

**National Association of Insurance Commissioners**  
**Health Insurance and Managed Care (B) Committee**  
**Senior Issues (B) Task Force**  
**Medigap PPACA (B) Subgroup**  
**PUBLIC HEARING ON PPACA REVISIONS TO MEDIGAP PLANS C AND F**  
**Spring National Meeting**  
**Hilton Austin Hotel**  
**Austin, Texas**

**TO BE OR NOT TO BE APPROPRIATE PHYSICIANS' SERVICES:  
OR IS IT NOBLER TO REVIEW AND REVISE?  
THE STAGE IS SET TO ADD NOMINAL COST SHARING  
TO MEDIGAP STANDARDIZED PLANS C AND F**

**By**  
**William G. Schiffbauer, Esq.**

**Schiffbauer Law Office**  
**1300 Pennsylvania Avenue, NW**  
**Suite 700**  
**Washington, DC 20004**  
**wgslaw@erols.com**

**March 28, 2011**

**Outline of Presentation**

- I. BACKGROUND--DIRECTIVE AND SCOPE OF REVIEW.**
- II. STATUTORY PROVISION--REQUEST TO REVIEW AND REVISE.**
- III. LEGISLATIVE HISTORY--UTILIZATION OF APPROPRIATE SERVICES.**
- IV. STATUTORY AMBIGUITIES--KEY PHRASES AND SPECIFIC SERVICES.**
- V. CLARIFYING AMBIGUITIES--BEYOND COMMITTEE REPORTS.**
- VI. PPRC REPORT IN 1997--INITIAL FIRST DOLLAR COVERAGE SCRUTINY.**
- VII. MEDPAC REPORT IN 2009--LINKING MEDIGAP TO HIGHER SERVICE USE.**
- VIII. MEDPAC REPORT IN 2010--LINKING TO PPACA DIRECTIVE.**
- IX. FIRST DOLLAR COVERAGE EFFECT--RECONSIDERED BY RAND.**
- X. ANALYSIS OF KEY ISSUES--INITIAL THIRTEEN QUESTIONS.**
- XI. CONCLUSION--DISCRETION TO REACH A PREDETERMINED END.**

### **Background--Directive and Scope of Review**

The Working Group is tasked to consider implementing the latest in a series of repeated changes and revisions to private Medigap insurance coverage required by the Congress. These changes have largely been driven by efforts to implement public policy to either: (1) reform and improve Medigap insurance coverage for policyholders; or, (2) make policyholders more cost-conscious by shifting Medicare costs to beneficiaries that have private Medigap insurance coverage.

This most recent directive by the Congress adopted in PPACA is among those efforts intended to make Medigap policyholders more cost conscious. This policy choice by the Congress is driven by so-called "first dollar coverage" effect concerns. This public policy rests on a theory that supplemental insurance coverage causes Medicare beneficiaries to "overuse" Medicare benefits, and is based on a simple comparison of those with and those without Medigap coverage.

PPACA addresses only Medigap insurance coverage. However, as MedPAC has illustrated, other forms of secondary coverage that also have a "first dollar coverage" effect include employer provided retiree benefits that supplement Medicare, Medicare Advantage plan benefits, and Medicaid. These other forms of private Medicare supplemental insurance are not captured in the PPACA provision that is under consideration by the Working Group.

### **Statutory Provision--Request to Review and Revise**

Section 3210 of the PPACA directs the NAIC to review and revise, to otherwise update the standards for model Plans C and F to include requirements for nominal cost sharing to encourage the use of appropriate Part B physicians' services under Part B. The revisions for nominal cost

sharing and updating must be based on evidence that is either published in peer-reviewed journals or that is taken from current examples used by integrated delivery systems.

The Secretary of HHS must "request" the NAIC to initiate this review and revision of the standards for Plans C and F. Once requested, the NAIC's review and revision of the standards must be consistent with the process established in the Social Security Act's Medigap standards for generally revising the NAIC Model Act. This includes the consultation of a Working Group of balanced representation and completion of the specified task within 9-months of the request.

The new standards for Medigap plan models C and F would be implemented for plans offered and sold as of January 1, 2015. The statutory language qualifies this implementation date with the phrase "to the extent practicable".

#### **Legislative History--Utilization of Appropriate Services**

Court-developed principles of statutory construction call first for the application of the "plain meaning" of the statutory language. For ambiguities, the courts will seek guidance from "official" legislative materials such as committee reports which are considered the most "reliable" source of legislative history. Prior to the current prejudice for committee reports, the courts also looked to a broader historical context or public record from which a statutory provision emerged.

Section 3210 was initially included as section 3209 in S. 1796, America's Healthy Future Act of 2009, as reported by the Senate Committee on Finance on October 19, 2009. The committee

report language sheds little light on the ambiguities of the statutory language. The report states only that nominal cost sharing must be based on evidence, either published or from integrated delivery systems, of how cost sharing affects utilization of appropriate physician care.

The House-passed version of this legislation did not include the Medigap provision to require the NAIC to review and revise Plans C and F. Furthermore, there is no conference report explanation because the PPACA was not considered under the usual legislative procedures.

For example, in the Medicare Modernization Act of 2003 the conference report explanation specifically asked the NAIC to "modernize" the standardized plans and highlighted the goal of "reforming first dollar coverage." In addition to new statutory Plans K and L, the report urged the NAIC "to consider broader changes to effectuate reduced premiums and more rational coverage policies that create incentives for appropriate utilization of services." See, H. Rept. No. 391, 108th Cong., 1st Sess. at 511 (November 21, 2003).

As a result of the conference report language, Plans M and N were developed as part of the Model Regulation revisions in 2007. Relevant to this latest task, Plan N includes required copayments of \$20 for physician office visits and \$50 for emergency room services. These amounts were not specified in the statute, but were arrived at through the Working Group process. These new Plans M and N were only recently made available for offer and sale beginning on June 10, 2010. See, 74 Fed. Reg. 18807 (April 24, 2009).

### **Statutory Ambiguities--Key Phrases and Specific Services**

Certain of the key phrases and directives to review and revise, and otherwise update, the standards for Medigap Model Plans C and F, are undefined. There are no "transition" rules with respect to the offer, sale, issuance, or experience pooling for premium rating, revised plan letter designation, and other related issues, for example. These would seem to be left to the "practicable" discretion of the NAIC Working Group's development of the standards.

Among the key issues for discussion that are not clearly defined in the statute are the following: (1) the meaning of "nominal" cost sharing; (2) the determination of specific physicians services that are inappropriately utilized; (3) the breadth of judgment exercised in determining the meaning of "appropriate" physician services; (4) the type of evidence and examples that the Working Group may rely upon; and (5) the actual implementation of the requirements to encourage use of appropriate physician services.

It is also unclear whether the NAIC must actually make "final" revisions. The statutory language provides that the Secretary "shall" request the NAIC to review and revise. There is no statutory language that explicitly states "and the NAIC shall make" such revisions. It implied, however, in the Secretary's request "to revise", and the application of the 9-month time period after which the Secretary is authorized to make such revisions, and finally in the specific implementation date--to the extent practicable.

What if, after a full review of the "evidence" the Working Group finds that physician services are not inappropriately utilized? Reaching a contrary conclusion, must the plans still be revised to include nominal cost sharing?

### **Clarifying Ambiguities--Beyond Committee Reports**

Absent additional official legislative history in the committee report, the Working Group must next rely upon the relevant "context" from which the provision emerged. While not official legislative history, guidance is can be found in the reports and transcripts of the Medicare Payment Advisory Commission ("MedPAC"), the official and independent advisory authority to the Congress on Medicare-related matters. Its members are appointed by the Comptroller General of the United States.

Prior to the enactment of PPACA, the MedPAC has held many hearings and published reports related to this topic that may be instructive as to the "context" in which this provision was adopted. Among the MedPAC materials are included detailed reports and discussion that illuminate the specific types of physicians' services that may be included in the Working Group's final recommendations, the meaning of nominal, and reference to various peer-reviewed studies.

### **PPRC Report in 1997--Initial First Dollar Coverage Scrutiny**

MedPAC, in its predecessor form as the Physician Payment Review Commission ("PPRC") first began its formal review of Medigap and the "first dollar coverage" effect in the 1997 Annual Report to the Congress. Chapter 16 of the report, entitled "Secondary Insurance for Medicare

Beneficiaries" examined the types of secondary insurance (Medigap, and employer-provided), and discussed the "first dollar coverage" effect on Medicare service use.

The PPRC included a range of approaches to address the "first dollar coverage" effect. First, incremental changes to Medigap that included reformulating the then-10 standardized Medigap plans to incorporate some beneficiary cost sharing. Other options included expansion of Medicare SELECT, establishing partial risk-sharing arrangements, and requiring insurers to assume full financial risk for Medicare and supplemental benefits (now Medicare Advantage).

### **MedPAC Report in 2009--Linking Medigap to Higher Service Use**

Section 3210 of PPACA is a direct descendent of MedPAC's June 2009 Report to the Congress that began with the Commission's hearings initiated in 2007. The June 2009 report included Chapter 6 that is entitled "Improving Traditional Medicare's Benefit Design". The report declared that by filling in Medicare's cost sharing requirements supplemental coverage can lead beneficiaries to use more or higher priced Medicare covered services.

The June 2009 Report concluded that researchers agree that beneficiaries with supplemental coverage tend to have higher use of services and spending than those with no supplemental coverage. The Commission contracted with Direct Research, LLC, to look at the effects of secondary insurance on the use of and spending for Medicare services. That study concluded that the presence of secondary insurance was "causative" with higher Medicare spending.

The study analyzed different components of beneficiary Medicare spending in detail to see what patterns emerged. The study found that office-based care was higher than hospital-based care, and that spending for elective inpatient hospital services, specialist care, and preventive care was higher with secondary coverage. The study also observed significant differences in demographics, income and health status between the compared groups of beneficiaries.

The study observed that the largest differences in spending were in areas where there was more discretion in providing the care. However, the report could not conclude that the additional care was a waste or of marginal value. The study noted that, although secondary insurance increased service use, that result of increased service use does not suggest that the additional services used were either all bad or all good.

As a final point, the study's author observed that policy actions in this area would require judgment as to whether the benefit of the additional health care use induced by insurance coverage does or does not appear to be worth the additional cost.

MedPAC included an illustration in the June 2009 Report to the Congress of using copayments in Medigap and employer-sponsored retiree coverage to "steer" beneficiaries toward certain types of care. These were: \$10 copayments for primary care office visits; \$25 copayments for specialty care (including chiropractors and physical therapists); and \$50 copayments for visits to emergency rooms.

### **MedPAC Report in 2010--Linking to PPACA Directive**

Immediately after enactment of PPACA, at its April 1, 2010 meeting, MedPAC staff discussed the provisions of section 3210, noting that the legislation doesn't say exactly what the nominal co-pays will be, and that it will be left to the NAIC. Staff also noted that it doesn't apply to employer-sponsored coverage, but "shows that the approach we've been talking about for redesigning supplemental coverage is being taken seriously." Transcript at page 254.

The June 2010 Report to the Congress continued the MedPAC discussion for "Improving Traditional Medicare's Benefit Design". The report noted that beneficiaries use of care is strongly affected by the recommendations of medical providers. However, the report observed that the amounts patients pay at the point of service can affect whether they seek care, the type of provider they see, and which treatment they use.

The report notes that researchers agree that beneficiaries with Medigap and retiree health benefits have higher use of services and spending than those without such coverage. The report also notes that researchers disagree on the impact, and that some studies find small or statistically insignificant induced demand for care resulting from supplement coverage after controlling for "selection bias" in that those with higher health care needs purchase insurance.

### **First Dollar Coverage Effect--Reconsidered by RAND**

The "first dollar coverage" theory that has prompted the PPRC and MedPAC discussions is attributed to the RAND Health Insurance Experiment that was conducted in 1982. In 2006, RAND researchers, reflecting on the 1982 study, cautioned that increased cost sharing reduced the use of both needed and unneeded health care services and that the 1982 study did not review the impact of increased cost sharing on Medicare beneficiaries. See "The Health Insurance Experiment: A Classic RAND Study Speaks to the Current Health Care Reform Debate" (RAND Health Research Highlights, January 2006).

In addition, the authors also found that increased cost sharing only reduced the use of services where the patient decided not to initiate treatment or services because of the higher cost sharing. However, once patients entered the health care system, cost sharing only modestly affected the intensity or cost of an episode of care and has little effect on costs once care is sought. This strongly suggests that physicians affect the "overuse" of Medicare services after patients seek treatment, more so than the presence of secondary coverage.

### **Analysis of Key Issues--Initial Thirteen Questions**

After a review of the statute and legislative history of the provision, a brief discussion of some of the key issues might be useful to "kick start" the Working Group's initial "review." This list is by no means exhaustive, but rather a first attempt to look at the specific language of the statute and to determine precisely what the scope of the Working Group's task will involve, once "requested," in order to meet the "review and revise" directive of Section 3210.

1. What is the meaning of "nominal" for purposes of cost sharing? The plain meaning of the term is literally in name only, or relatively very small. Some "nominal" cost sharing was applied to Plan N requiring a \$20 copayment for office visits, and up to a \$50 copayment for emergency room care. This is consistent with the assumptions used by MedPAC, except that the Hogan study found that emergency care was unaffected by supplemental insurance. Also, Medigap plans no longer cover preventive care which was highlighted by the MedPAC report.

2. What is the meaning of "cost sharing"? The plain meaning of the term includes many forms such as deductibles, coinsurance and copayments. A copayment is generally considered to be a fixed amount, and coinsurance is a set payment of a portion or percent of the cost of a service. The deductible is a set amount that is paid before any other benefit payment is made. Section 3210 appears intended to mean copayments as the type of "nominal" cost-sharing to be employed.

3. Which "physicians' services" under part B are targeted for nominal cost sharing? The plain meaning of this term would include the entire universe of services covered under Medicare Part B. Section 3210 appears to be concerned, however, with only those Part B physician services that are inappropriately utilized and that could be affected by cost sharing. These services include surgery, consultation, home, office, and institutional visits.

4. What is the meaning of "appropriate" physicians' services under part B? The plain meaning of the term is at once individualistic---suitable for a particular person and their medical condition---but it is also of general application, suitable but to whom, or for whom, or for what--

is the question. Again, the focus of Section 3210 appears to be those physician services that are "inappropriately" utilized by Medicare beneficiaries. This will require a "judgment" call.

5. What is the meaning of "to encourage" the use of such appropriate physician services? The plain meaning of the term is to support, or to favor, or to foster such use. The Working Group's task would appear to be the application of nominal cost sharing in such a manner and for such physician services as to favor or foster the appropriate utilization of physician care, and to "discourage" the use of inappropriate physician services.

6. What "evidence" of appropriate use in published peer-reviewed journals may be used? The plain meaning of the term is that which tends to prove, or that establishes a point or induces and persuades a belief as to the existence of a specific fact or proposition. Are the MedPAC reports and studies considered to be published "peer-reviewed" journals and as the most specific to the issue of adding nominal cost-sharing to Plans C and F.

7. What if "evidence" in peer-reviewed journals is not supportive of nominal cost-sharing? The use of "evidence" implies a probative exercise examining the truth or falsity of a fact in issue that can result in the disproof of a specific fact or proposition. Most recently the MedPAC discussed a study that found a substantial "offset" effect in terms of increased hospital utilization by retirees resulting from increased cost sharing for physician visits and prescription drug usage.

8. What are current examples of appropriate use by integrated delivery systems? Again, the term "appropriate" means that something is suitable or proper, and in this instance it must be so

in application to Original Medicare as a fee-for-service arrangement as opposed to a benefit design for managed care. Is it appropriate to use Medicare Advantage plan cost-sharing as a model for Original Medicare services?

9. What is the meaning of "to otherwise update" the standards? The phrase is used in following the Working Group's "review" and in describing the "revision" as otherwise updating the standards to add "nominal" cost sharing. It does not appear to provide the Working Group with discretion to make other changes in addition to nominal cost-sharing that would be considered "current"---the plain meaning of "update"---to the standards for Plans C and F.

10. What if physicians "waive" these Medigap nominal cost-sharing requirements? This is clearly not a Medicare-established cost-sharing requirement that could be routinely "waived". It may be the type of "waiver" that would violate the anti-kickback rules, or it may not be a concern of the anti-kickback rules. If physicians can "waive" this nominal cost-sharing then the purpose of adding this nominal cost sharing to Plans C and F is "muted" at best.

11. Is this cost-sharing that must be collected at the point of service? Like Medigap Plan N, the nominal cost-sharing that is to be required for Plans C and F will likely not be collected at the point-of-service since these are not Medicare cost-sharing requirements. These Medigap cost-sharing amounts will likely be deducted from the normal Medigap benefit payment, and this will occur after the Medigap insurer has received the Explanation of Medicare Benefits.

12. Will this nominal cost-sharing make beneficiaries cost conscious? Medigap coverage is supplementary to Medicare, and it is difficult at best to inflict "cost consciousness" after Medicare has determined that the service is "medically necessary" and has likely made its benefit payment. Medigap is obligated by its contract and standards to pay supplemental benefits for all services approved as "medically necessary" by Medicare itself. This is a key issue with respect to implementing the directive of PPACA Section 3210, and achieving its objective to encourage use of appropriate physician services.

13. Can this nominal cost-sharing be effectively implemented? To address point-of-service utilization, significant complexity and cost are added to the administration of Medigap coverage. This would entail the involvement of the treating physician to: (1) know that the Medigap coverage imposes nominal cost-sharing; (2) inform the beneficiary of these requirements; and (3) actually collect the cost-sharing amounts before the service.

### **Conclusion--Discretion to Reach a Predetermined End**

The "revisions" to Plans C and F by the Working Group will require a judgment call as to whether the benefit of the additional health care services used are really induced by Medigap Plans C and F coverage, and whether those additional services are worth the additional cost to the beneficiary and to Medicare. On the one hand, the Congress appears to have given the Working Group a wide breadth of discretion in determining what is "appropriate" use of physician services, however, on the other hand, the Congress also appears to direct the Working Group towards a foregone conclusion despite any evidence to the contrary.