

Draft Pending Adoption

Draft: 3/23/22

Senior Issues (B) Task Force
Virtual Meeting (*in lieu of meeting at the 2022 Spring National Meeting*)
March 17, 2022

The Senior Issues (B) Task Force met March 17, 2022. The following Task Force members participated: Marlene Caride, Chair (NJ); Jon Pike, Vice Chair (UT); Lori K. Wing-Heier represented by Sarah Bailey (AK); Jim L. Ridling represented by Yada Horace (AL); Ricardo Lara represented by Tyler McKinney (CA); Andrew N. Mais represented by Paul Lombardo (CT); Karima M. Woods represented by Brian Bressman (DC); Trinidad Navarro represented by Susan Jennette (DE); David Altmaier represented by Chris Struk (FL); John F. King represented by Matthew Padova (GA); Colin M. Hayashida represented by Kathleen Nakasone (HI); Doug Ommen represented by Andria Seip (IA); Dean L. Cameron represented by Shannon Hohl (ID); Vicki Schmidt represented by Julie Holmes (KS); Sharon P. Clark represented by Stephanie McGaughey-Bowker (KY); James J. Donelon represented by Ron Henderson (LA); Gary D. Anderson represented by Kevin Beagan (MA); Kathleen A. Birrane represented by Alexander Borkowski (MD); Eric A. Cioppa represented by Sherry Ingalls (ME); Anita G. Fox represented by Renee Campbell (MI); Grace Arnold represented by Cam Jenkins (MN); Chlora Lindley-Myers (MO); Troy Downing represented by Ashley Perez (MT); Mike Causey represented by Garlinda Taylor (NC); Jon Godfread represented by Chrystal Bartuska (ND); Eric Dunning (NE); Barbara D. Richardson (NV); Judith L. French represented by Tynesia Dorsey (OH); Glen Mulready represented by Mike Rhoads (OK); Andrew R. Stolfi represented by Ana K. Pace (OR); Michael Humphreys (PA); Larry D. Deiter represented by Jill Kruger (SD); Carter Lawrence represented by Brian Hoffmeister (TN); Cassie Brown represented by Chris Herrick (TX); Scott A. White represented by Bob Grissom (VA); Michael S. Pieciak represented by Mary Block (VT); Mike Kreidler represented by Molly Nollette (WA); Nathan Houdek (WI); and Allan L. McVey represented by Ellen Potter (WV). Also participating were: Kay Warrington (MS); Bogdanka Kurahovic (NM); Martin Wojcik (NY); Patrick Smock (RI); and Tana Howard (WY).

1. Adopted its Feb. 25, 2022; Feb. 8, 2022; and 2021 Fall National Meeting Minutes

The Task Force met Feb. 8 and agreed to submit comments in response to the federal Centers for Medicare & Medicaid Services' (CMS's) proposed rule on stricter marketing guidelines for Medicare Advantage (MA) plans.

The Task Force met Feb. 25 and adopted a letter in support of the CMS's proposed rule on stricter marketing guidelines for MA plans.

Ms. Kruger made a motion, seconded by Director Lindley-Myers, to adopt the Task Force's Feb. 8, 2022 (Attachment One); Feb. 25, 2022 (Attachment Two); and Nov. 30, 2021 (*see NAIC Proceedings – Fall 2021, Senior Issues (B) Task Force*) minutes. The motion passed unanimously.

2. Adopted the Letter to CMS Regarding the Treatment of Nonparticipating DME Suppliers Under Medicare's "Limitation on Beneficiary Liability"

Mr. Rhoads made a motion, seconded by Mr. Grissom, to adopt the Task Force's letter to the CMS (Attachment Three). The motion passed unanimously.

3. Heard a Presentation Regarding Medicare Part D and Auto-Enrollment

Harry Ting (Health Consumer Advocate) presented an issue that poses difficulties for State Health Insurance Assistance Program (SHIP) counselors and the harm inflicted on Medicare Part D enrollees. He said he is asking the Task Force to endorse some actions and contact the CMS regarding this problem.

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Dr. Ting said the situation arises when an insurer discontinues one of its Medicare Prescription Drug Plans (PDPs) for the next calendar year and the beneficiary is then crosswalked to another of the insurer's PDPs. He said enrollees are notified via the Annual Notice of Change (ANOC) mailing in September, and in 2021, 3.2 million PDP enrollees were crosswalked into a different PDP for 2022.

Dr. Ting said many of these ANOCs are confused with junk mail and thrown out by the beneficiary. He said the same ANOC formats are sent out every year to all Medicare Part D enrollees, but the choice they are presented with is confusing, and the beneficiaries are not given proper guidance. He provided an example of a client being crosswalked from the Mutual of Omaha Rx Value Plan and thus being switched from one of the lowest cost plans in the beneficiary's area to one of the highest. He said the change in premium for this client went from \$22.20 a month to \$77.90 a month. He said it is not really the fault of the insurance plan but rather the problem with the CMS's rules and regulations.

Dr. Ting said the ANOC tells beneficiaries to check the changes to the benefits and costs to see if they affect the beneficiary. He said this is very difficult for many beneficiaries to do. For example, he said one client of his takes 43 different medications and drugs, and the ANOC tells the beneficiary to go to the online drug list if there are changes. He said the online drug list is a 45-page formulary for the seniors to go through. He said the ANOC asks whether one's drugs are in a different tier with different cost sharing and points out that there are five tiers with 10 cost-sharing categories. He said the ANOC asks whether one's drugs have new restrictions, and it instructs the senior to call their insurer; if the senior can use the same pharmacy, the senior is instructed to go to a website or call to obtain a directory. He said there is no mention of Medicare or SHIP resources, and the section entitled "additional resources" tells the senior to call their insurer, which is not helpful when seeking unbiased and objective answers.

Dr. Ting said there are three changes the CMS can do to address this issue, and he asks that the NAIC act in contacting the CMS to implement these changes. He said the first change is for the CMS to notify crosswalked Medicare Part D enrollees directly so the ANOC letters are not confused as junk mail and the beneficiary has notice from the CMS about upcoming changes. He suggested a sample letter that the CMS could implement. He said the second change is to modify the ANOC template currently being used. He said additional language should be made available beyond the current standard language that this document is available in (e.g., Spanish, braille, and large print). He suggested that the section start with advising the beneficiary to call their SHIP or the 800 Medicare number, as well as provide the Medicare.gov web page.

Dr. Ting said the first two suggestions can be done by the CMS through its current rules. He said the third suggestion is for the CMS to allow crosswalked Part D plan enrollees to switch Part D plans during the January through March period, the same as MA enrollees. He said he believes this can be implemented through the CMS's regulations, but if not, he would propose it as an amendment. He said he would like the Task Force and the NAIC to support the three suggestions and ask the CMS to modify its Medicare Part D ANOC template to include objective resources and tell the CMS to give crosswalked Medicare Part D drug plan enrollees the same protections as those in MA plans.

Commissioner Caride asked if Task Force members have heard about these complaints. Mr. Henderson, Ms. McGaughey-Bowker, Ms. Seip, and Ms. Hohl said they have heard and are aware of these issues in their states. Ms. Hohl asked Dr. Ting if he has reached out to the CMS about whether the CMS has given any explanation as to why these suggestions are not already a requirement. Dr. Ting said he has reached out but has not received any response from the CMS. Commissioner Caride suggested that Task Force members take time to review the slides Dr. Ting presented, and the Task Force can discuss this matter in more detail at its next meeting.

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4. Heard a Discussion About Home Care Plans and Marketing Insurance

Bonnie Burns (California Health Advocates—CHA) said the issue she wants to bring to the attention of the state insurance regulators is a matter she has not dealt with in almost 10 years, and it involves the sale of access to home care through what is essentially a service contract. She said in the past, it was masqueraded as insurance and sold by insurance agents.

Ms. Burns said it has arisen again in the form of a membership organization where one pays a membership fee plus an annual fee, and that entitles the person to a certain number of home care hours. She said in the past, these hours could have been discounted costs from participating home health agencies or other entities. She said the last time she was involved with one of these contracts was in 2013 when the San Diego district attorney prosecuted and charged a person with seven felonies regarding this scheme. She said the company in question had operated in many different states and under a variety of names, and people were paying for access to what was essentially a discounted home care membership organization.

Ms. Burns said she is raising this because there may be some organizations operating in this space currently (e.g., she became aware today of an insurance product that is being sold as a home care indemnity product), and she believes they are using the short-term insurance model to provide these benefits. She said she wanted to bring this to the attention of state insurance regulators in case complaints are being received about this or people have made inquiries about this matter. She said as she learns more about the current adaptation of these home care indemnity products, she will give a presentation to the Task Force.

Commissioner Caride said her department has not received any calls or complaints about this matter, but that is not to say it is not happening across the country, and she asked if anyone is hearing about this in their state. Ms. Burns said the way these organizations operate is that complaints are not heard until the claims are not paid or the organization pays the small claims but not the larger ones.

5. Heard a Federal Legislative Update

David Torian (NAIC) said the fiscal year (FY) 2022 Omnibus legislation, which funds the government through Sept. 30, was passed by the U.S. House of Representatives (House) and the U.S. Senate (Senate) and signed into law by the president, and SHIP funding is maintained at \$57,115,000 for FY 2022.

Mr. Torian said the Omnibus includes two senior protection provisions. One is the creation of the Senior Scams Prevention Advisory Group, and the second is the Senior Fraud Advisory Office within the Federal Trade Commission (FTC). He said both provisions are aimed at improving interagency coordination on efforts to protect seniors from falling victim to fraud and scam attempts. He said the details about each provision is detailed in the printed version of the update, which is posted on the Task Force's web page unless the chair would like the details read in full. Commissioner Caride said anyone interested in the details can go to the Task Force's web page, and they can contact Mr. Torian if they have any questions.

Having no further business, the Senior Issues (B) Task Force adjourned.

[SITF 03-17-22 Minutes](#)

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Attachment One

Draft: 2/9/22

Senior Issues (B) Task Force
Virtual Meeting
February 8, 2022

The Senior Issues (B) Task Force met Feb. 8, 2022. The following Task Force members participated: Marlene Caride, Chair (NJ); Jon Pike, Vice Chair (UT); Lori K. Wing-Heier represented by Sarah Bailey (AK); Jim L. Ridling represented by Willard Smith (AL); Alan McClain represented by Carroll Astin (AR); Evan G. Daniels represented by Erin Klug (AZ); Ricardo Lara represented by Tyler McKinney (CA); Michael Conway represented by Peg Brown (CO); Andrew N. Mais represented by Paul Lombardo (CT); Karima M. Woods represented by Howard Liebers (DC); Trinidad Navarro represented by Susan Jennette (DE); David Altmaier represented by Chris Struk (FL); John F. King represented by Matthew Padova (GA); Colin M. Hayashida represented by Kathleen Nakasone (HI); Doug Ommen (IA); Dean L. Cameron represented by Kathy McGill (ID); Amy L. Beard represented by Rebecca Vaughan (IN); Vicki Schmidt represented by Julie Holmes (KS); Sharon P. Clark represented by Stephanie McGaughey-Bowker (KY); James J. Donelon represented by Ron Henderson (LA); Gary D. Anderson represented by Kevin Beagan (MA); Kathleen A. Birrane represented by Joy Hatchette (MD); Eric A. Cioppa represented by Sherry Ingalls (ME); Anita G. Fox represented by Renee Campbell (MI); Grace Arnold represented by Theodore Patton (MN); Chlora Lindley-Myers (MO); Mike Causey represented by Ted Hamby (NC); Jon Godfread represented by Yuri Venjohn (ND); Eric Dunning and Martin Swanson (NE); Barbara D. Richardson represented by Jack Childress (NV); Judith L. French represented by Tynesia Dorsey (OH); Jessica K. Altman represented by Michael Gurgiolo (PA); Elizabeth Kelleher Dwyer represented by Patrick Smock (RI); Larry D. Deiter represented by Jill Kruger (SD); Carter Lawrence represented by Brian Hoffmeister (TN); Cassie Brown represented by Dannette Smith (TX); Scott A. White represented by Bob Grissom (VA); Michael S. Pieciak represented by Mary Block (VT); Mike Kreidler represented by Molly Nollette (WA); Nathan Houdek represented by Jennifer Stegall (WI); and Allan L. McVey (WV). Also participating were: Eric Anderson (IL); Kay Warrington (MS); Ingrid Marsh (NH); Bogdanka Kurahovic (NM); Martin Wojcik (NY); Glen Mulready (OK); Andrew Dvorine (SC); and Mavis Earnshaw (WY).

1. Discussed the CMS's Proposed Rule on Stricter Marketing Guidelines for MA Plans

Commissioner Caride said the purpose of this Task Force meeting is to examine the proposed rule promulgated by the Centers for Medicare & Medicaid Services (CMS) to impose stricter marketing guidelines for Medicare Advantage (MA) plans. She said this meeting is not to target MA plans but to focus on the deceptive marketing advertisements to sell MA plans. She said the Task Force has heard from state insurance regulators, most notably from Louisiana and Nebraska, regarding consumers being switched from their original plans after either inquiring in response to ads or receiving cold calls from these marketers.

Mr. Swanson gave some background on what he has heard from Nebraska and other states regarding these solicitations. He said Nebraska has a very good working relationship with its regional CMS representatives and shares information with other states. He said these issues have been raised and are being examined by the Improper Marketing of Health Insurance (D) Working Group; and because many of these Working Group calls are regulator-only, frank discussions are had with the CMS and the federal Center for Consumer Information and Insurance Oversight (CCIIO). He said some of these calls have died down after open enrollment closed, but MA plan open enrollment does not end for another month.

Commissioner McVey said he has seen these advertisements; they are somewhat misleading at the very best, and they are close to fraudulent at the very worst. He said he would like to address this situation; even though he has seen one of the ads revamped, it is still not a good situation, and more complaints will come.

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Mr. Henderson said one of the biggest issues is that those third-party callers who are not necessarily agents can call seniors asking if they would like to change their plan, and the next thing the senior discovers is that they have been switched into another plan, and that new plan does not even take the senior's doctor. He related a story he told before about being present when a call came in to a senior; when he took the phone to ask for the caller's license, the caller hung up. He said Commissioner Schmidt, the Director of the Louisiana State Health Insurance Assistance Program (SHIP), is constantly making changes on behalf of seniors who have been moved out of their plans. He said many seniors are being incentivized to make changes because the marketing caller tells them they are not getting all they deserve when in fact they are getting what they need. He said it must be emphasized to the CMS that these third-party marketing callers are using unlicensed persons to make the calls and then hand the call over to a licensed person.

Commissioner Caride asked the Task Force if it would agree to comment on the CMS's proposed rule and any objections to commenting. Mr. Swanson said the regional CMS personnel he has engaged with would appreciate input from the NAIC to get the attention of the officials in the District of Columbia. Commissioner Caride noted that both Idaho and Missouri concur with Mr. Swanson's comments. She asked if there are any interested parties that wish to comment.

Bonnie Burns (California Health Advocates—CHA) said the CHA submitted a letter to the Task Force laying out its position and what it has commented to the CMS. She said there has been a massive increase in the number of people being switched to plans they either did not want or were not appropriate for them. She said she has seen those dually eligible being moved from their non-premium plans to plans with premiums and plans that have co-payments when they should not have any co-payments. She said the CMS's own statistics show there has been a jump in complaints. She said in 2020, the CMS received a total of 15,497 complaints related to marketing; and in 2021, excluding December, the CMS received 39,617 complaints. She said this is an indication of companies fighting for market share and agents and brokers fighting for sale commissions.

Ms. Burns said one area of great concern is that there is no indication to how any enforcement is taking place. She said some states have memorandums of understanding (MoUs) with the CMS so there would be a transfer of information, but when an agent or a broker where these actions are taking place is identified, there does not appear to be any formal process in the CMS proposed rule for these agents and brokers who are licensed to be disciplined through the states' licensing and enforcement system. She said the CMS is proposing a disclaimer to be added to websites and advertisements stating that the consumer is not being given all the information about plans available to them. She said such a disclaimer is ineffective, and she said she proposed in the letter to the Task Force what would be an adequate disclosure to consumers. She said SHIPs are not even referenced in the proposed rules, and she strongly believes SHIPs must be included. She also said the proposed rule should require agents and brokers to sign an attestation to show that what is being offered and sold is an improvement to the consumer from what they are already enrolled in. She said this already exists for Medicare Supplement plans, so it should apply to MA plans.

Mr. Henderson pointed out that most of the SHIPs are in states' Aging and Elderly offices, so if there is no connection to the state insurance departments, many of these issues are going unheard and are not being reported to insurance departments.

Harry Ting (Health Consumer Advocate) said he is an NAIC consumer representative and SHIP counselor. He said he had a client who was cold called, told the caller she did not want to change but was changed to a new plan that did not fit her needs. He said when he asked the new plan who the producer was who called the client and switched her to the new plan, they said they did not know. He said these marketing organizations have very little incentive to discipline their people, and when he asked the client if she would like to file a complaint, she was reluctant to do so.

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Dr. Ting said he agrees with Ms. Burns that the CMS proposed rule is not impactful enough. He proposed that the CMS use its complaint tracking module that counted over 39,000 complaints in 2021 to enter a star system calculation and assign a certain number of stars to those plans. He said it would make the marketing organization more sensitive and willing to take action to reduce complaints.

Commissioner Mulready said the Oklahoma Insurance Department has received dozens and dozens of calls and complaints, and it is supportive of letting the CMS know what states are experiencing. Ms. Burns said holding plans or marketing organizations accountable is laudable, but it does no good if the complaints and information are not getting to the states' departments of insurance (DOI), and in turn, there is no action on a state level holding these actual sellers accountable.

Commissioner McVey made a motion, seconded by Commissioner Pike, that the Task Force submit comments in response to the CMS's proposed rule on stricter marketing guidelines for MA plans. The motion passed unanimously.

Commissioner McVey asked about the process of submitting comments. Commissioner Caride asked David Torian (NAIC) to explain. Mr. Torian said he would like comments to be submitted by week's end, or Monday, Feb. 14 at the latest. He said he would collate the comments into a single letter for the Task Force to adopt via an e-vote. He reminded the Task Force that time is of the essence, as the deadline for comments to the CMS is March 7, and any comments adopted by the Task Force will need approval from the Government Relations (EX) Leadership Council. Commissioner Caride asked if there are any issues or problems with that process, and none were heard.

Having no further business, the Senior Issues (B) Task Force adjourned.

[SITF 02-08-22 Minutes](#)

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Attachment Two

Draft: 3/1/22

Senior Issues (B) Task Force
E-Vote
February 25, 2022

The Senior Issues (B) Task Force conducted an e-vote that concluded Feb. 25, 2022. The following Committee members participated: Marlene Caride, Chair (NJ); Jon Pike, Vice Chair (UT); Lori K. Wing-Heier (AK); Jim L. Ridling (AL); Alan McClain (AR); Ricardo Lara (CA); Andrew N. Mais (CT); Trinidad Navarro (DE); John F. King (GA); Colin M. Hayashida (HI); Dean L. Cameron (ID); Amy L. Beard (IN); Vicki Schmidt (KS); Sharon P. Clark (KY); James L. Donelon (LA); Gary D. Anderson (MA); Kathleen A. Berrane (MD); Eric A. Cioppa (ME); Anita G. Fox (MI); Chlora Lindley-Myers (MO); Troy Downing (MT); Mike Causey (NC); Jon Godfread (ND); Eric Dunning (NE); Barbara D. Richardson (NV); Judith L. French (OH); Jessica K. Altman (PA); Larry D. Deiter (SD); Carter Lawrence (TN); Cassie Brown (TX); Michael S. Pieciak (VT); Mike Kreidler (WA); Nathan Houdek (WI); and Allan L. McVey (WV).

1. Adopted a Letter in Support of the CMS' Proposed Rule on Stricter Marketing Guidelines for Medicare Advantage and Medicare Part D Plans

The Task Force conducted an e-vote to consider adoption of a comment letter in support of the Centers for Medicare & Medicaid Services' (CMS') proposed rule on stricter marketing guidelines for Medicare Advantage (MA) and Medicare Part D plans.

Without objection, the Task Force adopted the comment letter (Attachment One).

Having no further business, the Senior Issues (B) Task Force adjourned.

[SITF 02-25-22 Minutes](#)

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Attachment Three

Hon. Chiquita Brooks-LaSure - Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Administrator Brooks-LaSure:

We are writing on behalf of the National Association of Insurance Commissioners' (NAIC) Senior Issues (B) Task Force to request guidance from CMS regarding the treatment of nonparticipating durable medical equipment (DME) suppliers under Medicare's "Limitation on Beneficiary Liability" (the so-called "balance billing limits").

The NAIC is the standard setting organization representing the chief insurance regulators in the 50 states, the District of Columbia, and the United States territories.

The NAIC's Senior Issues (B) Task Force (SITF) is charged with considering policy issues; developing appropriate regulatory standards; and revising, as necessary, the NAIC models, consumer guides, and training materials on Medicare supplement (Medigap) insurance, long-term care insurance (LTCI), senior counseling programs, and other insurance issues that affect older Americans.

The SITF seeks critical guidance from CMS that a nonparticipating supplier of scooters or other DME items and services may only charge 15% more than the Medicare approved amount. The SITF has heard from many state regulators, consumer advocates and industry representatives about Medigap insurers being presented with "excess charges" claims for expensive motorized "scooters" that are submitted as Medicare covered DME. These claims are submitted by nonparticipating suppliers to Medicare for payment and beneficiaries are "balance billed" an enormous amount. The insurers have been paying these "excess charges" claims in full to satisfy policyholders and to avoid complaints.

These "excess charge" claims are becoming more frequent and more expensive. Insurers and state regulators are concerned about the appropriateness of these claims by nonparticipating DME suppliers and the resulting impact on Medigap premiums. The SITF has been presented with many examples of these excessive charges. One example illustrated billed charges from one scooter supplier ranging from \$15,789, to \$31,000, depending upon the model of the scooter. The Medicare approved amount is significantly lower than the actual billed amount. In one instance, Medicare was billed \$43,485.10, for a power wheelchair and the Medicare approved amount was \$4,702. The remaining "excess" balance of \$38,783.10 was then presented to a Medigap insurer for payment in full as an "excess charge."

Medigap policies are required to pay benefits based upon "Medicare eligible expenses." This term is defined in the *NAIC Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act* (Model #651) to mean "expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare." See Model #651 at Section 5.G ("Policy Definitions and Terms"). See also Model #651 at Sections 8, 8.1, 9. 9.1 ("Minimum Benefit Standards"). Accordingly, Medigap benefit payments require that Medicare must first determine that expenses are covered and must be recognized as reasonable and necessary.

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Model #651 requires that certain standardized plans must include a benefit for payment of Medicare Part B "Excess Charges." This benefit is described in Model #651 as coverage for a percentage of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge. See Model #651 at Sections 8.C; 8.1.C; 9.E; 9.1.E; and 10.M-N.

The benefit for "Medicare Part B Excess Charges" was adopted following the enactment of the 1990 federal Medigap standardization legislation. The NAIC debated how to properly characterize and phrase the requirement. There was agreement that these "excess charges" were billed by providers in amounts that were above the Medicare-approved amount, and so otherwise would not be paid for by the plans.

The NAIC considered changing the term "Medicare Part B Excess Charge" to "Part B Balance Billing" but concluded that the change would mean nothing to an average consumer. See Model #651, Proceedings Citation, Section 8C at page PC-651-8; and Section 17D at page PC-651-26. Separately, CMS defines "excess charge" as an amount that is "the difference between the Medicare-approved amount and the legally permitted higher charge." See CMS-NAIC, "Guide to Choosing a Medigap Policy-2021" at page 49 ("Definitions").

As described in the "Guide to Choosing a Medigap Policy" the phrase referring to "the legally permitted higher charge" is clearly a reference to the limits on "balance billing." Based on the timing of the NAIC's consideration of the "excess charges" benefit, and the NAIC debate about the phrase, it is clearly intended to address the so-called "balance billing" circumstances discussed below.

In 1993 the Congress amended the "balance billing" protection provision to clarify that the "extra-billing" limits also applied to non-participating "suppliers or other persons." See H.R. 2264, OBRA Act of 1993, Section 13517 (entitled "Extension of Physician Payment Provisions to Nonparticipating Suppliers and Other Persons"). The conference committee explanation simply states that the "nonparticipating suppliers would be prohibited from billing or collecting from any person an actual charge in excess of the Medicare limiting charge." See H.R. Rep. No. 213, 103d Cong. at 769-771 (August 4, 1993) (Conference Report to Accompany H.R. 2264)

Therefore, a nonparticipating supplier is legally only permitted to charge 115% of the Medicare-approved amount. The statutory text of the Social Security Act's "Limit on Beneficiary Liability" applies to a "nonparticipating physician or *nonparticipating supplier* (emphasis added) or other person who does not accept payment on an assignment-related basis for a physician's service" that is furnished to a Medicare beneficiary. See Social Security Act Section 1848(g)(1)(A).

Arguably the Social Security Act's "Limits on Beneficiary Liability" provisions apply to these "balance billing" claims for motorized scooters as well as other DME items submitted by nonparticipating DME suppliers.

In addition, CMS states that: "No longer are services of suppliers and other nonphysicians ... excluded from the limiting charge." See Medicare Carriers Manual, Part 3 - Claims Process, Section 17002 ("Limiting Charge") at page 17-7 (July 11, 2003).

The term "nonparticipating supplier" in this section of the statute does not provide any exception for a DME supplier or any other type of supplier. It is broadly defined elsewhere as "a supplier or other person that is not a participating supplier." See Social Security Act Section 1842(i)(2). The statute further provides that no person may bill or collect an actual charge for the service in excess of the

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limiting charge. See Social Security Act Section 1848(g)(1)(A)(i). Furthermore, the statute provides that no person is liable for payment of any amounts billed for the service in excess of such limiting charge. See Social Security Act Section 1848(g)(1)(A)(ii).

CMS regulations provide that a "supplier" who is nonparticipating and does not accept assignment may charge a beneficiary an amount up to the limiting charge. The regulations establish specific limits on the actual charges of nonparticipating suppliers for both "items and services" at 115% of the Medicare approved charge. See 42 CFR 414.48 (a)-(b) ("Limits on actual charges of nonparticipating suppliers").

Medicare Part B pays for DME that is used in a patient's home. A DME supplier is defined as an entity with a valid Medicare supplier number (both participating and nonparticipating). A power mobility device (PMD) is a covered item along with power wheelchairs and motorized scooters. To be covered a PMD requires: (1) first, a written order or prescription from a physician; (2) a face-to-face encounter with a physician; and (3) supporting documentation for "medical necessity." See 42 CFR 410.38(a) - (d).

A "supplier" is defined broadly in the CMS regulation as "an entity other than a provider that furnishes health care services under Medicare. See 42 CFR 400.202. In the preamble to the 1993 final rule CMS explains changes to the regulations that "in addition, the limiting charge provision will apply to nonparticipating suppliers or other persons. Previously, it had applied to the services of nonparticipating physicians only." See 58 Fed. Reg. 230 at page 63646 (December 2, 1993).

Finally, the consumer reliance on the marketing of these DME items at no cost to Medicare beneficiaries, who are then more likely to agree to purchase those items, contributes to driving up the costs to Medicare. It isn't just the cost to insurers and the impact on Medigap premiums but the resulting cost to Medicare Part B.

The Social Security Act's "Limitation on Beneficiary Liability" clearly references a "nonparticipating supplier or other person" without qualification or exceptions. See Social Security Act Section 1848(g)(1)(A). The Act's DME payment provisions clearly refer to providers of DME as "suppliers." See Social Security Act Section 1834(a).

The SITF requests guidance from CMS regarding nonparticipating DME suppliers and looks forward to CMS' response as it will help the State regulators, Medigap insurers and Medicare beneficiaries understand better how to address this matter.

Sincerely,

Marlene Caride
Chair, Senior Issues (B) Task Force
Commissioner, New Jersey Department
of Banking and Insurance

Jon Pike
Vice Chair, Senior Issues (B) Task Force
Commissioner, Utah Insurance Department