



Memo

To: Jane Sung, Gunther Ruch, National Association of Insurance Commissioners

From: Dotti Outland, Regulatory Affairs, UnitedHealth Group

Date: 12/2/11

RE: Changes to Plans C&F

1) "Suggestion to eliminate coverage for the Part B deductible for C and F (which would make them the same as D and G, thereby eliminating 2 plans)."

Discussions with MedPAC staff lead us to believe eliminating the Part B deductible will not be seen as sufficient. There will have to be additional cost sharing, different from Plan N so as not to duplicate plans. See #3 below for more details. Also, there should be some thought about a distinct name or designation other than C and F for these plans, now that we already have 1990 C&F, 2010 C&F, 1990 and 2010 High Deductible F, Select versions of these....

2) "Adding cost-sharing by rider in some fashion."

We'd discourage the use of riders for several reasons:

- Riders will add complexity to the text of the Model. There is more chance for technical errors in the Model itself and during the state adoption process.
- Some states require verbatim language from the Model to appear in insureds' policies or certificates. The additional complexity would make this more difficult for insurers and state reviewers, as well as making important insurance documents much harder for insureds to understand.
- There will very possibly be additional changes in Medigap cost sharing in the not too distant future. Multiple riders would get very complicated very quickly.

For all these reasons we urge a "clean" change to new versions of C and F rather than adding rider language to the old versions.

3) "Increasing cost sharing for specific services (such as those listed on the Hogan list)."

Increasing cost sharing for specific services (different from those subject to the Plan N copays) is a good way to achieve the goal of additional cost sharing while not duplicating Plan N. We have the following suggestions in this regard:

- The services must be well defined, down to the level of specific CPT codes, to promote ease of automated electronic claim processing and so that all carriers will pay claims in a uniform way. (Recall there was some confusion regarding the Plan N copays when that plan was launched.) While the text of the regulation itself should probably not be burdened with lists of CPT codes, perhaps a Drafting Note or an Appendix would be appropriate places?
- No more cost sharing than necessary should be imposed on insureds. Besides ensuring affordability of needed services and preventive care, as noted under #2 above there will very possibly be additional changes to Medicare/Medigap cost sharing in the near future, so this should be seen as just the "first round."
- Regarding which services should be subject to cost sharing, the Hogan list and other high volume services that are costly for Medicare or could be subject to overuse are candidates for discussion. Do we want to consider building in some flexibility for the NAIC to be able to change the list of services subject to cost sharing as the list of highest volume services or those subject to overuse changes, or Medicare adds new services?

In replying to your questions, we would like to suggest the following guiding principles in formulating changes to plans C and F:

- Preserve choice for the beneficiary,
- Keep it simple (well-defined operational changes using CPT or ICD-10 codes),
- No more than necessary/meet minimum requirements of the law,
- Preserve value throughout differing plan level benefits