

March 17, 2022

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.

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 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,

A handwritten signature in blue ink that reads "M. Caride". The signature is fluid and cursive, with the first letter of each name being capitalized and prominent.

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

A handwritten signature in blue ink that reads "Jonathan T. Pike". The signature is cursive and includes a middle initial, with the first letter of each name being capitalized.

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