indicating your name, address, and the interest or group you represent. If you wish to be notified when the Hearing Examiner's Findings and Recommendations are submitted to the agency, please so indicate.

2. The purpose of this hearing is to consider whether the proposed rules should be adopted and given the force of law, as if adopted by the Legislature itself. The agency must: (a) document its specific statutory authority to take the proposed action, (b) show that it has fulfilled all relevant substantive and procedural requirements of law or rule, and (c) demonstrate the need for and reasonableness of its proposed action with an affirmative presentation of facts. All persons wishing to express their views will have an opportunity to do so.

Hearing Exhibit No. 1
File No.
Date 5-7-76

3. When the Hearing Officer affords you an opportunity to testify, please step to the area designated for statements, spell your name for the benefit of the court reporter, identify your interest or firm, and speak clearly.

4. All witnesses testifying subject themselves to questioning by a representative of the agency, the Hearing Officer and others present. Non-agency interested persons may refuse to consent to questioning by other non-agency persons.

5. If a written statement or other matter reduced to writing is desired to be introduced in evidence, it should be presented to the court reporter to be marked as an exhibit and offered at the appropriate time. Written statements may be introduced at the time an individual offers an oral statement. The right of the agency or others to examine the individual presenting this written statement extends to the content of the statement offered in the written form.

6. This hearing will be recorded by a court reporter. Subsequently a transcript of the proceedings will be available. If you wish to have a copy of the transcript, for which there is a charge, kindly notify the reporter.

7. In order to aid the construction of a proper record, it is requested that witnesses observe the following rules:

a. Only one person shall be allowed to address the hearing at one time.

b. All answers must be verbalized. The court reporter cannot record gestures or the nodding of a head.

c. All technical terms and proper names should be spelled out for the benefit of the court reporter.

8. Attorneys unfamiliar with administrative practice should be aware that the emphasis will be on informality. Exclusionary rules of evidence will be interpreted liberally in the case of all presentations. Exceptions to any rulings are unnecessary and superfluous. The Hearing Examiner will determine what weight should be assigned to evidence and the Findings and Recommendations will be based only on substantial evidence.

9. It should be noted that anyone who desires to submit a written brief or other written comments bearing upon the proposed rules may do so within 20 days of the close of this hearing. Such materials should be submitted to:

Steve M. Mihalchick
Office of Hearing Examiners
Room 300
1745 University Avenue
St. Paul, Minnesota 55104

The materials must be received within the 20-day period to be considered.

* MUST BE RECEIVED BY MAY 27, 1976 *

10. You are advised that under Minnesota Statutes, Section 10A.01, Subdivision 11 (1974) any individual representing persons or associations attempting to influence administrative action, such as the promulgation of these rules, must register with the State Ethics Commission as a lobbyist within five days of the commencement of such activity by the individual.

Hearing Exhibit No. 2
File No.
Date 5-7-76

STATE OF MINNESOTA
COUNTY OF HENNEPIN

BEFORE THE MINNESOTA
STATE BOARD OF HEALTH

In the Matter of Proposed
Amendments Relating to
Health Maintenance
Organizations

NOTICE OF HEARING

Notice is hereby given that a public hearing will be held pursuant to Minn. Stat. § 15.0412 subd. 4 (1974), as amended by Minn. Laws 1975, ch. 380, in the above-entitled matter, in the Board Room, Minnesota Department of Health Building, 717 Delaware Street S.E., Minneapolis, Minnesota, on Friday, May 7, 1976, commencing at 1:30 P.M., and continuing until all representatives or other interested groups of persons have had an opportunity to be heard concerning adoption of the proposed rules captioned above by submitting either oral or written data, statements, or arguments. Statements or briefs may be submitted without appearing at the hearing.

Under Minn. Stat. § 10A.01 subd. 11 (1974) any individual engaged for pay or other consideration for the purpose of representing persons or associations attempting to influence administrative action, such as the promulgation of these proposed rules, must register with the State Ethics Commission as a lobbyist within five days of the commencement of such activity by the individual. The State Ethics Commission is located at 410 State Office Building, St. Paul, Minnesota 55155.

Pursuant to authority granted by Minn. Stat. § 62D.20 (1974) the Minnesota State Board of Health proposes to adopt amendments to existing rules relating to the following matters:

(a) Amendment of MHD 369(c)(3) to establish more complete standards relating to H.M.O. co-payments.

(b) Amendment of MHD 369(g) to change the effective date of these operating requirements from 60 to 180 days after the effective date of these rules.

(c) Amendment of MHD 371 to require an additional item of information in the annual report of an H.M.O.

(d) Amendment of MHD 372(a) relating to the termination of enrollees who move out of the area served by an H.M.O.

(e) Amend MHD 374 to provide additional time for the board to consider H.M.O. matters upon which it will act at a monthly board meeting and to insure sufficient documentation of matters submitted for consideration.

(f) Amendment of MHD 375 relating to areas an H.M.O. may serve.

A copy of the amendments proposed by the Minnesota State Board of Health is attached and made a part hereof.

Copies of the proposed rules are now available and may be obtained by writing to Mr. Kent Peterson of the Minnesota Department of Health, 717 Delaware Street S.E., Minneapolis, Minnesota 55440. Additional copies will be available at the door on the date of hearing.

Testimony or other evidence to be submitted for consideration should be pertinent to the matter at hand and may be presented either orally or in writing at the public hearing or by mailing a statement to the Secretary and Executive Officer of the Board at the Department of Health Building, address as above. If the person submitting a statement cannot be present to read his statement at the time of the hearing, the statement will be entered into the record. For those wishing to submit written statements or exhibits, it is requested that at least three (3) copies of such statement, exhibit or summary be furnished at the hearing. The record will remain open for

receipt of briefs or other written material relative to the proposed rules for twenty (20) days subsequent to the public hearing.

It is suggested that to save time and avoid duplication, those organizations or associations having a common viewpoint or interest in these proceedings join together where possible and present a single statement in behalf of such interests.

Dated: March 23, 1976

STATE OF MINNESOTA
BOARD OF HEALTH

WARREN R. LAWSON, M.D.
Secretary and Executive Officer

MINNESOTA DEPARTMENT OF HEALTH RULES
CHAPTER TWENTY-EIGHT

Proposed Amendments to Rules for
Health Maintenance Organizations

Section 1. MHD 369(c)(3) is amended as follows:

(3) Copayments, Limitations, Exclusions and Restrictions on Service. In addition to the limitations and exclusions allowed in MHD 369(c)(2), a health maintenance organization may impose copayments for services or goods provided and may impose certain restrictions on services;. ~~such as on frequency or length of time a health maintenance service is provided. Provided, however that all copayments, limitations and exclusions must be reasonable. The express policy of the Board is to favor limitations rather than exclusions, and the Board may limit the extent of limitations and/or exclusions which may be included in any health care plan to ensure that comprehensive health care services are reasonably available to enrollees. The standard of reasonableness shall be applied in full consideration of the general concept that a health maintenance organization must provide comprehensive health maintenance services in exchange for a single, prepaid sum.~~ Any such provisions must clearly be stated in the evidence of coverage in compliance with Minn. Stat. §62D.07, Subd. 3(b). and comply with the following standards:

(aa) Limitations and Exclusions. There may be no limitations or exclusions other than those allowed by the statutes or in rules promulgated pursuant to Minn. Stat. §62D.20. Where exclusions are allowed, it is the express policy of the Board to favor limitations rather than exclusions and the Board may limit the extent of limitations and/or exclusions which may be included in any health care plan to ensure that comprehensive health care services are reasonably available to enrollees. The standard of reasonableness shall be applied in full consideration of the general concept that a health maintenance organization must provide comprehensive health maintenance services in exchange for a single prepaid sum.

(bb) Restrictions. Reasonable restrictions other than limitations, exclusions and copayments are permissible. These include, but are not limited to restrictions on the frequency or length of time a health maintenance service is provided (example: repeated, frequent physical exams), or the denial of a service that is not reasonably required to maintain the enrollees in good health (example: physical exams requested only for the protection or convenience of third parties). The standard of reasonableness shall be applied in full consideration of the general concept that a health maintenance organization must provide comprehensive health maintenance services in exchange for a single, prepaid sum.

(cc) Copayments. Reasonable copayments as defined in Minn. Reg. MHD 367(k), are allowed. The standard of reasonableness shall be applied in full consideration of the general concept that a health maintenance organization must provide comprehensive health maintenance services in exchange for a single prepaid sum. Based on this measure of reasonableness, copayments shall be deemed reasonable and shall be approved by the Board upon the proper filing of a contract and evidence of coverage containing copayment provisions which comply with the following:

(i) Any amount or form of copayment may be imposed on services that, pursuant to MHD 369, may be excluded completely;

(ii) Copayments, other than those imposed pursuant to MHD 369(c)(3)(cc)(i) above and other than those for drug benefits, emergency care and out-of-area services, may not exceed twenty-five percent (25%) of the costs or charges for a particular service. In the case of emergency care by providers who do not have an arrangement with the health maintenance organization and in the case of out-of-area services, copayments may be imposed, either on specific services or in the aggregate, in the form of a reasonable "deductible," plus a twenty-five percent (25%) "coinsurance" feature, plus all charges which exceed a specified annual aggregate amount not less than $25,000.00. In the case of drug benefits,

a health maintenance organization may impose reasonable copayments as approved by the Board upon filing of the contract provision.

(iii) There may be no copayment imposed on preventive health care services as defined in MHD 367(e)(5) including, but not limited to, the administration of immunizations, well baby care, periodic screenings and prenatal care, provided that this prohibition against copayments on prenatal care shall not be construed to prohibit a copayment on maternity services in general, which may include prenatal care.

Sec. 2. MHD 369(g) is amended as follows:

(g) Effective date of Operating Requirements. When changes are required in existing evidences of coverage or health maintenance contracts in order to implement the provisions of these rules, such changes shall be implemented upon the renewal date of such documents commencing with the first renewal after 60 180 days after the effective date of these rules. New contracts or evidences of coverage to be implemented after 60 180 days after the effective date of these rules must be in compliance with these rules upon implementation.

Sec. 3. MHD 371 is amended as follows:

Annual Reports. In addition to all other information specified in the Act, every health maintenance organization shall include in its annual report to the Board the following:

(a) The results of any and all elections conducted during the preceding calendar year relative to consumer representation on the health maintenance organization's governing body.

(b) A copy of the health maintenance organization's most recent information summary provided to its enrollees in accordance with Section 62D.09 of the Act.

(c) A description of the method and results of the system to evaluate the quality of health services. Such evaluation shall include, but not necessarily be limited to, study of the quality of care for at least one disease condition or age group.

(d) A schedule of prepayment charges made to enrollees during the preceding year and any changes which have been implemented or approved up to the reporting date.

Sec. 4. MHD 372(a) is amended as follows:

(a) Termination of Coverage

(1) Justification. In addition to those reasons specified in Section 62D.12, Subdivision 2 of the Act, a health maintenance organization may, upon thirty (30) days notice, cancel or fail to renew the coverage of an enrollee if such enrollee:

(aa) Knowingly gives false, material information at the time of enrollment relative to his health status, provided such cancellation or non-renewal is made six (6) months of the date of enrollment.

(bb) Moves out of the geographic service area filed with the Board, provided such cancellation or non-renewal is made within one (1) year following the date the health maintenance organization was provided written notification of the address change.

Sec. 5. MHD 374 is amended as follows:

MHD 374 Periodic Filings

~~(a) Filing Requirements. Any filings that are required by Minn. Stat. §§62D.07, and 62D.08, Subd. 1, and this rule must be filed with the Department of Health no later than ten days~~

~~prior-to-the-second-Thursday-of-each-month,-which is-the-regular-meeting-date-of-the-Board,-unless there-is-an-important-and-unexpected-circumstance which-requires-filing-on-a-different-date.--If such-circumstance-exists,-the-filing-must-include a-statement-describing-the-circumstances-and-the urgency-of-the-Board's-attention-to-the-filing.~~

(a) Filing Requirements. Required filings will be acted upon at the next official meeting of the Board of Health following the filing date, provided the filing date is at least fifteen (15) days before said meeting. Exceptions to the requirement for filing fifteen (15) days in advance of a meeting will be made upon the filing of a statement of urgency and the circumstances involved.

(b) Provider Agreements. The provisions of Minn. Stat. §62D.08, Subd. 1 shall apply to any substantive modification in any agreement with providers as described and required for filing in MHD 368(e).

(c) The filing of any contracts or evidences of coverage pursuant to Minn. Stat. §62D.07 or §62D.08, Subd. 1, shall be accompanied by sufficient evidence on cost of services on which copayments are being imposed so as to allow the Board to determine the impact and reasonableness of the copayment provisions.

(d) Service Area. The filing of amendments to an H.M.O.'s geographic service area pursuant to Minn. Stat. §62D.08, Subdivision 1, and §62D.03, Subdivision 4(i) must contain sufficient supporting documentation of service area, facility and personnel availability and accessibility and existing community standards in receiving health care in other health care delivery systems so as to allow a determination of compliance with MHD 369(d).

(e) Upon receipt of any filing under Minn. Stat. §62D.07, 62D.08, Subd. 1 or MHD 374, the Board may request such additional data as is reasonably necessary to determine legal propriety of the filed material. Failure of a health maintenance organization to provide such data as required by MHD 374 or requested by the Board pursuant to this rule shall result in disapproval of the filing.

Sec. 6. MHD 375 is amended as follows:

MHD 375. Improper Practices

(a) It shall be an improper practice for a health maintenance organization to advertise or market its operation by making qualitative judgment or statements concerning any health professional who provides services for a health maintenance organization.

(b) A health maintenance organization shall not enroll a person who resides outside the health maintenance organization's defined service area, unless the health maintenance organization and prospective enrollee sign a statement of understanding. Such statement of understanding shall summarize the terms and conditions for provision of comprehensive health maintenance services and list the locations at which such services may be obtained.

Hearing Exhibit No. 3
In No.
HR Date 5-7-76

STATE OF MINNESOTA

COUNTY OF RAMSEY

In the Matter of the Proposed Amendments Relating to Health Maintenance Organizations

CERTIFICATE

I hereby certify that the 472 general labels and two page list for the Minnesota State Health Department all of which are attached and made a part hereof, constitute the complete lists of persons, associations, and other interested groups who as of 4:00 o'clock P.M., this 18th day of March, 1976, have requested pursuant to Minn. Stat. § 15.0412 subd. 4 (1974), that their names be placed on file with the Secretary of State for the purpose of receiving notice of public hearing on proposed rules on the subject captioned above.

Joan Anderson Growe
SECRETARY OF STATE

JOAN ANDERSON GROWE

By Cecil Dion

Hearing Exhibit No. 4
File No.
HxR Date 5-7-76

CERTIFICATE OF BOARD'S

AUTHORIZING RESOLUTION

I, Warren R. Lawson, M.D., do hereby certify that I am the Secretary and Executive Officer of the Minnesota State Board of Health, a board duly authorized under the laws of the State of Minnesota, and that the following are true, complete, and correct copies of resolutions adopted at meetings of the said Board of Health duly and properly called and held on the 11th day of December, 1975 and the 12th day of February, 1976; that a quorum was present at both meetings; that a majority of those present voted for the resolutions; that said resolutions are set forth in the minutes of each meeting and have not been rescinded or modified.

RESOLVED, that Warren R. Lawson, M.D., Secretary and Executive Officer of the Minnesota State Board of Health, be and he hereby is granted the authority and directed to call a hearing for the purpose of promulgating rules of the Board of Health relating to copayment provisions in Health Maintenance Organizations contracts and evidences of coverage as well as perform any and all acts incidental thereto, including but without being limited thereto, signing an order for hearing as well as acting as or appointing a presiding officer for all hearings.

December 11, 1975

RESOLVED, that Warren R. Lawson, M.D., Secretary and Executive Officer of the Minnesota State Board of Health, be and he hereby is granted the authority and directed to call a hearing for the purpose of amending rules of the Board of Health relating to certification and operation of Health Maintenance Organizations as well as perform any and all acts incidental thereto, including but without being limited thereto, signing an order for hearing and notice of hearing as well as acting as or appointing a presiding officer at all hearings.

February 12, 1976

IN WITNESS WHEREOF, I have hereunto subscribed my name this 7 day of May, 1976.

STATE OF MINNESOTA

BOARD OF HEALTH

Ellen Z Fiper
for WARREN R. LAWSON, M.D.
Secretary and Executive Officer

Hearing Exhibit No. 5
File No. 1kR Date 5-7-76

May 7, 1976

Warren R. Lawson, M.D.
Secretary and Executive Officer
State Board of Health
717 Delaware Street S.E.
Minneapolis, Minnesota 55440

Dear Doctor Lawson:

This letter is to serve as written comment on the proposed rules to be considered by the Board of Health at the hearings on Friday, May 7, 1976. This letter represents the consensus of several Health Maintenance Organizations including MedCenter Health Care, Nicollet-Eitel Family Health Plan, Physicians Health Plan, Share Health Plan and Ramsey Health Plan. Within the next few days, under separate cover, you may be receiving endorsement of the principles represented in this statement by several other HMOs. In general, it is our position that the proposed rules are unnecessary. While we recognize the need to clarify existing rules and regulations, we believe that the proposed new rules merely add further to the confusion which has existed since the passage of the HMO Act in 1973 and serve to unnecessarily complicate the ability of HMOs to deliver quality health care to citizens of Minnesota.

Our first general concern is that the legislative intent as described in 62D.01 subdivisions 2(a), 2(b), and 2(c) is not being fulfilled by the regulatory posture which has been adopted by the Board. It is our understanding that the purpose of the regulations is to carry out the intent of the legislature as stated in the aforementioned subdivisions. We take these passages to mean that it is the policy of the State of Minnesota to (a) "remove the barriers to the formation, promotion, and expansion of health maintenance organizations", (b) "to provide for their regulation by the State Board of Health", (c) "to exempt them from the operation of the insurance and non-profit health services plan corporation laws of the State..." and (d) "... to closely monitor the development of health maintenance organizations in order to assess their impact on the cost of health care to consumers, the accessibility of health care to consumers, and the quality of health care provided to consumers."

If the goal of the legislation is to make HMOs available to the people of Minnesota, then the goals of the regulations must be to allow HMOs to develop without encumbering them with strict requirements as to permissible organizational formats or the benefits they must offer.

We feel that the Board can better carry out the expressed policy of the legislation by concerning itself more with assuring that HMOs do not misrepresent themselves to their enrollees or to potential enrollees. We believe it is imperative to remember that no one is forced to join an HMO. Rather, each person has the right to choose between or among an indemnity insurance plan, a Blues plan, and one or a number of HMOs. Therefore, it should be the Board's primary concern to make sure that each potential enrollee is presented with a clear and concise statement of what the HMO proposes to offer in order that the enrollee may make an intelligent and rational decision. To that end, it should be the Board's policy to be flexible in dealing with HMOs, allowing them to set benefits within very broad parameters so long as they are well defined to prospective buyers.

It is also important to remember that it was envisioned by those sponsoring the HMO legislation that HMOs--as organized health care systems--would compete in the marketplace. We feel that the Board must set broad parameters because strict regulation will frustrate one of the most important principles behind the development of HMOs, that of market competition.

Finally, one of the effects of strict regulation is to fail to recognize the different wants and/or needs of the various enrollee populations to which HMOs must appeal. For instance, while some copays may act as a barrier to care for certain enrolled groups, the high premium cost of an HMO without copayments may, in fact, act as a barrier to a larger group of enrollees who wish to join an HMO.

A second general concern relates to the overall approach that the Board has taken in the past and in the proposed regulations. The burden of proof has been with an HMO to show that what the HMO proposes to do is not illegal. Furthermore, the Board has adopted the position that in the absence of a specific rule allowing an action, such action is assumed to be per se illegal. We believe that such a system denies the HMO due process. Worse yet, this approach stifles the opportunity for HMOs to be innovative. It is impossible for the Board to anticipate every public need and proactively promulgate a rule which permits HMOs to be responsive to existing and emerging public needs. Instead of concentrating on how to meet the requirements of our various publics, HMOs unfortunately now have to ask "what is permissible under the rules".

It is our belief that an HMO's filing should be accepted unless the Board can demonstrate in a clear and concise manner that what the HMO proposes is contrary to public law. Therefore, we propose that regulations be changed to require that, in the event that an HMO's filing is not accepted, the Board must provide written statement describing the grounds on which the denial was made.

Finally, to the extent that regulations are deemed necessary, the Board has an obligation to make them clear and concise. To that end, statements which appear in both the existing and proposed regulations such

as "the Board may request additional data as is reasonably necessary to determine", or "preventative health care services...including, but not limited to", must be replaced with clear and concise descriptions and/or definitions of what these terms mean and require. It is imperative that as businesses we know more definitively the boundaries within which we must live. Vagueness or ambiguities in the regulations only serve to make the task of complying with regulations more difficult and unnecessarily raise the cost of health care, which consumers ultimately bear. In addition, such variations and/or vagueness foster inconsistent regulation on the part of the Board when considering one HMO's contract versus the same contract or concept at a later date. And finally, variations and/or ambiguities in the regulations cause a great deal of uncertainty when we are in the marketplace attempting to serve the specific needs of our buyers.

Attached are specific recommendations and comments on the proposed new rules for Health Maintenance Organizations for your consideration on May 7, 1976. We honestly hope our recommendations will be received as a sincere effort to constructively assist the Board in implementing the spirit as well as the letter of of the 1973 HMO law.

Sincerely,

Ken Anderson
Executive Director
Ramsey Health Plan

Robert Ditmore
Executive Director
Share Health Plan

Steven Goldstone
Executive Director
MedCenter Health Care, Inc.

Doug Shaw
Executive Director
Physicians Health Plan

Douglas J. Westervelt
Executive Director
Nicollet-Eitel Family Health Plan

DJW:ch
Attachments

CHAPTER TWENTY-EIGHT

Proposed Amendments to Rules for
Health Maintenance Organizations

We recommend that Section 1. MHD 369(c)(3) be amended as follows:

(3) Copayments, Limitations, Exclusions and Restrictions on Service. In addition to the limitations and exclusions allowed in MHD 369(c)(2), a health maintenance organization may impose copayments for services or goods provided and may impose certain restrictions on services, such as on frequency or length of time a health maintenance service is provided. ~~Provided, however that all copayments, limitations and exclusions must be reasonable. The express policy of the Board is to favor limitations rather than exclusions, and the Board may limit the extent of limitations and/or exclusions which may be included in any health care plan to ensure that comprehensive health care services are reasonably available to enrollees. The standard of reasonableness shall be applied in full consideration of the general concept that a health maintenance organization must provide comprehensive health maintenance services in exchange for a single, prepaid sum.~~ However, any such copayment, limitation or exclusion must clearly be stated in the evidence of coverage in compliance with Minn. Stat. §62D.07, Subd. 3(b). ~~and comply with the following standards.~~

NOTE: All proposed new subsections (aa) (bb) (cc) should be eliminated.

(aa) Eliminate proposed new Limitations and Exclusions amendment.

(bb) Eliminate proposed new Restrictions amendment.

(cc) Eliminate proposed new Copayments amendment.

COMMENT: The proposed new subsections (aa), (bb) and (cc) to MHD369(c)(3) are unnecessary and introduce the inefficiencies of regulatory pricing in place of market determined prices. By not allowing HMO's the full flexibility of pricing in response to the spectrum of market demands, the Board assures that invariably some segment of society will be underserved.

. . . . . .

We recommend that the proposed new amendment Sec. 3. MHD371(d) be modified as follows:

(d) A schedule of prepayment charges made to enrollees during the preceding year. ~~and any changes which have been implemented or approved up to the reporting date.~~

COMMENT: As long as the Board affirms that this proposed new rule is not a prelude to premium regulation, we do not oppose it. The suggested modification simply avoids duplicating the same information which would be available (after the first year) in the previous year's annual report.

To Sec. 4. MHD 372(a), recommend (cc) be added as follows:

(cc) Abuses of the delivery system by repeatedly failing to keep scheduled appointments, or refuses to accept prescribed treatment provided that the enrollee is given a three (3) month notification of the intent to cancel or not renew coverage if such negligence continues.

We recommend that except for proposed new amendment (a) to Sec. 5. MHD374, the proposed new amendments (c), (d) and (e) be eliminated.

COMMENT: Repeating the thoughts expressed in greater detail in our cover letter, if the goal of the legislation is to make HMO's available to the people of Minnesota then the goals of the regulations must be to allow HMO's to develop without encumbering them with strict requirements as to permissible organizational formats or the benefits they must offer.

We feel that the Board can better carry out the expressed policy of the legislation by concerning itself more with assuring that HMO's do not misrepresent themselves to their enrollees or to potential enrollees. We believe it is imperative to remember that no one is forced to join an HMO. Rather, each person has the right to choose between or among an indemnity insurance plan, a blues plan, and one or a number of HMO's. Therefore, it should be the Boards' primary concern to make sure that each potential enrollee is presented with a clear and concise statement of what the HMO proposes to offer in order that the enrollee may make an intelligent and rational decision. To that end, it should be the Board's policy to be flexible in dealing with HMO's, allowing them to set benefits within very broad parameters so long as they are well defined to prospective buyers.

We recommend that in place of the proposed new (b) to Sec. 6. MHD375, the following be substituted:

(b) Upon receipt of a signed application, at its discretion an HMO may enroll a person living outside its service area.

COMMENT: Prospective enrollees receive notice of benefits and location of facilities as well as information on payments and copayments required and their obligations as an HMO enrollee. Consequently, (b) as proposed is an unnecessary duplication which is administratively burdensome and costly.

Central Minnesota
Group Health Organization, Inc.

RECEIVED
MAY 21 1976
OFFICE OF HEARING EXAMINERS

May 19, 1976

Steve Mihalchick
Office of Hearing Examiners
Room 300
1745 University Avenue
St. Paul, MN 55104

Dear Steve Mihalchick:

This letter is intended to serve as my endorsement of the principles represented in the recent letter sent Dr. Lawson by five other HMO Directors (5/7/76). Please give this detailed letter your careful consideration.

Sincerely,

Sharon Seivert

Sharon Seivert
Acting Executive Director

SS/jw

cc: Doug Westervelt

Exhibit No. AA
File No. HLTH-76-013-SM
SM Date 5/27/76

minnesota department of health
717 s.e. delaware st. minneapolis 55440

RECEIVED
MAY 26 1976
OFFICE OF HEARING EXAMINERS

May 24, 1976

Mr. Steven Mihalchick
Hearing Examiner
Office of the
Hearing Examiner
Room 300
1745 University Avenue
St. Paul, Minnesota 55104

Dear Mr. Mihalchick:

This letter is to supplement the written justifications submitted by the State Board of Health on May 7, 1976, in the matter of proposed rules for health maintenance organizations and, to further supplement the oral presentation delivered in the behalf of the State Board of Health at the May 7, 1976 public hearing.

The proposed amendment to MHD 369(c)(3) is needed for the State Board of Health to properly carry out its responsibilities to determine "reasonableness" of copayments charged by health maintenance organizations. Minn. Stat. §62D.02, Subd. 8, lists the following definition of a "health maintenance contract":

> "Subd. 8. 'Health maintenance contract' means any contract whereby a health maintenance organization agrees to provide comprehensive health maintenance services to enrollees, provided that the contract may contain reasonable enrollee copayment provisions. Any contract may provide for health care services in addition to those set forth in subdivision 7."

In order for the term "reasonable enrollee copayment provisions" to have the effect intended by the statute, there must be standards to determine the "reasonableness" of copayments and fee standards must be promulgated through the rulemaking process.

Further authorization for the State Board of Health to promulgate this rule is found in Minn. Stat. §62D.20, which requires the Board to promulgate rules to provide minimum requirements for H.M.O. services and reasonable exclusions therefrom.

Exhibit No. BB
File No. MLH-76-013-SM
Date 5/27/76

an equal opportunity employer

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It has been contended by some operators of health maintenance organizations that the Board should not promulgate rules specifying standards for the determination of "reasonableness," but should instead, permit Minnesota health maintenance organizations to make liberal use of copayments among their various benefit plans. Minnesota H.M.O. operators also suggest that the Board of Health should permit any copayments within large ranges of copayments based upon nationwide H.M.O. industry experience. The State Board of Health would then rule on copayment requests outside these ranges on a case-by-case basis.

It is the contention of the State Board of Health that the pending rules do permit an extremely broad range of copayments; that is, with certain exceptions, copayments are permitted up to 25% of the cost or charges of the health service. We believe that the 25% guideline is reasonable because charging the enrollee more than 25% of the cost or charge of the service would be contradictory to the basic philosophy of prepayment of a single, allocated sum of money. By using the 25% maximum figure there is considerable flexibility below that percentage sum for health maintenance organizations in Minnesota to effectively compete with other H.M.O.s and with health insurance plans and, to experiment with various levels of copayment and prepayment charges.

Attached is a chart showing the mandated H.M.O. services which have copayments being charged in at least some Minnesota health maintenance organizations. The chart lists the different copayment amounts and, the estimated average cost per service unit along with the percentage which this copayment represents.

We feel that this chart of percentages of copayments shows that the present level of H.M.O. copayments which would be affected by this rule is well below 25% of the average cost or charge of services. Therefore, there would be no adverse effect on current H.M.O. service copayments and, Minnesota health maintenance organizations would have considerable flexibility to develop new copayments if such is necessary according to their reasoning, up to the 25% level.

It is significant to point out that some H.M.O.s have no copayments on any of the above-listed, required services. No H.M.O. has all of these copayments; but instead, this above list represents an accumulation of the charges of all nine Minnesota health maintenance organizations.

It is the feeling of the Board that it would be undesirable to have total flexibility in the setting of copayment amounts and, it would be contrary to the intent of the law for the Board to not interpret the "reasonableness" of copayment proposals. The process of developing administrative rules for such matters as this is fundamental to Minnesota law and, the Board feels that

remaining silent in its rules on the copayment matter would be a disservice to the citizens of Minnesota. Furthermore, the Board has presented a reasonable standard for judging copayments which will not be a hardship on the current practice of the health maintenance organization industry, nor will it impose an unworkable structure for future consideration of copayment charges.

In other matters which have received comment from operators of Minnesota health maintenance organizations, we would first wish to provide additional information regarding amendments to MHD 371(d), relative to the annual report information. We believe that reporting of changes in the prepayment charges which have been implemented or approved up until the reporting date (April 1 of the year following the report year) is a necessary rule in order for the Board to obtain timely information of charge schedules by Minnesota health maintenance organizations. Pursuant to Minn. Stat. §62D.15, Subd. 1(d), the Board must be able to continually examine the financial responsibility of health maintenance organizations and must assess the organization's ability to meet its obligations to enrollees. One of the standards in determining financial responsibility, as established by Minn. Stat. §62D.04, Subd. 1(e), is "the financial soundness of its . . . schedule of charges."

To wait for an additional year to receive information on prepayment charges would be an improper delay and, would mean that the Board would not obtain appropriate information to evaluate the financial conditions of health maintenance organizations. Reporting of the changes which have been made between January 1 and April 1 would not impose any administrative burden on health maintenance organizations and, could be very simply entered onto the annual report form.

While there were other recommendations made by representatives of Minnesota health maintenance organizations, we do not feel that they require comment at this time because of our previous written justifications and oral comments which sufficiently cover these matters.

Sincerely,

Kent E. Peterson

Kent E. Peterson
H.M.O. Unit

KEP:kmt
Enclosure

REQUIRED H.M.O. SERVICES

SERVICE	COPAYMENT	EST. AV. COST/ SRV. UNIT	% OF AV. COST
I. HOSPITAL CARE			
A. Outpatient Hospital Visit	$10/Visit; Except when followed by admission	$ 46.00	21%
	$5/Visit; Except when followed by admission.	$ 46.00	10%
B. Inpatient Care for Mental, Emotional, Drug or Alcohol Addiction	$25/Day	$ 125.00	20%
	$15/Day	$ 125.00	12%
II. MEDICAL CARE (Inc. Lab & X-ray)			
A. Routine Visits in H.M.O. Clinic	$3/Visit	$ 26.00	11%
B. House Calls			
Anytime	$.25/Mile	$ 40.00	.6%
. . . . .	$10	$ 40.00	25%
Daytime	$3	$ 40.00	7%
. . . . .	$5	$ 40.00	12%
Night	$5	$ 40.00	12%
. . . . .	$7	$ 40.00	17%
C. Outpatient Treatment for Mental, Emotional, Drug or Alcohol Addiction	$5/Visit for 5 Visits and, $10/Visit Thereafter	$ 50.00	10%, 20%
III. MATERNITY CARE			
Medical/Hospital Combined (In-Plan)	$200	$1500.00	13%

GROUP HEALTH PLAN, INC.
2500 Como Avenue
Saint Paul, Minnesota 55108

May 11, 1976

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MAY 27 1976
OFFICE OF HEARING
EXAMINERS

Secretary and Executive Officer
State Board of Health
Minnesota Department of Health Building
717 Southeast Delaware
Minneapolis, Minnesota 55440

Dear Sir:

We are pleased to register some suggestions for improvements in the proposed amendments to rules governing Health Maintenance Organizations which you presented at a hearing on May 7, 1976.

Attached is a copy of your proposed amendments. Suggested changes are entered in red and though they are believed to be self-explanatory, some further explanations follow coinciding by number with the number on the left margin near the proposed change:

1. This statement is totally gratuitous. Either exclusions are allowed or they are not allowed.

2. There is no such thing as limiting the extent of an exclusion. Either it is excluded or it is not excluded.

3,4,5. This is a meaningless subjectivity. Repeated almost verbatim in three successive subparagraphs it has the ring of a litany. Has anyone ever defined the now threadbare, "Standard of Reasonableness"?

6. Why this? The State Catastrophic bill exists for the catastrophe. To put provisions like this in HMO coverage is to say no one with HMO coverage will ever get a Catastrophic benefit--and HMO's will pay for all catastrophes.

7. This gives and takes away in the same sentence.

8. Should be an obvious--but better stated.

9. Where you have a permitted limit of copayment percentage (25%), justification is inherent in it.

10. It is unethical to estimate the quality of service by others ("existing community standards") as much as to do the same for ourselves (see MHD 375). We believe that the board should recognize that the most compelling reason for expanding the service area is to make an alternative health care delivery system available.

Exhibit No. CC
File No. HLTH-76-013-SM
SM Date 5/27/76

11: The original language imposes too much of an administrative burden. The enrollee has been told of his strait. A letter notice to him, if he is accepted, should be adequate reinforcement.

Very truly yours,

John E. Thames

John E. Thames
Assistant to the General Manager

JET/kw
Encl.

MINNESOTA DEPARTMENT OF HEALTH RULES
CHAPTER TWENTY-EIGHT

Proposed Amendments to Rules for
Health Maintenance Organizations

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OFFICE OF HEARING
EXAMINERS

Section 1. MHD 369(c)(3) is amended as follows:

(3) Copayments, Limitations, Exclusions and Restrictions on Service. In addition to the limitations and exclusions allowed in MHD 369(c)(2), a health maintenance organization may impose copayments for services or goods provided and may impose certain restrictions on services~~,~~. ~~such-as-on-frequency-or-length-of-time a-health-maintenance-service-is-provided.--Provided,-however-that all-copayments,-limitations-and-exclusions-must-be-reasonable. The-express-policy-of-the-Board-is-to-favor-limitations-rather-than exclusions,-and-the-Board-may-limit-the-extent-of-limitations and/or-exclusions-which-may-be-included-in-any-health-care-plan to-ensure-that-comprehensive-health-care-services-are-reasonably available-to-enrollees.--The-standard-of-reasonableness-shall-be applied-in-full-consideration-of-the-general-concept-that-a-health maintenance-organization-must-provide-comprehensive-health-maintenance-services-in-exchange-for-a-single,-prepaid-sum.~~ Any such provisions must clearly be stated in the evidence of coverage in compliance with Minn. Stat. §62D.07, Subd. 3(b)~~.~~ and comply with the following standards:

(aa) Limitations and Exclusions. There may be no limitations or exclusions other than those allowed by the statutes or in rules promulgated pursuant to Minn. Stat. §62D.20. ~~Where exclusions are allowed it is the express policy of the Board to favor limitations rather than exclusions~~ and the Board may limit the extent of limitations ~~or exclusions~~ which may be included in any health care plan to ensure that comprehensive health care services are reasonably available to enrollees. ~~The standard of reasonableness shall be applied in full consideration of the general concept that a health maintenance organization must provide comprehensive health maintenance services in exchange for a single, prepaid sum.~~

(bb) Restrictions. Reasonable restrictions other than limitations, exclusions and copayments are permissible. These include, but are not limited to restrictions on the frequency or length of time a health maintenance service is provided (example: repeated, frequent physical exams), or the denial of a service that is not reasonably required to maintain the enrollees in good health (example: physical exams requested only for the protection or convenience of third parties). ~~The standard of reasonableness shall be applied in full consideration of the general concept that a health maintenance~~

organization to provide comprehensive health maintenance services in exchange for a single, prepaid sum.

(cc) Copayments. Reasonable copayments as defined in Minn. Reg. MHD 367(k), are allowed. The standard of reasonableness shall be applied in full consideration of the general concept that a health maintenance organization must provide comprehensive health maintenance services in exchange for a single, prepaid sum. Based on this measure of reasonableness, copayments shall be deemed reasonable and shall be approved by the Board upon the proper filing of a contract and evidence of coverage containing copayment provisions which comply with the following:

5

(i) Any amount or form of copayment may be imposed on services that, pursuant to MHD 369, may be excluded completely;

(ii) Copayments, other than those imposed pursuant to MHD 369(c)(3)(cc)(i) above and other than those for drug benefits, emergency care and out-of-area services, may not exceed twenty-five percent (25%) of the costs or charges for a particular service. In the case of emergency care by providers who do not have an arrangement with the health maintenance organization, and in the case of out-of-area services, copayments may be imposed, either on specific services or in the aggregate, in the form of a reasonable "deductible," plus twenty-five percent (25%) "coinsurance". The deductible charges which are used as specified in maintenance agreements shall not be less than $[illegible]. In the case of drug benefits, a health maintenance organization may impose reasonable copayments as approved by the Board upon filing of the contract provision.

6

(iii) There may be no copayment imposed on preventive health care services as defined in MHD 367(e)(5) including, but not limited to, the administration of immunizations, well baby care, periodic screenings, prenatal care. Nothing in this prohibition against copayments on prenatal care shall be construed to prohibit a copayment on maternity services in general, which may include prenatal care.

7

Sec. 2. MHD 369(g) is amended as follows:

(g) Effective date of Operating Requirements. When changes are required in existing evidences of coverage or health maintenance contracts in order to implement the provisions of these rules, such changes shall be implemented upon the renewal date of

such documents commencing with the first renewal after 60 180 days after the effective date of these rules. New contracts or evidences of coverage to be implemented after 60 180 days after the effective date of these rules must be in compliance with these rules upon implementation.

Sec. 3. MHD 371 is amended as follows:

Annual Reports. In addition to all other information specified in the Act, every health maintenance organization shall include in its annual report to the Board the following:

(a) The results of any and all elections conducted during the preceding calendar year relative to consumer representation on the health maintenance organization's governing body.

(b) A copy of the health maintenance organization's most recent information summary provided to its enrollees in accordance with Section 62D.09 of the Act.

(c) A description of the method and results of the system to evaluate the quality of health services. Such evaluation shall include, but not necessarily be limited to, study of the quality of care for at least one disease condition or age group.

(d) A schedule of prepayment charges made to enrollees during the preceding year and any changes which have been implemented or approved up to the reporting date.

Sec. 4. MHD 372(a) is amended as follows:

(a) Termination of Coverage

(1) Justification. In addition to those reasons specified in Section 62D.12, Subdivision 2 of the Act, a health maintenance organization may, upon thirty (30) days notice, cancel or fail to renew the coverage of an enrollee if such enrollee:

(aa) Knowingly gives false, material information at the time of enrollment relative to his health status, provided such cancellation or non-renewal is made within six (6) months of the date of enrollment.

(bb) Moves out of the geographic service area filed with the Board, provided such cancellation or non-renewal is made within one (1)

year following the date the health maintenance organization was provided written notification of the address change.

Sec. 5. MHD 374 is amended as follows:

MHD 374 Periodic Filings

~~(a)--Filing-Requirements.--Any-filings-that-are-required-by-Minn.-Stat.-§§62D.07,-and-62D.08,-Subd.-1,-and this-rule-must-be-filed-with-the-Department-of-Health-no later-than-ten-days-prior-to-the-second-Thursday-of-each month,-which-is-the-regular-meeting-date-of-the-Board, unless-there-is-an-important-and-unexpected-circumstance which-requires-filing-on-a-different-date.--If-such-circumstance-exists,-the-filing-must-include-a-statement describing-the-circumstances-and-the-urgency-of-the-Board's attention-to-the-filing.~~

(a) Filing Requirements. Required filings will be acted upon at the next official meeting of the Board of Health following the filing date, provided the filing date is at least fifteen (15) days before said meeting. Exceptions to the requirement for filing fifteen (15) days in advance of a meeting will be made upon the filing of an acceptable statement of urgency and the circumstances involved.

8

(b) Provider Agreements. The provisions of Minn. Stat. §62D.08, Subd. 1 shall apply to any substantive modification in any agreement with providers as described and required for filing in MHD 368(e).

(c) The filing of any contracts or evidences of coverage pursuant to Minn. Stat. §62D.07 or §62D.08, Subd. 1, shall be accompanied by sufficient evidence on cost of services on which copayments are being imposed so as to allow the Board to determine the impact and reasonableness of the copayment provisions, specifically that copayment provisions consisting of an acceptable percentage pursuant to MHD 369(c)(3)(cc)(ii) above require no evidence on cost of services

9

(d) Service Area. The filing of amendments to an H.M.O.'s geographic service area pursuant to Minn. Stat. §62D.08, Subdivision 1, and §62D.03, Subdivision 4(i) must contain sufficient supporting documentation ~~of service, access, facility and personnel availability and accessibility and existing community standards for receiving health care in other health care delivery systems~~ so as to allow a determination of compliance with MHD 369(d).

10

(e) Upon receipt of any filing under Minn. Stat. §62D.07, §62D.08, Subd. 1 or MHD 374, the Board may request such additional data as is reasonably necessary to determine legal propriety of the filed material. Failure of a health maintenance organization to provide such data as required by MHD 374 or requested by the Board pursuant to this rule shall result in disapproval of the filing.

Sec. 6. MHD 375 is amended as follows:

MHD 375. Improper Practices

(a) It shall be an improper practice for a health maintenance organization to advertise or market its operation by making qualitative judgment or statements concerning any health professional who provides services for a health maintenance organization.

(b) A health maintenance organization shall not enroll a person who resides outside the health maintenance organization's defined service area, unless the health maintenance organization ~~and a prospective enrollee sign a statement of understanding. Such statement of understanding shall summarize the terms and conditions for provision of comprehensive health maintenance services and list the locations at which such services may be obtained.~~ explains by letter to the enrollee the consequences.

STATE OF MINNESOTA

COUNTY OF HENNEPIN

BEFORE THE MINNESOTA

STATE BOARD OF HEALTH

In the Matter of the Proposed Amendments Relating to Health Maintenance Organizations.

ORDER ADOPTING RULES

The above-entitled matter came on for hearing before the Minnesota State Board of Health on the 7th day of May, 1976, at 1:30 P.M. in the Board Room, Minnesota Department of Health Building, 717 Delaware Street S.E., Minneapolis, Minnesota 55440, after proper notice required by Minn. Stat. § 15.0412 (Supp. 1975) was served upon all persons, associations and other interested groups registered with the Secretary of State for that purpose.

After affording interested persons an opportunity to present written and oral data, statements and arguments, and having heard and considered all of the testimony and evidence adduced and upon the records, files and proceedings herein, and applicable statutory standards or criteria, and having confirmed the need for the above-captioned rules and the reasonableness thereof.

NOW, THEREFORE, IT IS ORDERED that these rules identifed as Amendments Relating to Health Maintenance Organizations are adopted this 8th day of September, 1976, pursuant to authority vested in me by Minn. Stat. § 62D.20 (1974), and by resolution of the Minnesota State Board of Health duly adopted at a meeting of the said Board on the 12th day of August, 1976.

STATE OF MINNESOTA

BOARD OF HEALTH



WARREN R. LAWSON, M.D.
Secretary and Executive Officer

CERTIFICATE OF BOARD'S

ADOPTION OF RULES RESOLUTION

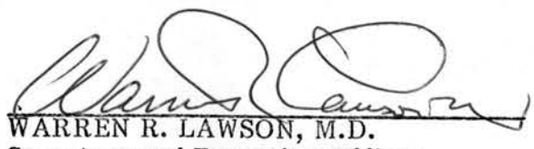
I, Warren R. Lawson, M.D., do hereby certify that I am the Secretary and Executive Officer of the Minnesota State Board of Health, a board duly authorized under the laws of the State of Minnesota, and that the following is a true, complete, and correct copy of a resolution adopted at a meeting of the said Board of Health duly and properly called and held on the 12th day of August, 1976; that a quorum was present at said meeting; that a majority of those present voted for the resolution; that said resolution is set forth in the minutes of said meeting and has not been rescinded or modified.

> "RESOLVED, that the amendments to the rules relating to Health Maintenance Organizations identified as MHD 369(c)(3), 369(g), 371, 372(a), 374 and 375 are found to be reasonable, necessary and supported by the evidence contained in the record, and are hereby approved and adopted, pursuant to authority vested in us by Minn. Stat. § 62D.20 (1974) and that Warren R. Lawson, M.D., Secretary and Executive Officer of the Minnesota State Board of Health, be and hereby is authorized to sign an order adopting those rules."

IN WITNESS WHEREOF, I have hereunto subscribed my name this 8th day of September, 1976.

STATE OF MINNESOTA

BOARD OF HEALTH



WARREN R. LAWSON, M.D.
Secretary and Executive Officer

STATEMENT OF COMPLIANCE WITH

MANUAL OF RULE MAKING PROCEDURES

I, Special Assistant Attorney General John A. Breviu, do hereby declare that I have examined the proposed rules relating to Health Maintenance Organizations and all related documents and that, based on them and my personal familiarity with the applicable procedures, the Manual of Rule Making Procedures has been followed.

Dated: September 15, 1976

John A. Breviu

JOHN A. BREVIU
Special Assistant
Attorney General

STATE OF MINNESOTA
OFFICE OF HEARINGS EXAMINERS

FOR THE MINNESOTA STATE BOARD OF HEALTH

In the Matter of Proposed Amendments Relating to Health Maintenance Organizations.

REPORT OF HEARING EXAMINER

The above-entitled matter came on for hearing on May 7, 1976 at Minneapolis before Steve M. Mihalchick, Hearing Examiner appointed by the Chief Hearing Examiner.

This is a rules hearing pursuant to Minn. Stat., Chapter 15, to determine whether proposed amendments to the following rules should be adopted: Minn. Rules MHD 369(c)(3), 369(g), 371, 372(a), 374 and 375.

John A. Breviu, Special Assistant Attorney General, appeared on behalf of the Department of Health. Kent Peterson appeared on behalf of the Department, HMO unit. Eight persons attending the hearing signed the register. The hearing continued until all interested groups and persons had an opportunity to be heard.

Pursuant to Minn. Stat. §§ 15.0412, subd. 4, and 15.052, subd. 4 (Supp. 1975), the Board of Health shall make this report available to all affected individuals upon request for at least ten days before it takes any final action on the proposed amendments.

The Board shall, if it proposes to adopt the rules as originally proposed or amended, submit the complete hearing record to the Chief Hearing Examiner no earlier than ten days subsequent to the receipt of this Report. It shall include the rules as originally proposed and the rules as proposed for adoption in final form.

The submission to the Chief Hearing Examiner shall precede review by the Attorney General. The Chief Hearing Examiner shall complete his reviewsand submit his report to the Board on the issue of substantial changes in the rule within ten calendar days. The Board will be responsible for filing the rules with the Attorney General.

Based upon the proceedings herein, the Examiner makes the following:

FINDINGS OF FACT

PROCEDURAL REQUIREMENTS

1. On March 26, 1976, the Board of Health (Board) filed the following documents with the Chief Hearing Examiner:

(a) A proposed Order for Hearing;

(b) A proposed Notice of Hearing with the proposed amendments attached; and

(c) A statement of the number of persons expected to attend and estimated length of hearing.

2. On April 2, 1976, the Board mailed the Notice of Hearing to all persons and associations who had registered their names with the Secretary of State for the purpose of receiving such notice, to all persons and associations on a list maintained by the Department of Health (Department) and to all members of the Legislature.

3. On April 12, 1976, the Board filed with the Office of Hearings Examiners the following documents:

(a) The Order for Hearing;

(b) The Notice of Hearing as mailed;

(c) The affidavit of receipt of the Secretary of State's list;

(d) The Affidavit of Mailing;

(e) The Statement of Need;

(f) The affidavit of mailing of a notice pursuant to Minn. Stat. § 15.0412, subd. 6, a copy of the Notice and material received pursuant to the Notice.

(g) The names of Department personnel who will represent the agency.

(h) A summary of evidence.

The documents were available for inspection at the Office of Hearing Examiners from the date of filing to the date of the hearing. On April 19, 1976, the Board filed an amended Affidavit of Mailing which, in substance, deleted the statement that the Secretary of State's list was attached.

4. The record was closed at the end of the day on May 27, 1976.

GENERAL AUTHORITY

5. The Health Maintenance Act of 1973 (Act), coded as Minn. Stat., Chapter 62D, is the statute governing Health Maintenance Organizations (HMOs) in Minnesota. Minn. Stat. § 62D.20 provides:

> REGULATIONS. The board may, pursuant to chapter 15, promulgate such reasonable rules and regulations as are necessary or proper to carry out the provisions of sections 62D.01 to 62D.29. Included among such regulations shall be those which provide minimum requirements for the provision of comprehensive health maintenance services, as defined in section 62D.02, subdivision 7, and reasonable exclusions therefrom.

6. By resolutions of December 11, 1975 and February 12, 1976, the Board authorized its Secretary and Executive Officer to conduct hearings for the purpose of promulgating and amending rules relating to copayment provisions, evidences of coverage, and certification and operations of HMOs.

PROPOSED AMENDMENTS TO MINN. RULE MHD 369(c)(3)

7. The Board, as part of its duty of approving and issuing certificates of authority under § 62D.04, and of approving modifications of operations or documents under § 62D.08, subd. 1, must approve health maintenance contracts with enrollees. Under § 62D.02, subd. 8, such contracts may contain reasonable enrollee copayment provisions. Under § 62D.20, the Board is specifically directed to define minimum requirements for provided services and reasonable exclusions therefrom. The existing MHD 369(c)(3) states generally that reasonable copayments, limitations, exclusions and restrictions may be imposed on provided services. The Board is authorized to set limitations and restrictions because they are, in effect, modified forms of exclusions. It is necessary to define, as much as possible, the parameters which the Board will use for determining whether any of these provisions are reasonable; both as guidelines for the Board in making its determinations, and for the HMOs in negotiating and drafting the contracts.

8. Subparagraph (aa) of the rule is a restatement of the existing part of the rule relating to limitations and exclusions and thus is not an amendment. Further justification is not required.

9. Subparagraph (bb) would further clarify the standard of reasonableness as applied to restrictions on provided services. Two factors in determining reasonableness are described:

(1) restrictions on the frequency or length of time a health maintenance service is provided; and

(2) the denial of a service that is not reasonably required to maintain the enrollee in good health.

The first of these factors is necessary so that repeated, frequent physical examinations or other similar procedures would not be required of HMOs. This factor is authorized under § 62D.02, subd. 7, which mandates only services which are "reasonably" required to maintain a person in good health. The "reasonableness" may be a factor of frequency or length of time. The second factor is specifically authorized in § 62D.02, subd. 7, which defines"comprehensive health maintenance services" to include only those services which "enrollees might reasonably require to be maintained in good health. . . ." Pursuant to that statute, the Board of Health has allowed HMOs to refrain from rendering services in certain circumstances or to refrain from providing certain kinds of services when the circumstance or the kind of service went beyond the scope of service defined in the statute. This addition to the rule would categorize that type of "exclusion" from the covered services and subject it to the reasonableness standard as is the case with all other limitations, exclusions and copayments. It is necessary and reasonable.

10. Subparagraph (cc) is the major revision in MHD 369 (c)(3). More complete standards for copayments are listed there. The proposed rule restates the existing standard, that reasonableness is determined in full consideration of the general concept that an HMO must provide comprehensive health maintenance services in exchange for a single, prepaid sum. However, this standard by itself created confusion and uncertainty in the management and operation of HMOs and in development and negotiation of HMO contracts. It was, therefore, necessary to develop more precise standards.

11. The first standard is that any amount or form of copayment may be imposed upon a service that the law and rules permit as an exclusion. It would be unreasonable to not permit a copayment on these services when the entire service may be excluded.

12. The second standard is that copayments on services, other than those listed otherwise, may not exceed 25 percent of the cost or charges for that particular service. This fixed, mechanical formula would be applied to all services of the health maintenance organization other than those specifically listed. Mr. Peterson testified that this is a reasonable means to provide the flexibility in the operating standards of health maintenance organizations to permit competitive pricing of the health maintenance organizations' contracts with the dual option health insurance contracts and contracts of nonprofit health service plans.

There was strong opposition by the group of HMOs, represented by Mr. Shaw, to the use of a mechanical formula to determine reasonable copayments. First, the legality of the requirement was questioned. Copayments and capitation rates make up HMO income; an adjustment to one necessarily requires adjustment to the other. Thus, it is argued that regulation of copayments amounts to regulation of rates. Second, it was argued that the market should determine what reasonable copayments are. These HMOS stated that they deal with sophisticated, but diverse buyers, and the needs of one group may make a high level of copayment on a particular service reasonable. Thus, these HMOs feel that the parameters for copayments should be very broad, and each contract examined on a case by case basis to determine reasonableness.

The Board has legal authority to limit copayments because it has authority to define minimum requirements for provided services and because it must determine whether contracts contain "reasonable" copayment terms. It is a basic function of rule-making to define and clarify such broad terms where possible.

The 25 percent guideline is reasonable because charging the enrollee more than 25 percent of the cost or charge of the service would be contradictory to the basic philosophy of prepayment of a single, allocated sum of money. By using the 25 percent maximum figure, there is considerable flexibility below that percentage sum for health maintenance organizations in Minnesota to effectively compete with other HMOs and with health insurance plans and to experiment with various levels of copayment and prepayment charges. No current HMO contract in the state has copayment rates on any service above 25 percent.

13. Emergency care and out-of-area services are not provided through arrangements by the health maintenance organization, and, therefore, it is quite reasonable that other payment mechanisms may be used for these services. The rule permits deductibles or coinsurance features to be used in these situations where the plan organized system is not used, and the service is controlled by other factors of the health care delivery system. It is necessary for certain HMOs to control these "unarranged" services in a more stringent fashion, and, thereby, the additional copayment flexibility is reasonable and necessary.

14. Drug benefits are much less frequently found in health insurance and nonprofit health service plan contracts, and, therefore, the health maintenance organization has difficulty competing with these other plans. While drug benefits are necessary to maintain a person in good health, it is quite reasonable that the copayment on these drug benefits may need to be higher than 25 percent of the cost for the particular service when the dual option indemnity plan has no drug benefits. Therefore, the drug benefit copayment is reasonably more flexible than the 25 percent standard.

15. Proposed Minn. Rule MHD 369(c)(3)(cc)(iii) completely prohibits copayments on those services which are defined to be preventive health care services. Mr. Peterson felt that imposition of a copayment on preventive services may present a barrier

to people achieving a maintenance level of health. His research indicated that the presence of copayments acts as a deterrent to low-income persons receiving even preventive care. Preventive care for a fixed fee is the basic philosophy of the Act. Thus, this requirement is reasonable and justified. Questions were raised as to the vagueness of the definition of preventive health care services and to the fact that it is not always possible for an HMO to determine, at the outset, whether a provided service, an office visit, for example, is a preventive service or not. The vagueness is caused by the use of the term "including,but not limited to, . . .". The Examiner agrees that the clause defeats the purpose of the rule - to define and clarify. Therefore, as written, MHD 369(c)(3)(cc)(iii) is not reasonable. If the clause "but not limited to," is stricken, the rule is reasonable.

16. General support for the amendments to MHD 369(c)(3) was expressed in prehearing comments by Med Center Health Plan, Inc., and the Director of group health services for Northwestern National Life Insurance. Med Center later joined in Mr. Shaw's objections. Group Health Plan, Inc. did not object to the rule but offered several grammatical suggestions.

The Examiner is concerned with an apparent internal inconsistency in MHD 369(c)(3)(cc). The last sentence in the introductory paragraph states that contracts complying with the following subparagraphs will be "deemed reasonable." Technically, only MHD(c)(3)(cc)(i) is phrased as a "reasonable" provision. Subparagraphs (ii) and (iii) are phrased as limitations or exclusions, in other words, as "non-reasonable" provisions. The last sentence of the introductory paragraph should be deleted or subparagraphs (ii) and (iii) should be reworded to remove the inconsistency.

PROPOSED AMENDMENT TO MINN. RULE MHD 369(g)

17. Consistent with the authority to adopt rules is the authority to delay their implementation to allow changes in administrative systems, documents and contracts to be made by the agency and the HMOs. Failure to allow a delay would place an

impossible burden on the HMOs and thus a delay is necessary.

18. Considering the time necessary to draft new contracts, arrange the services under the different rules and to coordinate the administrative procedures to perform the services, 180 days is a reasonable period of delay. There was no opposition to this amendment.

PROPOSED AMENDMENT TO MINN. RULE MHD 371.

19. Minn. Stat. § 62D.08, requires that each certified HMO submit an annual report on or before April 1 relating to the preceding calendar year. The report is to contain certain items listed in the statute. Subdivision 3(e) of that section provides that the Board may require such other information as is necessary to carry out its duties. The amendment specifies one additional item of information: A schedule of prepayment charges during the preceding year and changes implemented or approved up to the reporting date.

20. Information on the current schedule of enrollee charges is necessary for the Board to assess the financial stability of HMOs as required by Minn. Stat. §§ 62D.04, subd. 1(e)(1) and 62D.15(1)(d), and to assess the general reasonableness of charges as required by Minn. Stat. § 62D.19.

21. Requiring the submission of this information in the regular annual report is a reasonable means of meeting the need. Except for an apprehension that the submission of the schedule of prepayment charges was "a prelude to premium regulation" expressed by Mr. Shaw, there was no opposition to the amendment. Mr. Shaw's group did recommend that the requirement of reporting changes effective between the end of the reporting year and the report date be deleted. The same information would be submitted the following year. However, without the most current information, the Board cannot properly perform its continuing responsibility to assess the financial condition of HMOs. The Board would be operating with stale information. The burden on the HMOs of noting rate changes on their annual report is not unreasonable.

PROPOSED AMENDMENT TO MINN. RULE MHD 372(a)

22. The proposed amendment defines and clarifies limits on the right of HMOs to terminate enrollees who move out of the service area. Such termination, or failure to renew, is permitted under Minn. Stat. § 62D.12, subd. 2. The section also provides that the Board may promulgate additional grounds for allowing termination of enrollment.

23. The amendment is necessary to prevent an HMO from terminating an enrollee at a late date for grounds other than moving out of the service area, but stating that basis as its reason.

24. Requiring that such termination be made within one year of notification of an address change is a reasonable means of preventing HMO abuse of the privilege to terminate. It places no burden on the HMO which can choose whether to terminate within that period. No objection to the amendment was made.

25. Mr. Shaw's group recommended that an additional grounds for termination be added to the rule. It would allow termination of an enrollee for failure to keep scheduled appointments or failure to accept prescribed treatment provided a three-month notice be given. The Examiner believes that such an amendment would be a substantial change from the rules as proposed, and therefore, should not be adopted at this time. The Board may consider the recommendation for future adoption.

PROPOSED AMENDMENT TO MINN. RULE MHD 374

26. Periodic filings are required under Minn. Stat. §§ 62D.07 and 62D.08, subd. 1, whenever an HMO intends to modify certain operations or documents. Such modifications are subject to Board approval. Authority to specify the form and content of such filings is within the general authority of § 62D.20.

27. MHD 374(a) would be amended to require such filings 15 days ahead of the next official Board meeting. The current rule requires ten days. Some period of time is necessary to allow agency personnel to review and analyze the filing. Agency

personnel have found that ten days is inadequate. A 15-day period is reasonable, especially since the rule allows exceptions in urgent circumstances. There was no opposition to this amendment.

Group Health Plan, Inc., recommended that the section be modified to require "an acceptable" statement of urgency to come within the exception. The rule as it exists and as proposed to be amended appears to make granting the exception automatic and mandatory upon filing any statement of urgency describing the circumstances involved. No testimony was given as to whether that interpretation is consistent with the intention of the drafters of the rule or as to the experience of the Department with the existing rule. While the existing rule may create an opportunity for abuse by HMOs, it is preferable to adding the qualification because the term "acceptable" is vague and would require further definition.

28. Proposed MHD 374(c) relates to the documentation that must be submitted with filings of any contracts or evidences of coverage which contain copayment provisions. As stated, the Board must determine the impact and reasonableness of copayment provisions; therefore, sufficient evidence of the cost of the services on which copayments are being proposed is necessary and reasonable to make full determination of the percentage of such copayments and other determinations of proper copayments.

Objection was raised that the word "sufficient" in the rule makes it vague and may require the HMO to submit information that it does not normally keep or collect in the first instance. The rule requires that HMOs accompany filings containing copayment provisions with "sufficient evidence on costs of services on which copayments are being imposed . . .". The word "sufficient" refers to the quality or competence of the evidence, not to the type of evidence. What must be submitted is something that states what the cost of the service is, nothing else. The rule is reasonable as written. It should not be an unreasonable burden for HMOs to submit an estimated or average cost of a particular service.

29. MHD 374(d) would require certain "sufficient supporting documentation" with filings of amendments to service areas. Mr. Peterson stated that the documentation listed is necessary for the Board to make a proper determination of availability and accessibility under MHD 369(d). That is true except for the requirement of "existing community standards in receiving health care in other health care delivery systems." Such information is not listed in MHD 369(d) and is not logically necessary to a determination of the accessibility and availability of provider services to enrollees. Further, if that part of the rule requires the HMO to make a qualitative judgment of existing services, it creates an unreasonable burden. Such judgments are difficult, if not unethical, to make. If the rule only requires a quantitative assessment of existing facilities, it still creates an unreasonable burden, particularly in large metropolitan areas. The remainder of the rule is necessary and reasonable.

30. Proposed MHD 374(e) states that the Board may request additional data when it is necessary to determine the legal propriety of the filing. Such additional data may be necessary to fully explain the scope, nature or extent of the filed material. It is proper that the Board should request such additional data and failure to submit such data may quite likely place the Board in the situation where it lacks sufficient information to make an affirmative finding on the matter. This provision was objected to because it apparently would allow the Board to require additional and different types of information, thus placing a burden on the HMOs in that they could not properly gather and submit all information the Board might desire. As with the word "sufficient" in MHD 374(c), this rule deals with the quality, competence or form of the evidence, not the type of evidence. It would not allow the Board to require types of evidence beyond those specified in the Act or rules. It is necessary for the Board to determine the reliability of the evidence submitted and that is what the rule allows. Further, it allows HMOs to add support to a filing that

might otherwise be disapproved. The rule is necessary and reasonable.

PROPOSED AMENDMENT TO MINN. RULE MHD 375.

31. New MHD 375(b) allows for the enrollment of enrollees outside the defined service area if a statement of understanding is signed by the HMO and the enrollee. Minn. Stat. § 62D.03, subd. 4(i), requires health maintenance organizations to describe their service areas at the time they apply for a certificate of authority from the Board. Likewise, an HMO must file an amendment to its service area with the Board prior to implementing such change. Minn. Stat. § 62D.15, subd. 1(a), grants the Board the authority to suspend or revoke a certificate of authority of any HMO which is operating contrary to the information submitted to it under Minn. Stat. § 62D.03. This information includes the HMO's service area. Therefore, it is implicit that the service area established by an HMO is intended to be the primary area of new enrollment. Since the law clearly permits the Board to initiate disciplinary proceedings, if an HMO is operating beyond its service area, the Board does have authority to regulate this area of operation.

32. There are situations that arise where potential enrollees who do not live in the service area may desire to enroll with a particular HMO. They may live very near the area or they may work in the area. It is necessary to allow these people to enroll. There was no disagreement on this point.

33. There was disagreement on the reasonableness of requiring a signed statement of understanding with the terms listed in the rule. All persons agreed that it was necessary for the enrollee to know the terms of his special enrollment. Mr. Peterson felt that the provisions of the rule were the only means of assuring notice to the enrollee. Mr. Shaw's group felt that the rule would create an undue administrative burden on the HMOs and that further notice was not required because all prospective enrollees receive notice of all the terms and services provided, and thus only a signed application should be required. Group Health Plan, Inc. agreed that a signed

sstatement of understanding would be an undue administrative burden and suggested that a letter of notice would be adequate reinforcement.

The Examiner finds that it is both necessary and reasonable to require that the enrollee be specially notified because of the limitations which his special enrollment under this rule creates. However, requiring a cosigned statement of understanding is unreasonable because of the undue burden placed on the HMOs. The rule should be amended as suggested by Group Health Plan, Inc.

ADDITIONAL COMMENTS

34. Mr. Shaw's group also suggested that the rules be amended to require that the Board, should it disapprove a filing, provide a written statement of the grounds for the denial. That is already required by the Act. Section 62 D.04, subd. 2, states:

> "If the board determines that the applicant is not qualified, it shall so notify the applicant and specify the reason or reasons for such disqualification."

Being that subsequent filings are amendments to the application under § 62D.08, subd. 1, it seems that the same provision for notice and reasons would apply.

Upon the foregoing Findings, the Hearing Examiner makes the following

CONCLUSIONS

1. All relevant, substantive and procedural requirements of law and rule have been fulfilled.

2. The Board of Health has authority under Minn. Stat. § 62D.20 to adopt rules necessary to carry out the provisions of Minn. Stat. Chapter 62D.

3. All the proposed amendments to the rules herein are necessary except that part of Proposed Minn. Rule MHD 374(d) which reads ". . . and existing community standards in receiving health care in other health care delivery systems."

4. All the proposed amendments to the rules herein are reasonable except:

(a) That phrase found unnecessary above.

(b) Proposed Minn. Rule 369(c)(3)(cc)(iii) as long as it contains the words "but not limited to."

(c) The requirement of Proposed Minn. Rule MHD 375(b) for a co-signed statement of understanding.

Pursuant to Minn. Stat. § 15.052, the Hearing Examiner now makes the following

RECOMMENDATIONS

1. That the Proposed amendments herein be modified as follows:

(a) Minn. Rule MHD 369(c)(3)(cc). Delete the last sentence of the introductory paragraph that now reads:

> "Based on this measure of reasonableness, copayments shall be deemed reasonable and shall be approved by the Board upon the proper filing of a contract and evidence of coverage containing copayment provisions which comply with the following:"

(b) Minn. Rule MHD 369(c)(3)(cc)(iii). Delete the phrase: ", but not limited to,".

(c) Minn. Rule MHD 374(d). Delete the phrase: "and existing community standards in receiving health care in other health care delivery systems".

(d) Minn. Rule MHD 375(b). Amend the rule to read:

> "(b) A health maintenance organization shall not enroll a person who resides outside the health maintenance organization's defined area of service unless the health maintenance organization provides the enrollee with notice of the consequences of his special enrollment."

2. That the proposed amendments, so modified, be adopted following compliance with Minn. Laws 1975, Ch. 434, § 22, if required.

Dated this 25th day of June, 1976.

STEVE M. MIHALCHICK
Hearing Examiner

271

John A. Breviu
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Attorney General

October 28, 1976

- Chapter Twenty-eight Proposed Amendments to Rules for Health Maintenance Organizations-MHD 369, 371, 372, 374, 375.

271

February 2, 1977

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Attorney General

- Governing Dual Option Requirements of Employers Providing Health Benefit Plans and Service Area Requirements of Health Maintenance Organizations.