4685.0801 COPAYMENTS.

Subpart 1. **Copayments on specific services.** Copayments on comprehensive health maintenance organization services, as defined in part 4685.0700, are allowed provided the copayment does not exceed 25 percent of the provider's charge for the specific service or good received by the enrollee, except as provided in subparts 2 and 6.

For the purposes of this part, "provider's charge" for a specific service or good means the fees charged by the provider which do not exceed the fees that provider would charge any other person regardless of whether the person is a member of the health maintenance organization. This is typically known as the provider's fee schedule or billed charge for such service or good. The service must be based on a specific diagnosis or procedure code such as the codes defined by the Physicians' Current Procedural Terminology (CPT), published by the American Medical Association for physician charges, or the Diagnosis Related Groups (DRGs) used by the Centers for Medicare and Medicaid Services, or any similar coding system used for billing purposes. For example, an enrollee who receives brief office medical services at a specific clinic may be charged up to 25 percent of that clinic's charge for brief office medical services.

Subp. 2. **Flat fee copayments.** The health maintenance organization may establish predetermined flat fee copayments for categories of similar services or goods. Flat fee copayments based on categories of similar services or goods must be calculated independently for Medicare plans, individual plans, and group plans. For example, calculations may be made by combining data from all individual plans but data from individual plans may not be combined with data from group plans. The flat fee copayment cannot exceed 25 percent of the median provider's charges for similar services or goods received by enrollees. For example, if the median charge for all prescription drugs received by enrollees is $20, the health maintenance organization may determine a flat fee copayment of up to $5 for any prescription drug that is purchased by an enrollee.

A health maintenance organization may request a copayment which exceeds the 25 percent limitation for prescription drug benefits for Medicare related products. The request must be made in writing to the Department of Health and must include sufficient documentation to demonstrate to the department that the requested copayment is reasonable under the general provisions described in this part.

The categories of similar services or goods must be determined according to subpart 3. The median provider's charges for a category of similar services or goods must be determined according to subpart 4.

Subp. 3. **Categories.** For the purposes of this part, a category of similar services or goods is any group of related services for which a single copayment is sought. Examples of categories include the following or any subset of the following:

A. inpatient hospital care;

B. inpatient physician care;

C. outpatient health services (or typically, "office visit") which may include outpatient laboratory, and radiology;

D. outpatient surgery which may include provider and facility charges;

E. emergency services which may include provider and facility charges;

F. outpatient prescription drugs;

G. skilled nursing care; and

H. any other nonphysician service categorized singly according to provider.

For example, there may be one flat fee copayment for a physical therapy service and another flat fee copayment for a speech therapy service. Nonphysician services may include such services as chemical dependency services, speech therapy services, mental health services, or physical therapy services.

Services or goods used to calculate the copayment for a category of services or goods may not be included in any other category. Services or goods used in this way must be eliminated from any other category in which they would otherwise be included, before the copayment is calculated. For example, if there is a copayment specifically for infertility or hormone therapy drugs, they must be eliminated from the category of outpatient prescription drugs.

Subp. 4. **Determination and filing of median charge.** To determine the median aggregate charge for a category of similar services, the health maintenance organization must follow the following steps and submit the results to the Department of Health with the request for approval of the copayment:

A. Identify all charges for the service or good for the relevant type of product, Medicare, individual, or group. The health maintenance organization may use all charges or may choose a sample of charges from the total population. Any sample used must be randomly selected and large enough to be statistically reliable. "Statistically reliable" means that any other sample drawn in the same manner would produce essentially the same results.

(1) If the entire health maintenance organization population is used, describe the population including the size of the total population, the range of charges, the mean, the median, the quartiles, and the standard deviation for each category submitted.

(2) If a sample of the population is used, describe the sample including the size of the sample, the range of charges, the mean, the median, the quartiles, and standard deviation for each category submitted.

(3) If a health maintenance organization wants to use a flat fee copayment but has an insufficient population size for its data to be statistically reliable, the health maintenance organization may submit copayment requests based on statistically reliable data from other populations within the health maintenance organization.

B. If the health maintenance organization does not use charges that span 12 months, the health maintenance organization must explain how the time period used is sufficient to include seasonal fluctuations in the utilization of services.

C. A statement that the sample is statistically reliable, with an explanation of how the sample is drawn so that it is representative of the larger health maintenance organization population.

D. A narrative description of the services included in the category, including diagnosis or procedure codes if applicable.

E. If costs are adjusted for inflation, the health maintenance organization must base its inflation adjustments on changes in the medical care component of the consumer price index or a similar national or regional index.

Subp. 5. **Required disclosure.** The health maintenance organization must include a notice which describes the copayment charges in its Medicare, individual, and master group contracts and certificates or evidences of coverage. The notice must include the following language or similar language approved by the commissioner: "THE AMOUNT CHARGED AS A COPAYMENT IS BASED ON THE PROVIDER CHARGES FOR THAT SERVICE."

If the copayment is a flat fee copayment based upon a category of services, the notice must include a general, narrative description of the types of services which were included in determining the median charge. For example, if the health maintenance organization is imposing a copayment upon office visits, the contract must disclose what types of services, such as laboratory services and radiology services, are included in the office visit copayment.

Subp. 6. **Exclusions.** Any amount or form of copayment shall be deemed reasonable when imposed on services which, according to parts 4685.0400 to 4685.1300, may be excluded completely, provided that the copayment is not greater than the provider's charge for that particular service.

Subp. 7. **Out-of-plan services.** Copayments may be imposed on out-of-plan emergency care, including inpatient, by providers who do not have arrangements with the health maintenance organization, in the form of a reasonable deductible not to exceed

$150, plus a 25 percent copayment, plus all charges which exceed a specified annual aggregate amount not less than $90,000.

Subp. 8. **Preventive health care services.** No copayment may be imposed on preventive health care services as defined in part 4685.0100, subpart 5, item E, including child health supervision, periodic health screening, and prenatal care.

Statutory Authority: *MS s 62D.05; 62D.08; 62D.182; 62D.20*

History: *16 SR 2478; L 2002 c 277 s 32; 31 SR 35*

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