CHAPTER 4652
DEPARTMENT OF HEALTH
HEALTH CARE GROUP PURCHASER REPORTING

4652.0010 INCORPORATIONS BY REFERENCE.

The ICD-9 diagnostic codes referenced in part 4652.0100, subparts 4 and 19, are contained in the fourth edition of the International Classification of Diseases, Clinical Modification, 9th Revision, 1994, and corresponding annual updates. This document is subject to annual revisions and is incorporated by reference. It is published by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, and may be purchased through the Superintendent of Documents, United States Government Printing Office, Washington, D.C. 20402. It is available through the Minitex interlibrary loan system.

The CPT codes referenced in part 4652.0100, subparts 4 and 19, are contained in the Physician's Current Procedural Terminology, (CPT manual) 4th edition, 1993. It is subject to frequent change. It is published by and may be purchased from the American Medical Association, Order Department: OP054193, P.O. Box 10950, Chicago, Illinois 60610. It is available through the Minitex interlibrary loan system.

Statutory Authority: *MS s 62J.35*
History: *19 SR 1515; L 2002 c 277 s 32*

4652.0100 DEFINITIONS.

Subpart 1. **Scope.** For the purposes of chapter 4652, the terms in this part have the meanings given them.

Subp. 1a. **Administrative services fee revenue.** "Administrative services fee revenue" includes all revenue from fees related to health administrative services only contracts written for Minnesota residents. An administrative services only contract means a contract between a group purchaser and a third party, including a self-insured, under which the group purchaser provides claims administration and other services.

Subp. 2. **Billing and enrollment expenses.** "Billing and enrollment expenses" means all costs associated with group and individual billing, member enrollment and premium collection and reconciliation functions. Billing and enrollment expenses includes costs for the collection and reconciliation of cash, group and membership setup and maintenance, contract, identification card, and directory preparation and issuance, electronic data interchange expenses pertaining to billing and enrollment, and enrollment materials. Examples of traditional expense categories that a group purchaser may allocate in whole or in part to billing and enrollment expenses are: finance and information systems.

Subp. 3. **Charitable contributions expenses.** "Charitable contributions expenses" means all costs related to contributions made for charitable purposes.

Subp. 4. **Chemical dependency services expenses.** "Chemical dependency services expenses" means all costs related to inpatient and outpatient chemical dependency services that are coded using one or more of the following codes or amended equivalent codes:

A. ICD-9 diagnosis code ranges 303.00 to 305.92; and

B. CPT codes 90801, 90841, 90843, 90844, 90844.22, 90846, 90847, 90847.22, 90849, 90853, 98900, 98902, 98910, and 98912.

Chemical dependency services expenses also means all costs related to inpatient and outpatient chemical dependency services that are coded using codes from another

coding system where the commissioner determines that the codes indicate diagnoses or procedures comparable to or consistent with codes listed in items A and B. A group purchaser may use a nationally recognized standardized reporting system to capture costs for chemical dependency inpatient, outpatient, and other professional services. Chemical dependency services expenses does not include prescription drugs or supplies administered or dispensed which are billed directly through a hospital or health care provider.

Subp. 5. **Claim processing expenses.** "Claim processing expenses" means all costs associated with the adjudication and adjustment of claims, coordination of benefits processing, maintenance of the claim system, printing of claim forms, claim audit function, electronic data interchange expenses pertaining to claim processing, and fraud investigation. Examples of traditional expense categories that a group purchaser may allocate in whole or in part to claim processing expenses are: information systems and legal.

Subp. 6. **Commissioner.** "Commissioner" means the commissioner of the Minnesota Department of Health and authorized agents.

Subp. 7. **Customer service expenses.** "Customer service expenses" means all costs associated with individual, group, or provider support relating to membership, open enrollment, grievance resolution, claim problems, and specialized phone services and equipment. Examples of traditional expense categories that a group purchaser may allocate in whole or in part to customer service expenses are: information systems, finance, legal, and sales and marketing.

Subp. 8. **Dental services expenses.** "Dental services expenses" means all professional and other costs provided under dental services contracts or riders.

Subp. 9. **Durable medical goods expenses.** "Durable medical goods expenses" means all costs for such items as wheel chairs, eyewear, hearing aids, surgical appliances, bulk and cylinder oxygen, equipment rental, and other devices or equipment that can withstand repeated use.

Subp. 10. **Emergency services expenses.** "Emergency services expenses" means all costs for medical care provided in the emergency room of a hospital. Emergency services expenses includes the room, board, and any services such as X-ray and laboratory services billed by the facility. Emergency services expenses does not include expenditures for physician services.

Subp. 11. **General administration expenses.** "General administration expenses" means all costs not attributed or allocated to the categories of billing and enrollment, claim processing, customer service, product management and marketing, regulatory compliance and government relations, provider relations and contracting, quality assurance and utilization management, wellness and health education, research and product development, and charitable contributions. Examples of traditional expense categories that a group purchaser may allocate in whole or in part to general administration expenses are: human resources, facility maintenance, payroll, general accounting, finance, executive, internal audit, treasury, actuarial, finance, information systems, office management and occupancy costs, general office supplies and equipment, legal, board, outside consulting services, membership fees in trade organizations, public relations, and mail room. General administration expenses does not include taxes and assessments.

Subp. 12. **Group purchaser.** "Group purchaser" means a person or organization that purchases health care services on behalf of an identified group of persons, regardless of whether the costs of coverage or services is paid for by the purchaser or by the persons receiving coverage or services, as further defined in rules adopted by the commissioner. Group purchaser includes, but is not limited to, integrated service networks; community integrated service networks; health insurance companies, health maintenance organizations, nonprofit health service plan corporations, and other health plan companies; employee health plans offered by self-insured employers; trusts established in a collective bargaining agreement under the federal Labor-Management

Relations Act of 1947, United States Code, title 29, section 141, et seq.; the Minnesota comprehensive health association; group health coverage offered by fraternal organizations, professional associations, or other organizations; state and federal health care programs; state and local public employee health plans; workers' compensation plans; and the medical component of automobile insurance coverage.

Subp. 13. **Home health care expenses.** "Home health care expenses" means all costs for medical care services delivered in the home under the direction of a physician. Home health care expenses includes costs for noninpatient hospice care.

Subp. 14. **Inpatient hospital services expenses.** "Inpatient hospital services expenses" means all costs for those services furnished by a hospital for inpatient services, including inpatient hospice care. Inpatient hospital services expenses does not include costs of mental health services and chemical dependency services.

Subp. 15. **Insurance company.** "Insurance company" means an organization licensed under Minnesota Statutes, chapter 60A, to offer, sell, or issue a policy of accident and sickness insurance as defined in Minnesota Statutes, section 62A.01.

Subp. 16. **Member.** "Member" means a person who has been enrolled as a subscriber or an eligible dependent of a subscriber for whom the group purchaser has accepted the responsibility for the provision of basic health services under a contract.

Subp. 17. **Member liability.** "Member liability" means the total amount payable by the member for health care services. Member liability includes deductibles, coinsurance, copayments, and amounts beyond plan maximums.

Subp. 18. **Member month.** "Member month" means the equivalent to one member for whom the group purchaser has recognized premium revenue for one month.

Subp. 19. **Mental health services expenses.** "Mental health services expenses" means all costs related to inpatient and outpatient mental health services that are coded using one or more of the following codes or amended equivalent codes:

A. ICD-9 diagnosis code ranges 290 to 302.9 and 306 to 319; and

B. CPT codes: 90801, 90841, 90843, 90844, 90844.22, 90846, 90847, 90847.22, 90849, 90853, 98900, 98902, 98910, and 98912.

Mental health services expenses also means all costs related to inpatient and outpatient mental health services that are coded using codes from another coding system where the commissioner determines that the codes indicate diagnoses or procedures comparable to or consistent with codes listed in items A and B. A group purchaser may use a nationally recognized standardized reporting system to capture costs for mental health inpatient, outpatient, and other professional services. Mental health services expenses does not include prescription drugs or supplies administered or dispensed which are billed directly through a hospital or health care provider.

Subp. 19a. **Minimum premium plan revenue.** "Minimum premium plan revenue" means revenue from insurance plan policies written from Minnesota residents whereby an employer self-funds a fixed percentage of the estimated monthly claims and the insurer covers the remainder.

Subp. 20. **MinnesotaCare tax expenses.** "MinnesotaCare tax expenses" means all payments made for the MinnesotaCare tax under Minnesota Statutes, sections 295.52 and 295.582.

Subp. 21. **Minnesota resident.** "Minnesota resident" means a person who is listed on the records of the group purchaser as a member having a zip code within Minnesota. The group purchaser may use subscriber records if it does not have separate records for each member.

Subp. 22. **Other health professional services expenses.** "Other health professional services expenses" means costs for all services provided by health professionals other than physicians and dentists, including chiropractors, therapists, social workers, nurse practitioners, and medical dental services. Other health professional services expenses does not include costs of mental health services and chemical dependency services.

Subp. 23. **Other taxes and assessments expenses.** "Other taxes and assessments expenses" means all payments or amounts payable to government agencies except for the MinnesotaCare tax under Minnesota Statutes, section 295.52. Other taxes and assessments expenses does not include fees or fines paid to government agencies.

Subp. 24. **Outpatient services expenses.** "Outpatient services expenses" means all costs for those services offered by a hospital which are furnished to ambulatory patients not requiring emergency care and for which there is not a room and board charge. Outpatient services expenses does not include costs of mental health services and chemical dependency services.

Subp. 24a. **Patient services revenue.** "Patient services revenue" means fee-for-service revenue received for medical and dental services delivered to patients by clinics that are owned by the group purchaser.

Subp. 25. **Pharmacy and other nondurable medical goods expenses.** "Pharmacy and other nondurable medical goods expenses" means all costs paid by the group purchaser to a pharmacist or medical supply company to provide pharmaceuticals and nonreusable supplies or pieces of equipment that are used to treat a health condition. Pharmacy and other nondurable medical goods expenses does not include the cost of pharmaceuticals and other nondurable medical goods administered or dispensed which are billed directly through a hospital or health care provider.

Subp. 26. **Physician services expenses.** "Physician services expenses" means costs for all services provided by or under the supervision of licensed medical doctors and doctors of osteopathy, including pharmaceuticals and supplies administered or dispensed from the physician's office and billed directly through the physician. Physician services expenses does not include costs of mental health services and chemical dependency services.

Subp. 27. **Product management and marketing expenses.** "Product management and marketing expenses" means all costs associated with the management and marketing of current products, including costs relating to product promotion and advertising, sales, pricing, broker fees and commissions, internal commissions and commissions processing, marketing materials, account reporting, changes or additions to current products, and enrollee education regarding coverage. Examples of traditional expense categories that a group purchaser may allocate in whole or in part to product management and marketing expenses are: information systems, underwriting, legal, finance, actuarial, public relations, and network management.

Subp. 28. **Provider relations and contracting expenses.** "Provider relations and contracting expenses" means all costs associated with contract negotiation and preparation, monitoring of provider compliance, field training with providers, provider communication materials and bulletins, and administration of provider capitations and settlements. Examples of traditional expense categories that a group purchaser may allocate in whole or in part to provider relations and contracting expenses are: finance, legal, accounting, actuarial, and information systems.

Subp. 29. **Quality assurance and utilization management expenses.** "Quality assurance and utilization management expenses" means all costs associated with quality assurance, practice protocol development, utilization review, peer review, credentialing, outcomes analysis related to existing products, nurse triage, and other medical care evaluation activities. Examples of traditional expense categories that a group purchaser may allocate in whole or in part to quality assurance and utilization management expenses are: information systems and legal.

Subp. 30. **Regulatory compliance and government relations expenses.** "Regulatory compliance and government relations expenses" means all costs associated with federal and state reporting, rate filing, state and federal audits, tax accounting, lobbying, licensing and filing fees, and costs associated with the preparation and filing of all financial, utilization, statistical and quality reports, and administration of government programs. Examples of traditional expense categories that a group purchaser may allocate in whole or in part to regulatory compliance and government relations

expenses are: information systems, finance, actuarial, sales and marketing, underwriting, contract, legal, utilization management, quality assurance, and compliance.

Subp. 30a. **Reinsurance assumed revenue.** "Reinsurance assumed revenue" means total revenue from reinsurance plan policies for Minnesota residents received by a group purchaser who writes the reinsurance plan policies. Reinsurance assumed revenue does not include payments received for reinsurance claims.

Subp. 31. **Research and product development expenses.** "Research and product development expenses" means all costs associated with outcomes research, medical research programs, product design and development for products and programs not currently offered, and major systems development. Examples of traditional expense categories that a group purchaser may allocate in whole or in part to research and product development expenses are: actuarial, information systems, marketing, finance, underwriting, and wellness programs.

Subp. 32. **Skilled nursing facilities expenses.** "Skilled nursing facilities expenses" means all costs for those services furnished by a facility primarily engaged in providing skilled nursing care and related services for patients who require medical or nursing care or rehabilitation services. Skilled nursing facilities expenses includes room and board incurred at skilled nursing facilities. Skilled nursing facilities expenses does not include costs of mental health services and chemical dependency services.

Subp. 33. **Subscriber.** "Subscriber" means a person who has been enrolled with a group purchaser and for whom the group purchaser has accepted the responsibility for the provision of basic health services under a contract, where the contract is either directly between the person and the group purchaser or between the employer of the person and the group purchaser. The subscriber may or may not have dependents who are covered under the contract.

Subp. 34. **Total premium revenue.** "Total premium revenue" means all premiums charged on all health insurance policies written for Minnesota residents, including the change in unearned premium from the previous year, minus refunds based on experience. Total premium revenue does not include minimum premium revenue, administrative services fee revenue, utilization review fee revenue, reinsurance assumed revenue, and patient services revenue.

Subp. 34a. **Utilization review fee revenue.** "Utilization review fee revenue" means all revenue from fees not part of premium revenue related to health utilization review products written for Minnesota residents.

Subp. 35. **Wellness and health education expenses.** "Wellness and health education expenses" means all costs associated with wellness and health promotion, disease prevention, member education and materials, provider education, and outreach services. Examples of traditional expense categories that a group purchaser may allocate in whole or in part to wellness and health education expenses are: marketing, medical services, and printing.

Statutory Authority: *MS s 62J.321; 62J.35*

History: *19 SR 1515; 20 SR 2185; L 1997 c 225 art 2 s 62*

4652.0110 GROUP PURCHASER REPORTING.

Subpart 1. **Group purchasers must report; exceptions.** All group purchasers, except as noted in items A to D, shall file with the commissioner a financial and statistical report on forms or computer format provided or approved by the commissioner.

A. An insurance company, as defined in part 4652.0100, subpart 15, that collected less than $3,000,000 in total health premiums for Minnesota residents in the year prior to the year that the data is covering, may file a short report in lieu of filing a report that meets the requirements of part 4652.0120. The short report must be in writing, must state the amount that the group purchaser collected in total health premiums for Minnesota residents in the year prior to the year that the data is covering, and must provide the total number of members and subscribers covered at

the end of the reporting period. For purposes of this item, "health premiums" means premiums for health and medical related coverages, excluding accidental death and dismemberment coverages, short-term disability coverages, long-term disability coverages, long-term care coverages, workers' compensation coverages, the medical component of automobile insurance coverages, and personal accident coverages.

B. A state agency that reports under Minnesota Statutes, section 62J.40, is not subject to the reporting requirements of chapter 4652.

C. An employee health plan offered by a self-insured employer or an employee organization is not subject to the reporting requirements of chapter 4652. However, those employee health plans are encouraged to comply with these reporting requirements.

D. A group purchaser is not subject to the reporting requirements of this chapter if the coverages the group purchaser writes are limited to one or more of the following: accidental death and dismemberment coverages, short-term disability coverages, long-term disability coverages, long-term care coverages, workers' compensation coverages, automobile insurance coverages, and personal accident coverages.

Subp. 2. **Date for filing; reporting period.** The group purchaser shall file its report on or before April 1 of each year. The report must contain data for the preceding calendar year.

Subp. 3. **Organizations operating more than one group purchaser.** Group purchasers that are affiliated may elect to file a combined report, if they have elected to meet a combined growth limit under Minnesota Statutes, section 62J.041. Affiliated group purchasers that file a combined report must include in the report the name of each affiliated group purchaser.

Subp. 4. **Extensions.** The commissioner shall grant a group purchaser an extension to file the report when the commissioner determines that the group purchaser has shown reasonable cause. To apply for an extension, the group purchaser must provide the commissioner with a written request for an extension to file, specifying the reason or reasons for the requested extension, and the proposed date for filing the report. "Reasonable cause" means that the group purchaser can demonstrate that compliance with the reporting requirements imposes an unreasonable cost to the group purchaser, or that technical or unforeseen difficulties prevent compliance.

Statutory Authority: *MS s 62J.321; 62J.35*

History: *19 SR 1515; L 1995 c 234 art 3 s 9; 20 SR 2185*

4652.0120 CONTENTS OF REPORT.

The report filed by a group purchaser must meet the requirements of items A to G. The information for each item must pertain to health and medical related coverages, excluding accidental death and dismemberment coverages, short-term disability coverages, long-term disability coverages, long-term care coverages, workers' compensation coverages, the medical component of automobile insurance coverages, and personal accident coverages.

A. The report must include total premium revenue and other revenue. "Other revenue" means, and must be specifically itemized into, the categories of minimum premium plan revenue, administrative services fee revenue, utilization review fee revenue, reinsurance assumed revenue, and patient services revenue. Each revenue category must separate commercial, Medicare, Medicare supplement, and other public programs amounts.

B. The report must include total expenses incurred by type of policy, including commercial, self-insured, Medicare, Medicare supplement, and other public programs. The report must separately list member liability for each policy category.

C. The report must include total expenses incurred by service category, including physician services, other health professional services, inpatient hospital services, outpatient services, skilled nursing facilities, home health care, emergency services, pharmacy and other nondurable medical goods, durable medical goods,

chemical dependency services and mental health services, dental services, and total indirect health care expenses. Each service category must be itemized by type of policy as specified in item B. For coverages designed solely to provide payments on a per diem, fixed indemnity, or non-expense-incurred basis, the report may list total expenses rather than itemizing the expenses for these coverages by service category.

D. The report must include total member liability, or its actuarial estimate, for all covered persons.

E. The report must include total indirect health care expenses by the following categories: billing and enrollment; claim processing; customer service; product management and marketing; regulatory compliance and government relations; provider relations and contracting; quality assurance and utilization management; wellness and health education; research and product development; charitable contributions; general administration; MinnesotaCare taxes; and all other taxes and assessments. The information required for this report may be estimated from existing accounting methods with allocation to specific categories.

F. The report must include the total number of members and subscribers, as of the end of the reporting period, by type of policy, including family policies and individual policies and member months for the reporting period. Member months must be totaled for the calendar year of the report. This information must be reported separately for medical and dental contracts. Each category must be itemized by commercial, self-insured, Medicare, Medicare supplement, and other public programs. Group purchasers that do not maintain member information may submit actuarial estimates of total number of members covered under all health policies.

G. The report must include a statement that the revenue and expense amounts reported under items A and B reconcile to audited financial statements. A group purchaser that does more than 80 percent of its business in Minnesota shall reference the appropriate entries from its audited financial statements and shall do so either by using the audited financial statements for its entire health care business or by separating its experience for Minnesota residents. The group purchaser's choice of method must be consistent from year to year. A group purchaser that does 80 percent or less of its business in Minnesota shall have an actuary or financial officer certify that the amounts reported reconcile to the audited financial statement in a manner consistent with prior reporting years and shall include an accounting or actuarial memorandum describing the methods used to identify and separate Minnesota data.

Statutory Authority: *MS s 62J.321; 62J.35*

History: *19 SR 1515; 20 SR 2185*

4652.0130 REVIEW OF REPORTS.

Subpart 1. **Record complete.** No report required by this chapter is considered to be filed until the commissioner has determined that the report is complete. "Complete" means that the report contains adequate and appropriate data for the commissioner to begin the review and is in a form determined to be acceptable by the commissioner according to chapter 4652.

Subp. 2. **Review by commissioner.** The commissioner shall review each report required by chapter 4652 in order to ascertain that the report is complete. If the report is found to be complete or if the commissioner has not notified the group purchaser within 60 days of receiving the report that the report is incomplete, then the report is deemed to be filed as of the day it was received.

Subp. 3. **Incomplete report.** A report determined by the commissioner to be incomplete must be returned to the group purchaser with a statement describing the report's deficiencies. The group purchaser must resubmit an amended report to the commissioner. If the report is resubmitted within 30 days and is determined to be complete by the commissioner, then it shall be deemed to be filed as of the day it was first received by the commissioner.

Subp. 4. **Amending reports.** If a group purchaser discovers a material error in its statements or calculations in any of its submitted reports ascertained by the commissioner to be complete, the group purchaser shall immediately inform the commissioner of the error and, within a reasonable time, submit a written amendment to the report. Submission of an amendment under this subpart does not affect the date of filing.

Subp. 5. **Error in reports.** If the commissioner discovers a material error in the statements or calculations in a report, the commissioner shall require the group purchaser to amend and resubmit the report by a date determined by the commissioner.

Statutory Authority: *MS s 62J.35*

History: *19 SR 1515*

4652.0140 VARIANCES.

Subpart 1. **Data from other sources.** On a request by a group purchaser or on the commissioner's own initiative, the commissioner shall determine whether to use data from other sources instead of collecting data required by this chapter. To make this determination, the commissioner shall consider whether:

A. the data from other sources are duplicative of data required under this chapter;

B. the data from other sources are available at a reasonable cost;

C. the commissioner has the resources readily available to use the data from other sources; and

D. the commissioner will be able to use the data from other sources to meet all statutory data collection, analysis, and privacy requirements.

Subp. 2. **Aggregate reporting for systems.** An organization operating a group purchaser which is part of a system of group purchasers, hospitals, or clinics may request to report to the commissioner for all components of the system as an aggregate. If the commissioner determines that the commissioner will be able to use the data from the system as an aggregate to meet all statutory data collection, analysis, and privacy requirements, then the commissioner shall grant the request.

Statutory Authority: *MS s 62J.321*

History: *20 SR 2185*