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Medicare HMOs Changing Coverage

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By The Associated Press

NEW YORK (AP) -- About 200,000 Medicare HMO recipients will be forced to change health plans next year and millions of additional seniors will face higher rates for fewer benefits as HMOs complain that government reimbursements no longer are keeping up with their costs.

PacifiCare Health Systems, Humana and Foundation Health Systems -- three of the nation's biggest Medicare health maintenance organizations -- said Wednesday they will stop covering Medicare members in several markets.

CIGNA and several regional HMOs previously said they will withdraw from a number of Medicare markets on Jan. 1, 2000, while Aetna and United Healthcare are expected to join the trend on Thursday.

Several of the HMOs said they expect to raise premiums and reduce some benefits on many of their remaining members as a way to make staying in the program financially viable.

But while the HMOs complain the government is cutting back, Medicare officials say payments continue to grow, but at a slower rate in some markets.

"Studies continue to show that Medicare managed care plans are still being overpaid," said Nancy Ann DeParle, administrator of the Health Care Financing Administration which oversees Medicare.

The health plans were required to notify the federal government by Thursday of any changes to their Medicare HMO operations.

"It seems virtually every Medicare (HMO) beneficiary will be affected by some type of cutback," said Karen Ignagni, president of the American Association of Health Plans, an HMO trade group.

Medicare HMO members will receive notices in the next several days if their plan is withdrawing from Medicare, and they will either have to choose another health plan -- if one is available -- or choose traditional Medicare. Members will be notified of precise benefit changes and premium increases in the fall.

Humana, for example, said some of its members will no longer get coverage for any prescription drugs other than generics. Some Humana members also will have to pay part of the cost of outpatient hospital care.

About 6.2 million of the 39 million Medicare enrollees now get health insurance coverage through an HMO. Seniors have signed up with HMOs as an alternative to Medicare's traditional fee-for-service coverage because the HMOs offer them prescription drug coverage and fewer co-payments.

President Clinton on Tuesday unveiled his plan to offer a prescription drug program for traditional Medicare, though Republican opposition is likely to hurt its chances for

passage.

In many retirement areas such as South Florida and Arizona, federal reimbursement for HMOs had been so high the plans did not charge seniors a premium.

But HMO officials say that's about to change.

Last year, about 400,000 Medicare recipients in more than 30 states had to change health plans when more than 100 HMOs opted against renewing Medicare contracts after the federal government cut the growth in the reimbursement rate. Until then, Medicare had been seen as the most lucrative market for HMOs.

The Medicare payment changes, part of the 1997 balanced-budget law, were made in response to reports that Medicare was overpaying the health plans.

While fewer Medicare recipients will have to change health plans in 2000 compared to 1999, industry officials say the situation is worse because so many Medicare HMO members will face higher premiums, Ignagni said.

Los Angeles-based Foundation, one of California's biggest health insurers, said it will drop about 5 percent of its 283,000 Medicare enrollees in 2000. The company said it's planning to drop Medicare coverage in parts of several states where it operates. It refused to disclose specific details.

Last month, Hartford-based CIGNA said it would drop coverage of about 10,000 Medicare beneficiaries next year or about 5 percent of its Medicare members. CIGNA is leaving six markets: Little Rock, Ark., Cleveland, Kansas City, Kan., Philadelphia and southern New Jersey.

Louisville, Ky.-based Humana said Wednesday it will withdraw its Medicare HMO from the following markets: Tucson, Ariz., Las Vegas, Dallas, Kansas City, Kan., Austin, Texas, Milwaukee, Wis. and Melbourne, Fla. Humana also plans to exit parts of the San Antonio and Houston markets. As a result, about 46,000 of Humana's 480,000 Medicare HMO members will be affected.

"When government reimbursement of care for seniors in Medicare Choice plans is no longer adequate to cover the cost of quality care, we have no choice but to discontinue the product," said Gregory H. Wolf, Humana's president and chief executive officer.

Santa Ana, Calif.-based PacificCare said Wednesday it is pulling its Medicare plan out of several markets including: Dayton, Ohio, Medford, Ore., McMinnville Ore., Spokane, Wash. and central California. The move will affect 16,400 of its 991,000 Medicare HMO members.

Blue Cross and Blue Shield of Arizona said it plans to quit covering Medicare members in that state, forcing 13,000 of its members to find another insurance option.

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The Easy Path To Scoreable Medicare Savings: Neutralize "Medigap" Insurance

Why Do Beneficiaries Want Medigap?

How Can Medigap Be Neutralized?

The large cost imposed on the Medicare program by the "medigap problem" is widely recognized as a potential source of government budget savings. The medigap problem is that beneficiaries, by purchasing private supplemental insurance (medigap) to pay all of Medicare's intended cost-sharing, use more services than they would otherwise. Thus, Medicare's costs are considerably higher than they would be if the cost-sharing were not subverted by medigap, which more than 75% of beneficiaries own.

Effectively solving this problem presents the best source of scoreable budget savings, because the savings produced are the result of efficiency improvements, not from imposing costs on taxpayers, beneficiaries or providers of their medical care.

Why Do Beneficiaries Want Medigap?

The medigap policy (Plan C) that pays all of Medicare's cost sharing requirements covers:

- Part A deductible, \$760
- Part A hospital coinsurance for days 61 to 90 in the hospital, \$190 per day
- Part A hospital coinsurance for days 91 to 150 in the hospital, \$380 per day
- All charges for extra 365 days in the hospital
- Part A blood deductible, 3 pints of blood
- Part B deductible, \$100
- Part B coinsurance, 20% of expenses in excess of \$100
- Skilled nursing facility coinsurance for days 21 to 100, \$95 per day
- Emergency care in foreign countries

Medicare's potential cost-sharing liability is more than \$34,000 per year. This potential out-of-pocket cost is draconian. It is also irrational because it frightens most beneficiaries to own medigap (at an average cost of \$1,092 to cover the potential liability in 1997) even though 20% of beneficiaries incur no cost sharing liability each year, 70% incur a cost-sharing liability of less than \$500, and 80% incur a cost-sharing liability of less than \$999.

If beneficiaries were not exposed to such potentially high out of pocket costs, they (and/or their former employers who provide medigap as a retirement benefit) would not have to waste so much money on medigap coverage. The government does not need to expose beneficiaries to such high risk and precipitate a needless waste of money. Not only do most beneficiaries incur far less cost-sharing liability than they pay for medigap, but medigap premiums have risen far faster than the rate of Medicare inflation in the last few years. The government can give beneficiaries and their former employers an economic break by eliminating their need for medigap.

In so doing, the government can also lessen the pressure that medigap puts on the budget. Beneficiaries with medigap insurance view their covered care as essentially free, and they utilize 28% more medical services than they would otherwise, according to the PPRC. These extra costs are borne primarily by the

Medicare program rather than medigap insurers because medigap pays only the deductible and coinsurance for covered services while the Medicare program pays the rest.

How Can Medigap Be Neutralized?

Congress should reduce Medicare's cost-sharing requirement to a reasonable, rational level. This means a level that would not strongly encourage beneficiaries to purchase medigap to insure against the potential liability, but a level that would also provide an effective incentive for beneficiaries to reasonably moderate their demand for covered services.

The AMA proposes that Medicare restructure its cost-sharing to reduce potential beneficiary liability in a manner that eliminates the need for private medigap insurance and, in exchange, beneficiaries would pay a higher premium than they do now. The premium charged by Medicare for the expanded coverage would be much less than that charged by private insurance companies because the government's premium would not include selling expense and profit. Government outlays for medical services would be reduced by the effective cost-sharing.

As an illustration of the approach, the average cost of the medigap Plan C that covers all of Medicare's potential cost-sharing liability (\$1,092 in 1997) can be divided into two parts, consisting of a modest, single deductible for both Parts A and B of Medicare, and a premium for the extra Medicare coverage represented by eliminating all existing cost-sharing liability except for the single deductible. Dividing the current cost of medigap Plan C into two parts, a deductible and a premium for extra coverage, would guarantee that beneficiaries would incur no greater out-of-pocket expense than they do now, and that many would save money.

For example, consider dividing the current medigap cost into a \$500 deductible and a premium of \$592. According to actuarial analysis by Price Waterhouse LLP, the average beneficiary would spend only \$360 of the \$500 deductible, saving \$140 per year compared with the current cost of \$1,096 for medigap. By neutralizing the first-dollar-coverage incentive of medigap, the Medicare program would save an average of \$273 per beneficiary, which could be returned to beneficiaries in the form of reduced a Part B premium or additional coverage. If the government savings were used to reduce the deficit, a total of \$50 billion of savings would accrue over the period 1998-2002.

Summary

Medicare's draconian and irrational cost-sharing requirements are self-defeating because they frighten beneficiaries into insuring against them with expensive private coverage. By incorporating most of medigap's coverage into Medicare benefits, the government could save beneficiaries money by reducing the premium required for the coverage. In turn, the government could achieve the intended benefit of effective cost-sharing to reduce program expenditures. The economic inefficiency associated with current Medicare cost-sharing requirements and private medigap is significant. Neutralizing medigap is a win-win for beneficiaries, the government, and taxpayers.

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United States Senate

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Comments: - Info. on new GAP and plan

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Fact Sheet on Non-Renewals

Background and General Information on Medicare Health Maintenance Organizations (HMOs) and Non-renewals:

- For many years, the law has allowed Medicare to contract with HMOs to enroll beneficiaries. Currently, about 6 million beneficiaries receive their Medicare benefits through Medicare-contracting HMOs. The law that governs Medicare-contracting HMOs through 1998 (the "older" law) is being replaced by a new law. This new law creates the Medicare+Choice program. The Medicare+Choice program allows HMOs as well as other health plans to contract with Medicare. Beginning January 1, 1999, if HMOs that had been operating under the older law want to continue their Medicare participation, they must contract under the new Medicare+Choice program. Some currently-contracting HMOs have decided to continue under the Medicare+Choice program; others have decided not to continue.
- Under both the older law and the new Medicare+Choice program, Medicare HMOs must make annual business decisions about whether or not to continue to participate in the Medicare program. Under the older law, a decision not to participate was generally referred to as a non-renewal, because the HMO was deciding not to "renew" its existing contract with HCFA. This year, however, since under the Medicare+Choice law existing HMO contracts cannot be renewed, a "non-renewal" represents a decision by an HMO not to enter into a new Medicare+Choice contract for 1999. Non-renewal decisions can apply to a plan termination or to a service area reduction.
- For plans that want to contract with HCFA to enroll Medicare beneficiaries, HCFA initially approves the plan for its contract and then conducts periodic monitoring reviews. However, HCFA has no control over the annual business decisions of plans to continue participating in Medicare, that is, HCFA cannot require plans to enter into a Medicare+Choice contract for 1999 or maintain their existing service area under such a contract.
- Regulations governing contracts under the older law require HMOs to notify HCFA 90 days before the contract ends (i.e., October 2) of a decision to nonrenew and to notify affected enrollees 60 days prior to the end of the contract (i.e., November 2).

Information for Medicare Enrollees In Non-renewing Plans:

1. **In General.** Non-renewing HMOs will continue to provide services to their Medicare enrollees through December 31, 1998; that is, current enrollees can remain in their HMO through December 31, 1998. They can also disenroll prior to that time and either (1) return to the original Medicare plan or (2) enroll in another Medicare-contracting HMO or other Medicare+Choice plan if one is available in their geographic area (see item 3 below on effective dates and exceptions regarding who is eligible to enroll in another plan). All beneficiaries have the option of returning to the Original Medicare Plan. Non-renewing

HMOs are required to send all affected enrollees an information package by November 2, 1998. This package will provide information on enrollees' options with respect to either (1) returning to the original Medicare plan with supplemental coverage or (2) enrolling in another Medicare-contracting HMO or other Medicare+Choice plan.

2. **Returning to the Original Medicare Plan.** Individuals can return to the Original Medicare Plan in one of two ways: (1) they can remain enrolled in the Non-renewing plan until December 31, 1998 and be automatically returned to the Original Medicare Plan starting January 1, 1999; or (2) they can return to the original Medicare plan before December 31, 1998, by (a) submitting a written request to disenroll to the Non-renewing plan or (b) contacting the Social Security Office or Railroad Retirement Board Office. The member will be disenrolled effective the first day of the first month following the month the request for disenrollment was made. For example, if the individual requested disenrollment on November 20, he/she will be returned to the Original Medicare Plan effective December 1, 1998.

Individuals should understand that, until their disenrollment is effective, they must continue to comply with plan rules when seeking medical services.

3. **Choosing Another Medicare HMO.** Individuals may be able join another Medicare-contracting HMO or other Medicare+Choice plan. Beginning January 1, 1999, beneficiaries can enroll in any Medicare+Choice plan that serves their geographic area if they are entitled to Medicare Parts A and B and do not have permanent kidney failure (End Stage Renal Disease). If individuals choose to enroll in another plan before December 31, 1998, they will automatically be disenrolled from their current plan. Medicare-contracting HMOs and other Medicare+Choice plans that will be available in their geographic area will be required to accept enrollments in November 1998 to be effective January 1, 1999. It should also be noted that some of these plans may also accept enrollments during the month of December. Be sure to enroll no later than December 31, 1998 for your coverage to begin January 1999.

4. **Supplemental Insurance through Medigap.**

Requirements for Medigap Insurers:

- As long as individuals apply for a Medigap policy no later than 63 days after the coverage with the Non-renewing plan terminates, they are guaranteed the right to buy any Medigap plan designated "A", "B", "C" or "F" that is offered in the State. Accordingly, if individuals who remain enrolled until the Non-renewing plan terminates their coverage on December 31, 1998 apply for one of these Medigap policies no later than March 4, 1999, companies selling these policies cannot place conditions on the policy (such as an exclusion of benefits based on a pre-existing condition) or discriminate in the price of the policy because of health status, claims



experience, receipt of health care or medical condition.

CAUTION: While individuals can apply for a Medigap policy before December 31, 1998, the protections described here will NOT be guaranteed if they voluntarily disenroll before the HMO contract terminates December 31, 1998. Individuals must keep a copy of their plan's termination letter to show a Medigap insurer as proof of loss of coverage under this plan.

- If individuals dropped a Medigap policy to join the Non-renewing plan and they were never enrolled in a similar managed care plan since starting Medicare, they may be able to return to the Medigap policy that was dropped if (1) the Medigap policy dropped is still being sold by the same insurance company; (2) they disenroll from their current HMO before December 31, 1998; (3) they have been enrolled in their current HMO for no more than 12 months; and (4) they apply for the Medigap policy no later than 63 days after their coverage from their current HMO terminates.

If the previous Medigap policy is no longer available, the individual is still guaranteed the right to buy from any Medigap carrier a Medigap Plan designated "A", "B", "C", or "F" that is offered in that state (as described above).

CAUTION: If the previous policy is no longer available, the individual is still guaranteed the right to buy from any Medigap carrier any Medigap plan designated A, B, C or F that the carrier offers in that State (as described above.). However, in this situation the 63-day period for filing your the new Medigap application will begin on the effective date of disenrollment.

The individual should therefore make sure the old policy is still available from the original insurer before disenrolling from the non-renewing plan. If it is not available, the individual will have more time to make a decision about Medigap options by simply remaining enrolled until the current health plan terminates coverage on December 31. The individual will then have 63 days from the last day of coverage under the current plan to apply for a plan designated A, B, C or F.

Requirements for Plans:

- By law Medicare HMOs must arrange for individuals to be protected against any pre-existing condition exclusions under a Medigap policy for up to six months after a plan terminates coverage. Plans will provide individuals with specific information regarding the arrangements that will be made available to beneficiaries in the information package that Non-renewing plans must send by November 2, 1998.

5. **Supplemental Coverage Through a Former Employer.** Beneficiaries who have coverage with a Medicare HMO through their former employer should consult with their former employer's retirement office before making any changes.
6. **Possibility of Seeing the Same Doctor as Before.** Beneficiaries who choose to return to the Original Medicare Plan may be able to continue to see the same physicians that they had seen through the HMO because most HMO physicians (except those in staff or group model HMOs) also provide services under the Original Medicare Plan. If there are other Medicare-contracting HMOs or other Medicare+Choice plans in their geographic area, some of their current physicians may also participate with those plans.
7. **Information on Other Medicare HMOs.** On November 2, comparative information on Medicare-contracting HMOs and other Medicare+Choice plans that plan to contract with Medicare for 1999 will be available on the worldwide web at www.medicare.gov under "Medicare Compare". Information can be accessed by zip code or by state and county. Some plans are available only in certain counties within a state or zip codes within a county. Many libraries and senior centers can help beneficiaries obtain information from this source.
8. **General Assistance for Medicare Beneficiaries on Health Insurance Matters.** Beneficiaries can contact their State Health Insurance Assistance Program (SHIP) for assistance; they can also contact the U.S. Administration on Aging (AoA) central toll-free number (1-800-677-1116) to be referred to their local area agency on aging.

Questions and Answers

The Health Care Financing Administration (HCFA) is the Federal agency that administers the Medicare program. This includes administration of Medicare risk-based contracts with health maintenance organizations (HMOs). Some of these plans have decided not to renew their contracts with HCFA to provide Medicare services to Medicare beneficiaries in certain states and selected counties.

The following is designed to assist you in answering the most commonly asked questions arising from managed care plan non-renewals and service area reductions.

Q1 HMO plans are leaving Medicare. How do beneficiaries get information about whether this is true?

A1 Individuals affected by a termination will be receiving notification from the HMO no later than November 2, 1998.

Q2 Why are HMOs terminating their contracts with HCFA?

A2 HMOs are independent businesses that make business decisions to either participate or not participate in a contract with HCFA. HMOs voluntarily choose to enter into contracts with HCFA to serve Medicare enrollees. Each year HMOs have to make a choice to continue their contracts, adjust premiums and/or benefits, or not renew the contracts. Some HMOs have made business decisions to terminate their Medicare contracts in certain areas. In some cases, the termination of the contract was the result of the merger between the two plans where only one corporate entity will continue in the Medicare program.

Q3 Can the Health Care Financing Administration (HCFA) force Medicare HMOs to continue their contracts to provide services to Medicare beneficiaries?

A3 No. While HCFA is responsible for ensuring that contracting HMOs meet their contractual obligations, we do not influence their core business decisions, nor can we force them to stay in the Medicare program.

Q4 How are HMOs paid by the Federal government?

A4 HCFA pays HMOs a monthly amount for each enrolled Medicare member in exchange for providing all Medicare covered services to these members. The amounts vary from county to county and are determined based on a methodology prescribed in the statute. HCFA will make monthly payments to plans terminating their contracts through December, 1998. NOTE: \$379.84 is the lowest Federal government reimbursement rate for the aged allowed for 1999 by the Balanced Budget Act (BBA) of 1997. These rates are only the

base rate and the actual payments to HMOs reflect adjustments to the base rate for factors like age, sex, etc.

Q5 Are there any other HMOs in the affected areas that Medicare beneficiaries can join?

A5 In most instances, there is at least one other managed care option available. Beneficiaries will receive a notification from the terminating HMO with a list of options along with an available Medicare supplement (Medigap) option no later than November 2, 1998.

Q6 Are all HMOs terminating?

A6 No. The changes for January 1999 only affect certain Medicare contracts.

Q7 How many Medicare beneficiaries are affected by these changes?

A7 As a result of decisions by HMOs, approximately 48,000 Medicare beneficiaries -- less than one percent of the 6 million enrolled in Medicare managed care -- no longer have any Medicare HMOs in their areas. Approximately 7 percent of Medicare beneficiaries in managed care plans will be affected by these changes. This represents about 1 percent of the total Medicare beneficiaries.

Q8 After a plan terminates, what health care coverage will be available for Medicare beneficiaries who were enrolled in these plans?

A8 Many beneficiaries who are currently members of the terminating HMOs will be able to enroll in other Medicare managed care plans available in their area. Also, the Original Medicare Plan continues to be available to all Medicare-eligible individuals. Beneficiaries who return to the Original Medicare Plan and wish to purchase a Medicare supplement (Medigap) policy will have specific rights, discussed below. Each terminating HMO will be mailing a list of all health care options to its members by November 2, 1998.

Q9 Is there anything that will be made available to individuals being terminated from an HMO, such as a Medicare supplemental (Medigap) insurance policy?

A9 Current members of HMOs have certain beneficiary protections. First, as long as you apply for a Medigap policy not later than 63 days after your HMO coverage terminates on December 31, 1998, all Medigap insurers must sell you any Medigap plan designated "A", "B", "C", or "F" that they offer. The insurance company cannot place conditions on the policy (such as an exclusion of benefits based on a pre-existing condition) or discriminate in the price of the policy because of your health status, claims experience, receipt of health care, or your medical condition.

In addition, your HMO is required to make arrangements that ensure beneficiaries are protected for up to six months for out-of-pocket expenses related to any pre-existing condition exclusion in a Medigap policy. However, beneficiaries are free to seek other coverage which may or may not have a pre-existing condition exclusion.

Members should contact their State Health Insurance Assistance Program (SHIP) for further information.

Q10 What health coverage is available for members who are under the age of 65, and eligible for Medicare because of a disability?

A10 For beneficiaries under age 65 (i.e., entitled to Medicare because of a disability or as a result of End Stage Renal Disease (ESRD)), Medigap insurers have the same responsibility to sell you a Medigap policy designated "A", "B", "C" or "F" that they do for beneficiaries over age 65. However, terminating HMOs must only make arrangements for Medicare supplemental (Medigap) insurance based on what is available in the local marketplace. Members should contact their local State Health Insurance Assistance Program (SHIP) for further information.

Q11 What if I dropped a Medigap policy before I joined this plan? Can I return to this Medigap policy? What happens if I do this before December 31, 1998?

A11 If a beneficiary was previously enrolled in a Medigap policy and this was the first managed care plan the beneficiary enrolled in since starting Medicare, the beneficiary has the right to return to the Medigap policy if:

1. the Medigap policy dropped is still being sold by the same insurance company;
2. the beneficiary has not been enrolled in this plan for more than 12 months;
3. the beneficiary disenrolls from this plan before December 31, 1998; and
4. the beneficiary reapplies for that previous policy no later than 63 days after coverage from this plan terminates.

If the previous policy is no longer available, the beneficiary is still guaranteed the right to buy a Medigap Plan designated "A", "B", "C", or "F" that is offered in that state. Before the beneficiary disenrolls, the beneficiary should make sure the policy is still available from the original insurer before disenrolling from the plan.

Q12 Will members be able to keep prescription drug coverage, or is new coverage being made available?

A12 If a member currently has prescription drug coverage through a terminating HMO, this coverage will also end December 31, 1998. Members have the option to enroll in other managed care plans available in their area which may cover prescription drugs. However, the Medigap policies that must be made available to members of terminating HMOs (plans "A", "B", "C" and "F") do not include prescription drug coverage. Similarly, the requirement that terminating HMOs make certain supplemental coverage available does not require them to make arrangements that include prescription drug coverage. Medicare supplemental plans that contain prescription drug coverage are available, but members must seek them out on their own. These plans may refuse to sell you a policy based on your health status, and may impose waiting periods for pre-existing conditions.

Q13 How soon will a decision need to be made for new health care coverage?

A13 Members may remain enrolled in their HMOs until December 31, 1998, or they may disenroll from their HMOs and return to the original Medicare plan before December 31, 1998 (As noted above, this decision may affect which Medigap options are available). It is recommended that members apply for a Medicare supplemental (Medigap) plan as soon as possible, in order to have Medigap coverage begin when the beneficiary returns to the Original Medicare Plan on January 1, 1999. However, as long as members apply within 63 days after HMO coverage terminates on December 31, 1998, their rights to get a new Medigap policy will be protected.

Members currently enrolled in an HMO who have Part B only and who wish to enroll in another Medicare managed care plan must do so no later than December 1 in order to ensure they can continue to be enrolled in a Medicare managed care plan option. The Balanced Budget Act does not allow beneficiaries with Part B-only coverage to enroll in a Medicare+Choice health plan option.

Q14 What are the benefits under the Original Medicare Plan?

A14 Beneficiary focused information, including an explanation of Medicare benefits, is available at www.medicare.gov.

Q15 Will members be able to go to their same doctors?

A15 For those members returning to the Original Medicare Plan it is very likely that they will be able to continue seeing the same doctors and other providers as they had seen through the HMO. Most physicians also participate in the Original Medicare Plan. Members need to check with their doctor and other providers to find out. If the providers participate in Medicare, there is no need for a change. If a member chooses to enroll in a new Medicare



HMO, he or she may need to select a new primary care physician (PCP) and begin using a new network of providers. Before making a decision to enroll in a new health plan option, the member should check with each managed care plan.

Q16 What happens if a currently enrolled member, who is hospitalized prior to January 1, 1999, is still a hospital inpatient after January 1?

A16 Most participating acute care hospitals are paid by Medicare based on the Prospective Payment System (PPS); non-PPS hospitals operate only in the state of Maryland. Other hospitals, like rehabilitation hospitals, free-standing psychiatric hospitals, and long-term care hospitals, are paid on a cost basis and not under PPS. For PPS hospitals, the HMOs will continue to be responsible after December 31, 1998, for inpatient hospital charges until the member is discharged. For non-PPS hospitals and for other charges, such as physician charges, related to inpatient PPS hospital stays after December 31, 1998, the original Medicare plan will be responsible for payment, minus normal deductible and copayment amounts. Members with Medicare supplemental insurance may have these deductible and copayment amounts paid by their Medigap policy.

Q17 What if a currently enrolled member is receiving other services at home? How can he or she receive assistance during this transition?

A17 Members who are currently receiving ongoing care, such as home health care, or who are using medical equipment, such as oxygen or wheelchairs, need to call the phone number shown on their HMO identification card and ask for Utilization Management (UM) when they are ready to change insurance plans. UM will help members make the change to receive care under the Original Medicare Plan or under a new managed care option. Members who select a new HMO should contact that HMO as soon as possible and ask for the UM department. Members who elect to return to the Original Medicare Plan should instruct their providers to bill Medicare directly after January 1, 1999.

Q18 What happens if a member needs to get additional information after January 1, 1999?

A18 HCFA requires HMOs to provide appropriate assistance to their members for as long as necessary. Individuals can also contact their State Health Insurance Assistance Program (SHIP) for additional assistance.

Q19 Does a current member of a terminating HMO have to wait until January 1, 1999 to change his or her Medicare coverage?

A19 No. If a member chooses to enroll in another Medicare managed care plan prior to January 1, 1999, that enrollment will automatically disenroll the member from his or her HMO. If a member chooses to disenroll and go to the Original Medicare Plan before January 1, 1999,



the member must submit a request to disenroll in writing to the plan or go to the local Social Security District Office; disenrollment will be effective through the end of the month in which the plan or Social Security Office receives the request. If the member takes no action, the member will be returned to the Original Medicare Plan on January 1, 1999.

Q20 How can members receive additional assistance or more information about their choices?

A20 Individuals can contact their State Health Insurance Assistance Program (SHIP). The following agencies can also give beneficiaries information on Medicare supplemental insurance plans and help with other health care decisions.

- County Aging Services
- Senior Centers
- State Insurance Departments
- The U.S. Administration on Aging
- HCFA Regional Offices

INFORMATION ON MEDICARE SUPPLEMENTAL INSURANCE

Questions and Answers

A Medicare supplement policy, also known as Medigap insurance, is an insurance policy offered by private entities (insurance companies or associations) to individuals entitled to have benefits paid by the Original Medicare Plan. Medigap provides reimbursement for certain expenses incurred for services or items for which payment may be made by the Original Medicare Plan but which are not reimbursable because of deductibles or coinsurance. A Medigap policy may also pay for certain items or services not covered by Medicare at all, such as prescription drugs. Medigap only works with the Original Medicare Plan. It will not cover out-of-pocket expenses, such as copayments, in a managed care plan.

The following is designed to assist you in answering the most commonly asked questions arising from managed care plan terminations and service area reductions.

What Happens If Your Managed Care Plan Terminates Coverage in Your Area Because it Does Not Continue in the Medicare Program?

If your health plan will no longer continue its contract with the Medicare program to provide health care to Medicare beneficiaries, the following alternatives are available to you.

1. You may remain enrolled in the non-renewing health plan until the end of the contract period. If you choose this option, you need take no further action; you will automatically be disenrolled from the plan and returned to the Original Medicare Plan as of the effective date of the health plan's termination. Until your disenrollment from the non-renewing health plan is effective, you must continue to use health plan providers.
2. You may join another managed care plan in your area that contracts with the Medicare program. If you choose this alternative before the end date of your coverage, you will automatically be disenrolled from the non-renewing health plan when you enroll in the new HMO. Health plan(s) in your area that have contracts with Medicare will be identified for you. They are required to accept your enrollment. Contact these plans concerning benefits and premiums in order to make the best selection for your personal needs.
3. You may disenroll from the non-renewing health plan and return to the Original Medicare Plan before your coverage terminates. If you choose this option, you may disenroll by notifying the non-renewing health plan. You may also disenroll by writing to or visiting your local Social Security office or your local Railroad Retirement office if you are a railroad retiree. You will be disenrolled effective the first day of the month following the month in which you requested disenrollment. For example, if you request disenrollment on November 20th, you will be returned to the Original Medicare Plan effective December 1.

If I Choose to Enroll in the Original Medicare Plan, Can I Purchase a Medigap Policy?

Yes. If you return to the Original Medicare Plan, you may wish to purchase a Medigap policy. A Medigap policy requires an additional monthly premium and will pay for some of your out-of-pocket costs which are not covered under the Original Medicare Plan. Your non-renewing plan has a legal obligation to arrange for you to be protected against any pre-existing condition exclusions under a Medigap policy for up to six months after the plan terminates your coverage. The plan may do this in a number of ways. The plan must notify you of what arrangements it has made for such coverage no later than November 2, 1998.

Some plans will identify a Medigap insurer, and the insurer will waive (i.e., not apply) the waiting period for coverage of pre-existing conditions. You may then enroll for the new policy between specific dates identified by the non-renewing managed care plan. Your Medigap insurance will have an effective date that should coincide with the ending of the plan's Medicare contract so that you will have continuous coverage.

May I Shop Around for a Medigap Policy Rather Than Accept the One Chosen by the Non-renewing Plan?

Yes. You may shop for a Medigap policy on your own and find the one that meets your needs and provides coverage at the lowest premium available in your state.

Am I Eligible for Any Protections If I Choose a Medigap Policy Other than the One Chosen by the Non-renewing Plan?

The law has an important protection for you in these circumstances, if you purchase Medigap plans "A", "B", "C", or "F". The insurance company selling the policy may not:

1. deny or apply any condition to the sale of the policy;
2. discriminate in the pricing of the policy because of your health status, prior history of claims experience, receipt of health care, or medical condition; or
3. impose a preexisting exclusion for any condition you may have.

However, you only have 63 days after your coverage ends in which to apply for coverage from a Medigap insurer. Contact your State Health Insurance Assistance Program for further information.

How Do I Go about Finding a Medigap Insurer?

Begin your inquiries as soon as you receive the non-renewing plan's notice of termination. This way, you will have time to find the best coverage to meet your needs and have it go into effect on the day following the effective date of your non-renewing plan's termination from the Medicare program.

Your best course of action in such situations is to contact your State Health Insurance Assistance Program (SHIP) or State insurance department. Your SHIP has been trained to assist you in resolving situations like these. The telephone number for the SHIP in your state is available on www.medicare.gov. To find out about your state's health insurance assistance program, check the State Government listing in your telephone book, and contact your State's Office on Aging or Insurance Commission.

Do These Special Protections Apply to All Medicare Beneficiaries?

Effective July 1, 1998, a Medigap insurer must make any plans "A", "B", "C", and "F" that the insurer makes available in the marketplace, available to all beneficiaries (aged, disabled, and individuals with End Stage Renal Disease) whose Medicare managed care plans are terminated or not renewed. The protections discussed above apply in these cases.

HEALTH CARE FINANCING ADMINISTRATION

**ADDRESSEE:***Devorah***FROM:***Peter*

OFFICE OF THE ADMINISTRATOR
200 INDEPENDENCE AVE., S.W.
ROOM 314G
WASHINGTON, DC 20201

PHONE: _____**PHONE:** 202-690-6726**FAX :** 202-690-6262**TOTAL PAGES:****ADDRESSEE'S FAX MACHINE NUMBER:****DATE:****REMARKS:**

Plans that Left Medicare or Reduced Their Service Al

Contract Number	Contract Name	Contract Type	Non-Renew or SAR	ST.	County Name	AAPCC	Eligibles	# Benes Enrolled	Plans Available
H3307	Oxford NY	Risk C	SAR	NY	ORANGE	\$489.40	41,627	1,023	5
H3307	Oxford NY	Risk C	SAR	NY	PUTNAM	\$811.39	10,302	814	3
H3307	Oxford NY	Risk C	SAR	NY	ROCKLAND	\$805.07	39,395	3,828	5
H3307	Oxford NY	Risk C	SAR	NY	WESTCHESTER	\$584.38	141,697	14,127	7
H3354	NYLCare - NY	RISK C	Non-Renew	NY	BRONX	\$757.66	148,764	5	8
H3354	NYLCare - NY	RISK C	Non-Renew	NY	KINGS	\$733.87	298,179	5	8
H3354	NYLCare - NY	RISK C	Non-Renew	NY	NASSAU	\$810.30	224,719	2,736	9
H3354	NYLCare - NY	RISK C	Non-Renew	NY	NEW YORK	\$741.93	214,408	6	8
H3354	NYLCare - NY	RISK C	Non-Renew	NY	QUEENS	\$685.46	288,687	3,071	10
H3354	NYLCare - NY	RISK C	Non-Renew	NY	RICHMOND	\$798.35	58,438	0	7
H3354	NYLCare - NY	RISK C	Non-Renew	NY	SUFFOLK	\$568.77	195,782	3,954	8
H3354	NYLCare - NY	RISK C	Non-Renew	NY	WESTCHESTER	\$584.38	141,697	1	7
H3360	Vytra	RISK C	SAR	NY	NASSAU	\$810.30	224,719	5,395	9
H3360	Vytra	RISK C	SAR	NY	SUFFOLK	\$568.77	195,782	10,264	8
H3361	Wellcare	RISK C	SAR	NY	BROOME	\$379.84	39,143	2,021	0
H3361	Wellcare	RISK C	SAR	NY	COLUMBIA	\$382.24	11,306	645	1
H3361	Wellcare	RISK C	SAR	NY	DELAWARE	\$390.08	9,315	717	1
H3361	Wellcare	RISK C	SAR	NY	OTSEGO	\$390.60	10,888	670	1
H3371	Community Health Plan	RISK C	Non-renew	NY	BROOME	\$379.84	39,143	2,761	0
H3371	Community Health Plan	RISK C	Non-renew	NY	TIOGA	\$379.84	7,431	364	0
H3379	United Health Care NY	RISK C	SAR	NY	ORANGE	\$489.40	41,627	597	5
H3379	United Health Care NY	RISK C	SAR	NY	PUTNAM	\$811.39	10,302	36	3
H3379	United Health Care NY	RISK C	SAR	NY	ROCKLAND	\$805.07	39,395	187	5
H3379	United Health Care NY	RISK C	SAR	NY	ULSTER	\$444.27	27,372	439	3
H3379	United Health Care NY	RISK C	SAR	NY	WESTCHESTER	\$584.38	141,697	352	7
H3386	Pru - NY	RISK C	Non-Renew	NY	BRONX	\$757.66	148,764	105	8
H3386	Pru - NY	RISK C	Non-Renew	NY	KINGS	\$733.87	298,179	197	8
H3386	Pru - NY	RISK C	Non-Renew	NY	NEW YORK	\$741.93	214,408	134	8
H3386	Pru - NY	RISK C	Non-Renew	NY	QUEENS	\$685.46	288,687	156	10
H3386	Pru - NY	RISK C	Non-Renew	NY	RICHMOND	\$798.35	58,438	97	7

HEALTH CARE FINANCING ADMINISTRATION



ADDRESSEE:

CBS Jim B - 5487
OMB Greg Whit - 7840
WH - D. Adler - 5557.

PHONE: _____

FROM: Peter Murbage

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TOTAL PAGES:	ADDRESSEE'S FAX MACHINE NUMBER:	DATE:

REMARKS:

Final copy of the letter. The letter
Has been released. Attachments + Q+As will
be emailed.



The Administrator
Washington, D.C. 20201

OCT 23 1998

Dear Insurance Commissioner:

I am writing to inform you of new requirements contained in the Balanced Budget Act of 1997 (BBA) which apply to Medicare Supplement ("Medigap") insurance policies. These provisions were enacted at the same time as creation of the new Medicare+Choice program, which changes and expands health care options for Medicare beneficiaries. The new provisions strengthen the rights of beneficiaries who are involuntarily terminated from Medicare managed care plans (and certain beneficiaries who leave HMOs voluntarily) to obtain Medigap coverage if they return to original Medicare.

This protection will be particularly important in the next few months, because, as you probably know, the Health Care Financing Administration (HCFA) has been notified recently by a number of HMOs serving portions of 30 States and the District of Columbia that they will no longer serve some or all of their current Medicare enrollees. A small percentage of beneficiaries (less than 1% of the 6 million beneficiaries enrolled in Medicare HMOs) may be left with no HMO plan option and will need to transition back to original Medicare with Medigap, while a number of others who are losing their HMO coverage may also wish to return to original Medicare with Medigap.

We are committed to trying to guard beneficiaries from undue concern and unnecessary hardship as they make this transition. However, in order to protect these vulnerable individuals, we **urgently request your cooperation in immediately alerting Medigap issuers in your State to the need to comply with the new Federal requirements.**

I call your attention to two key issues, which are further explained below. First, the rights established by the BBA apply to most Medicare beneficiaries, including many who are eligible for Medicare based on disability or end-stage renal disease (ESRD). Second, there are both State and Federal enforcement mechanisms that apply to these rights.

Section 4031 of the BBA mandates several new situations in which Medicare beneficiaries are guaranteed issue of Medigap insurance. Two of these new protections apply to beneficiaries now enrolled in HMOs that are terminating contracts or reducing service areas.

Most beneficiaries whose coverage is terminating have a key protection: **the right to guaranteed issue of any Medigap plans A, B, C, or F that are offered to new enrollees by issuers in your State.** In Massachusetts, Minnesota, and Wisconsin, section

1882(s)(3)(C) of the Social Security Act (added by the BBA) provides that issuers must provide guaranteed issue of policies that are comparable to plans A, B, C, or F. As an alternative, some beneficiaries may qualify to use a second protection guaranteed by the BBA: if they have been enrolled in their **HMO less than 12 months and were never enrolled in any other Medicare HMO**, they may return to their previous Medigap policy if the same issuer still sells the policy in the State. In either case, Medigap issuers may not: (1) deny or condition the sale of the policy; (2) discriminate in the pricing of the policy because of the individual's health status, prior history of claims experience, receipt of health care or medical condition; or (3) impose an exclusion for any preexisting condition.

HMOs will be sending termination notices to all affected Medicare beneficiaries by November 2. While some beneficiaries will have the option of continuing in another HMO, others will not. In order to ensure a seamless transition into a new Medicare+Choice plan, or to obtain Medigap coverage in conjunction with returning to original Medicare, beneficiaries will need to make decisions on new options for receiving their Medicare benefits well before their current HMO coverage ends on December 31. Many of these beneficiaries will be contacting Medigap insurers and your Department about Medigap insurance options available to them as they make decisions on their future Medicare coverage options.

As you address these new Federal requirements in your State, we want to advise you of two important considerations in interpreting the provisions in the BBA:

Applicability. The Medigap rights are guaranteed to "individuals" who meet the statutory criteria (e.g., their prior coverage is terminated). **The statute does not distinguish between individuals eligible for Medicare based on age and those whose eligibility is based on disability or end stage renal disease (ESRD).** Issuers must now make plans A, B, C or F – if those plans are offered to new enrollees – available on a guaranteed issue basis without exclusions for preexisting conditions to all Medicare beneficiaries who meet the statutory criteria. This provision, however, does not require that issuers that offer only some of the four designated plans begin to offer the others. Nor does it require that issuers not now selling these plans to disabled or ESRD beneficiaries under 65 must start selling to those individuals.

Where policies are sold, it is important to emphasize that the statute mandates that the premium charged must not be established in a way that discriminates based on health status. This means that issuers cannot consider the health status of individual applicants

in determining eligibility or premium levels. Issuers must accept these applicants at the same premium rate provided to otherwise similar new applicants with no health problems. Issuers that adjust rates for non-health status factors, such as age or geographic location, can apply those adjustments if done on a nondiscriminatory basis.

Although the BBA did not extend these protections where Medigap issuers are not now selling plans to beneficiaries under 65, we encourage States to find ways to help these beneficiaries. For example, by approving policy forms for these beneficiaries on an expedited basis or by urging plans to extend coverage voluntarily.

Enforcement. The BBA mandated a July 1, 1998, effective date for these requirements. Some confusion has resulted from the fact that the statute incorporates two parallel enforcement mechanisms – one State and one Federal.

- States clearly have the primary authority for enforcement of Medigap requirements under their approved regulatory programs. The law, however, recognizes that you may need to make changes to your Medigap regulatory program in order for it to continue to be an approved program under section 1882(b) of the Social Security Act. If changes are required in order for your State to enforce these provisions, the BBA deems your program to continue to be an approved program during a transition period of, in most cases, up to a year after the NAIC adopted its Model Regulation. Shortly, we will be publishing a *Federal Register* notice transmitting this Model Regulation to the States.
- Regardless of when State laws and regulations come into conformity with the Federal requirements, section 1882(s)(4) contains a Federal civil monetary penalty that can be imposed independently of any State enforcement mechanisms. HCFA will be developing further guidance to specify the Federal requirements, including more detailed interpretations of the statutory provisions on guaranteed issue and nondiscrimination in pricing. It is essential for Medigap issuers to understand that the Federal guaranteed issue requirements added to section 1882(s) by the BBA, as well as the Federal civil monetary penalty enforcement authority in section 1882(s)(4), apply to all Medigap issuers as of the statutory effective date, July 1, 1998.

We stand ready to work with you and your staff to ensure that Medicare beneficiaries can benefit from the protections that have been afforded them. Staff from our Regional Offices will contact you shortly to follow up on any questions raised by these

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requirements. In addition, through the regional offices, HCFA has initiated an extensive outreach campaign to help all Medicare beneficiaries understand their rights and options. We encourage you to work with your HCFA Regional Office to identify issues that could serve as barriers to the effective implementation of the Medicare beneficiary protections guaranteed under Federal law.

Sincerely,

A handwritten signature in black ink, appearing to read "Nancy-Ann DeParle". The signature is fluid and cursive, with a long horizontal stroke at the end.

Nancy-Ann Min DeParle
Administrator

cc: All State Medicaid Directors
All HCFA Regional Offices
All HCFA ARAS, DMSO
APHSA
NGA
NAIC
NCSL
SHIPs

DETAILED BACKGROUND

Before the BBA was enacted, the primary managed care option open to Medicare beneficiaries was to enroll in a health maintenance organization (HMO) or similar organization that had contracted with Medicare, under section 1876 of the Social Security Act, to provide Medicare covered services to beneficiaries in return for payment by Medicare. Most of these organizations had "risk" contracts that paid them a monthly amount for each enrolled beneficiary. Others had "cost" contracts or contracts as health care prepayment plans (for Part B services only) that reimbursed the organization's reasonable costs. The BBA eliminates the old risk contract program at the end of 1998 and replaces it with comparable managed care plans under the new Medicare+Choice program enacted as part of the BBA. Beginning in 1999, the primary managed care option available to beneficiaries will be through organizations that enter into contracts under Medicare+Choice. (For simplicity, we will use the terms "HMO" and "managed care plan" interchangeably here.)

Plan Decisions to Terminate Contracts or Reduce Service Areas

HCFA has been notified by more than 100 HMOs that they will not enter into new Medicare+Choice contracts or that they will sign Medicare+Choice contracts for a reduced service area, effective December 31, 1998. Included are HMOs with risk contracts, HMOs with cost contracts, health care prepayment plans, and two plans operating as part of the Medicare Choices demonstration. The beneficiaries currently enrolled in these plans will be seeking new options for receiving their Medicare benefits, effective on or before January 1, 1999. Included among these beneficiaries are some who will not have access to another managed care plan, primarily because they live in an area that is no longer served by any Medicare-contracting HMOs. A small number of beneficiaries who have end-stage renal disease (ESRD) (permanent kidney failure) and are enrolled in the terminating managed care plan will be precluded by law from enrolling in a plan offered by another managed care organization. These beneficiaries may enroll in plans offered by the same organization. We have enclosed a list of the counties and numbers of beneficiaries affected in each State (similar information is available on HCFA's Internet Website at www.hcfa.gov).

Information for Affected Beneficiaries

Most Medicare beneficiaries will be able to choose between enrolling in another HMO, or returning to the "Original" Medicare fee-for-service program. When an HMO terminates coverage because it leaves the Medicare program entirely, or reduces the

service area covered by its contract, the individuals it has served have certain statutory rights to enroll with a new managed care plan, or to purchase Medigap insurance if they return to "Original" Medicare. However, these rights are time-limited. It is therefore critical that all affected beneficiaries be given sufficient information about their choices, as soon as possible, to allow them to make the best decision about how to cope with the change in their health care options.

Part of this information will come from the managed care plans. First, under section 1876 of the Social Security Act, the terminating HMO is required to inform enrolled beneficiaries about other Medicare-contracting HMOs, if any, that will be available to them. However, the beneficiaries will generally be required to decide before the end of November whether they wish to enroll under one of these plans. Second, the HMO is still required under the law that pre-dated the new BBA protections to ensure that beneficiaries who wish to return to Original Medicare are protected against out-of-pocket costs related to pre-existing condition exclusions in Medigap policies. This right, which might in some cases be more attractive than the new BBA protections, is also likely to involve a deadline for making a choice.

Finally, the HMO is required by the Medigap provisions at section 1882(s)(3)(D) of the Social Security Act (added by the BBA) to inform beneficiaries of their new rights with respect to purchasing Medigap insurance. A copy of the letter approved by HCFA for use by the HMOs is enclosed for your information. This letter will likely be used by beneficiaries to demonstrate to Medigap issuers that the beneficiaries qualify for the new guaranteed issue protections. In that notice, HCFA is advising beneficiaries who have any problems with Medigap insurers in your State to contact your department.

Medigap Rights Extended by the Balanced Budget Act

The most important protection created by the BBA for Medicare beneficiaries enrolled with an HMO (of any type) that is terminating its contract with Medicare applies to most individuals who are enrolled in that plan at the time the contract terminates. These individuals have the right to **guaranteed issue of any Medigap plans A, B, C, or F** that are offered to new enrollees by issuers in your State. In the three States with waivers (Massachusetts, Minnesota, and Wisconsin), section 1882(s)(3)(C) provides that issuers must provide guaranteed issue of policies that are comparable to plans A, B, C, or F.

The above right applies to individuals by virtue of the involuntary termination of their coverage. However, certain Medicare beneficiaries in the terminating plans may have another, separate basis for entitlement to guaranteed issue of a Medigap policy. In

particular, if an individual (1) has been enrolled for less than 12 months with the HMO that is terminating coverage, (2) was never enrolled in any other Medicare HMO, and (3) was previously enrolled in a Medigap policy, the individual may terminate enrollment with the HMO before the contract terminates, and return to the previous Medigap policy if the same issuer still sells the policy in the State. If the policy is no longer available from that issuer, the individual may purchase Medigap plans A, B, C, or F from any issuer which sells those plans in the State.

Note that, if an issuer does not market all four of the specified benefit packages, the Federal law does not require it to add the other policies.

For either of these groups of beneficiaries, an issuer may not:

- (1) deny or condition the sale of the policy;
- (2) discriminate in the pricing of the policy because of the individual's health status, prior history of claims experience, receipt of health care or medical condition; or
- (3) impose an exclusion for any preexisting condition.

These rights are guaranteed to "individuals" who meet statutory criteria (e.g., their prior coverage is terminated). The statute does not distinguish between individuals eligible for Medicare based on age, and those whose eligibility is based on disability or ESRD. As a result of the BBA provision, any issuer now offering plans A, B, C or F to beneficiaries over 65 must make these plans available on a guaranteed-issue basis without exclusions for preexisting conditions to all Medicare beneficiaries who meet the statutory criteria described above. Issuers now offering these plans to beneficiaries entitled to Medicare due to disability or ESRD must make the same plans available to disabled or ESRD beneficiaries who meet the statutory criteria. Issuers not now selling to those under 65 are not required to start selling to those individuals. Finally, it is important to emphasize that the statute mandates that the premium charged in these circumstances must not be established in a way that discriminates based on health status.

In either of the above situations, the Medicare beneficiary must apply for the Medigap policy not later than 63 days after the date that HMO coverage terminates, unless your State law provides for a longer period (The 63-day period will generally begin January 1, 1999, unless a beneficiary meets the criteria for re-enrolling in a previous Medigap policy. In that case, the 63-day period begins on the effective date of the individual's

disenrollment.) However, most beneficiaries will prefer to apply before the beginning of this period. While issuers may not sell a policy with an effective date before a beneficiary's HMO coverage terminates, because that would be duplicate coverage, nothing in the law prevents an issuer from accepting applications in order to make the new coverage effective the day after the old coverage ends.

As with previous amendments to the Federal Medigap law, section 4031 of the BBA specifies that State law and regulations must comply with the requirements of section 1882 of the Social Security Act and with standards contained in the NAIC's Medicare Supplement Model Regulation. The Model Regulation, as revised to reflect the BBA amendments, tracks the statutory language of these protections. As you may be aware, HCFA has worked with the NAIC to correct an error in the drafting note that follows section 12.B(2) of the Model Regulation, and the NAIC issued a memorandum on October 16 explaining this change. A *Federal Register* notice, being published shortly, will transmit to the States the revised Model Regulation. This revised version is the Model Regulation that must be adopted by all States. (The error, regarding the significance of the statutory reference to the year 2002, does not in any way affect the rights of beneficiaries whose current section 1876 managed care plans are terminating. It only pertains to beneficiaries who may, in the future, be covered by a Medicare+Choice organization.)

There may be some confusion on the part of Medigap issuers regarding the effective date of the guaranteed issue requirements described above. These requirements were added to section 1882(s) of the Social Security Act by section 4031(a) of the BBA. Section 4031(d)(1) mandated a July 1, 1998 effective date. The confusion results from the fact that the statute incorporates two parallel enforcement mechanisms – one State and one Federal.

States clearly have the primary authority for enforcement of Medigap requirements under their approved regulatory programs. In order for your State to continue to have an approved regulatory program under section 1882(b) of the Social Security Act, State laws and regulations must conform to the new Federal requirements. If changes to your State laws and regulations are required in order for the State to enforce these provisions, section 4031(e) of the BBA deems your program to continue to be an approved program during a transition period of, in most cases, up to a year after the NAIC adopted its Model Regulation, which was April 29, 1998.

However, regardless of when the State laws and regulations come into conformity with the Federal requirements, it is essential for Medigap issuers to understand that the Federal

guaranteed issue requirements added to section 1882(s) by the BBA, as well as the Federal civil money penalty enforcement authority in section 1882(s)(4), apply to all Medigap issuers as of the statutory effective date, July 1, 1998.

Finally, we are aware that some States have no approved policy forms for beneficiaries under 65 and that the NAIC Model Regulation specifies that issuers may not issue new policy forms without filing them for your approval. Approval of policy forms for beneficiaries under 65 who meet the specific statutory requirements is desirable if it can be done on an expedited basis. If this is not possible, however, we believe the guaranteed issue protections for these beneficiaries exist only for a policy "that is offered and is available for issuance to new enrollees by such issuer" (section 1882(s)(3)). We request that you make this clear to issuers in your State as quickly as possible.

The prohibition on discrimination in pricing also raises the issue of agent compensation. Some issuers have, in the past, attempted to circumvent statutory guaranteed issue requirements imposed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) by reducing or eliminating agent compensation for sales to individuals who meet the statutory requirements. If this were to happen, we assume that States would act as they did in the HIPAA context to address similar abuses.

HCFA's Outreach Campaign

Through our regional offices, HCFA has also initiated an outreach campaign to help Medicare beneficiaries understand their rights and options. This campaign will target those areas where Medicare beneficiaries are most affected by HMO withdrawals and inform them of their rights and options – both that they are automatically eligible for the Original Medicare Plan and what their Medigap rights and protections are. As part of this plan, HCFA is enlisting a large network of public and private partners who serve the Medicare population (including the State Health Insurance Assistance Programs, the American Association of Retired Persons, Area Agencies on Aging, and other aging consumer groups) to provide their audience with needed information through newsletters, conferences, and targeted information campaigns. As part of this campaign, you should be aware that beneficiaries who are denied access are being instructed to contact their State's insurance department. They are also instructed to contact HCFA's regional offices if they have difficulty resolving their individual concerns. In those States with significant plan withdrawals, staff from our regional offices will contact your office to identify ways that we can work together to ensure that the correct information is shared with beneficiaries. In addition, HCFA will post new information on the Medicare

Internet site (www.medicare.gov), so that beneficiaries in every local area have the most up-to-date information on available HMO coverage options.

What are These 10 Standard Plans?

Medigap policies pay most, if not all, Medicare coinsurance amounts. In addition, they may provide coverage for Medicare's deductibles. Some of the 10 standard plans pay for services not covered by the original Medicare plan, such as prescription drugs. See the attached chart for a brief outline of the 10 Medigap plans. More detailed information is available in the *Guide to Health Insurance for People with Medicare*.

Are Each of the 10 Plans Sold in My State?

States can limit which plans will be sold in the State, although they must permit all Medigap insurers to make Plan A available. (Plan A includes the "basic benefits." These cover Part A coinsurance; 365 days of hospitalization after Medicare benefits end; Part A coinsurance; and the first three pints of blood each year. The basic benefits are also included in all other Medigap plans.) Insurers can decide which of the 9 optional plans they will sell as long as the State permits them to be sold, and most insurers offer several plans in addition to plan A. Some offer all 10.

However, Minnesota, Massachusetts and Wisconsin have different sets of plans because their State rules that pre-dated the Federal law that now governs Medigap were found to provide comparable protections. Further information is available from each State insurance department.

What is Medicare SELECT?

A Medicare SELECT policy is a Medigap policy that is permitted to restrict enrollees to a specific network of hospitals and, in some cases, doctors, except in an emergency. In other words, Original Medicare will pay for covered services regardless of which providers are used, but out-of-pocket costs will only be covered by the Medigap policy when the beneficiary uses network providers. Otherwise, it must meet all of the requirements that apply to a standard Medigap policy and it must be one of the 10 standard plans. This coverage is usually available with lower premiums than a standard Medigap policy.

How are Medigap Insurance Premiums Established?

Premium prices can vary from one insurance company to depending on which method they use to calculate premiums:

Age Rating: The premium is based on a beneficiary's age and will increase as the beneficiary ages. Typically, these plans will appear to be less expensive at younger ages, but they may cost considerably more in later years.

Community Rating: Everyone pays the same premium regardless of age. For people over 75, this type of policy may be less costly. Community rating is also referred to as "no age rating".

This following shows an example of the effect of beneficiary age on insurance premiums under the two rating methodologies:

Rating Methodology	Premium Beneficiary Age = 65	Premium Beneficiary Age = 75
Age Rating	\$70	\$90
Community Rating	\$80	\$80

Beneficiaries should consider what one policy is likely to cost over the next five or ten years compared to premiums for other policies. It is also wise to be alert for discounts that some insurance companies make available to couples or nonsmokers.

Premiums are also affected by inflation and by the claims history of the population of beneficiaries enrolled with a particular insurance company. Consequently, premiums for the same standardized plan such as A, B, C, etc., sold by different insurance companies may vary considerably. It pays to comparison shop.

Who Is Covered?

About 13 to 15 million, of the approximately 38 million Medicare beneficiaries have Medigap coverage. Beneficiaries expend about \$12 billion annually in premiums. Another 15 million beneficiaries have employer coverage that supplements Original Medicare, and about 4 to 5 million beneficiaries have Medicaid coverage which covers at least some of their out-of-pocket Medicare costs. This is important to note since some people may not need Medigap insurance if they have other coverage.

How are Medigap Standards Established and Enforced?

In order for States to regulate Medigap insurance, they must adopt laws and regulations that are at least as strict as requirements included in the federal Medicare statute, and in a model law and regulation developed the National Association of Insurance Commissioners (NAIC). And all States have done so. However, States are free to adopt provisions that are more stringent or consumer friendly.

The primary responsibility for enforcing the Medigap standards is therefore through State insurance departments. HCFA reviews and approves State regulatory programs for Medigap insurance and is charged with seeing that States actually enforce the laws and regulations they adopt. HCFA receives periodic reports from the States through the NAIC on complaint data, loss ratio information and enforcement action, among others.

However, in addition to State enforcement, HCFA and/or the Office of the Inspector General of the Department of Health and Human Services can have authority to impose invoke Federal sanctions on issuers or sellers of insurance that violate any of the certain Medigap standards designated by the Congress. These sanctions include civil monetary penalties and, in some cases, criminal penalties.

What are SHIPs?

State Health Insurance Programs (SHIPs) are agencies in each State that are Federally funded to assist Medicare beneficiaries in learning about the availability and cost of Medigap insurance. They can help compare the different Medicare and Medigap options available in a State. They also assist individuals who have problems in understanding the program or its implementation. SHIPs are usually found in State insurance departments or the area agencies on aging.

Where Should a Person Take Complaints?

If you have complaints about the practices of an insurance company you are dealing with, and the problem cannot be resolved to your satisfaction, please contact your State's insurance department.

What is the *Guide to Health Insurance for People with Medicare*?

The *Guide to Health Insurance* describes Medigap insurance (including purchase, use, changing plans, and protections) which is designed to work only with the original Medicare plan. The 1998 edition of the *Guide* is available now.

GUARANTEED ISSUANCE OF MEDIGAP POLICIES

When Is a Person Guaranteed Issuance of a Medigap Policy?

If a beneficiary becomes eligible for Medicare at age 65 or older, that person is guaranteed issuance of *ANY* Medigap plan if the application is submitted no later than 6 months after the date of enrollment in Medicare Part B. Persons who were eligible for Medicare before age 65 have the same choice of any Medigap plan, as long as they submit their applications no later than 6 months after turning 65.

Can a Beneficiary Change from One Medigap Policy or Insurance Company to Another?

Yes. However, care should be taken when switching companies or policies and buying replacement coverage, because premiums may rise. Policies should be changed only for improved benefits, better service, or a more affordable price. Beneficiaries may have certain rights to have the new insurance company waive waiting periods and preexisting condition exclusion periods if they had similar coverage under the prior policy for at least six months. It may be advisable to keep the first insurance in force until the waiting period has expired for the replacement policy, as long as the applicant indicates that he/she is planning to terminate the old policy. Persons replacing existing policies should ask the new issuer for information on this possibility.

If a person is enrolled under an employee benefit plan that provides benefits which supplement Medicare, but the employee plan terminates or ceases to provide such benefits, what can be done?

When an employer plan terminates or ceases to provide benefits, participants have certain rights, but must exercise them within 63 days after coverage terminates.

If a person enrolls in a Medigap policy within 63 days, the seller or issuer of that policy may not:

- (1) refuse to sell the person any Medigap policy designated A, B, C or F that the issuer sells in the State;
- (2) discriminate in the pricing of such policy because of health status, claims experience, receipt of health care, or medical condition, or
- (3) impose a pre-existing condition exclusion.

A summary chart of all Medigap plans is attached. Further information is available from each State's insurance department or SHIP.

PRE-EXISTING CONDITION EXCLUSIONS

What Are Pre-existing Condition Exclusions, and When Would a Person Be Subject to Them?

Pre-existing conditions are generally defined as health problems that were diagnosed or treated during a certain time period, usually the six months before the date that the policy goes into effect.

Are There Limitations to Applying the Pre-existing Condition Exclusion?

Yes. If a person qualifies for guaranteed issue of a policy for one of the reasons described above (such as termination of a prior health plan or Medigap policy), the issuer cannot impose any preexisting condition exclusion.

If a person purchases a policy that replaces another Medigap policy, and held the prior policy for at least six months, the new policy cannot include a preexisting condition exclusion for similar benefits.

There is an additional protection that went into effect July 1, 1998, limiting the application of a pre-existing condition exclusion during the initial 6-month open enrollment period for persons age 65 or older. This exclusion cannot be imposed if, on the date the person applied for insurance coverage, he/she already had a continuous period of at least 6 months of prior health insurance coverage that meets the definition of "creditable coverage" (described below). If the person had less than 6 months prior coverage, the policy must reduce the pre-existing exclusion by the amount of the coverage. A number of rules apply to determining whether prior coverage must be counted. The insurance company or State insurance department will have further information. (In addition, some insurance companies have reduced or eliminated the 6 month period.)

What Is Creditable Coverage?

Creditable coverage is coverage under:

- (1) a group health plan,
- (2) health insurance coverage,
- (3) Part A or B of Medicare,
- (4) Medicaid,
- (5) a medical program of the Indian Health Service or a tribal organization,

- (6) a State health benefits risk pool,
- (7) the health care program for active military personnel,
- (8) the Federal employees health benefit plan,
- (9) a public health plan, or
- (10) a health benefit plan under the Peace Corps Act.

The person must have had no breaks in health insurance coverage of more than 63 days.

SUPPLEMENTAL INSURANCE and MEDICARE + CHOICE (M + C)

May Someone Who Currently Has a Medigap Policy Enroll in a M + C Plan?

Yes.

Can a Person Keep a Medigap Policy If He/She Enroll in a M + C Plan?

Yes. A person can keep a Medigap policy after enrollment in a M + C Plan. Keeping the Medigap policy may give the individual time to determine whether to stay in the M + C or continue in original Medicare fee-for-service, with Medigap insurance. However, expenses paid for by the M + C plan will not be reimbursed by the Medigap insurer as well. Eventually the person should drop Medigap coverage if he/she is satisfied with the M + C plan.

Can a Person Already Enrolled in a M + C Plan Also Buy Medigap Insurance?

No. However, the person has the right to purchase a Medigap policy if he/she returns to original Medicare fee-for-service coverage. (See next question).

If Someone Already Has Coverage under M + C, What Circumstances Would Guarantee That Person a Medigap Policy? (The short answer is below -- a more detailed discussion follows.)

To be guaranteed the right to get Medigap insurance the person must terminate enrollment in a M + C plan within 12 months of your entry into that plan, AND not have had any previous enrollment in a Medicare managed care plan.

If a Person Leaves the M + C Plan, but Had Either a Previous Enrollment in a M + C Plan or Was in the Plan for Longer than 12 Months, Could That Person Revert to the Original Medicare Plan and Purchase a New Medigap Insurance?

A person may be able to purchase a new Medigap policy at that time. But, if the individual had been in a managed care plan on a previous occasion, or remained in a M + C plan for more than 12 months, he or she would not have the protections described in this section. In addition, there may be increased

premiums based on medical history or advanced age. The same is true if a person is in the original Medicare plan and changes from one Medigap insurance company to another.

Can An Individual Be Sold a Medigap Insurance Policy When the Seller Knows That the Person Is Enrolled in a M + C Plan or Has the Same Coverage under Another Policy?

No. It is unlawful for a Medigap policy to be sold or issued if a person has elected enrollment in a M + C plan or has similar coverage in another Medigap policy, where the seller has knowledge that the policy duplicates health benefits to which the individual is already entitled under the M + C plan or another Medigap policy. If someone tries to sell a Medigap policy under these circumstances, this should be reported to the State insurance department.

What Happens If a M + C Plan Terminates Coverage Because it Leaves the Medicare Program or Loses its M + C Certification?

Plan enrollees have certain rights to new coverage, but these are time limited. The M + C plan is required to provide certain information to assist in making decisions about continuing M + C enrollment, or switching to original Medicare with Medigap to supplement the coverage. In general, individuals who are enrolled with a managed care plan that terminates its contract with Medicare have the right to guaranteed issue of any Medigap plans "A", "B", "C", or "F" that are offered to new enrollees by issuers in the State. (Minnesota, Massachusetts and Wisconsin have special waivers that allow them to provide guaranteed issue of policies that are comparable to plans "A", "B", "C", and "F".

These rights apply to individuals by virtue of the involuntary termination of their coverage. However, certain Medicare beneficiaries in the terminating plans may have another, separate basis for entitlement to guaranteed issue of a Medigap policy. If a person had been enrolled in the M + C plan for fewer than 12 months, was never enrolled in any other Medicare HMO, and had a previous Medigap policy, that individual may return to the former Medigap plan if the previous Medigap insurance company still sells the policy in the State.

If coverage is not available under the previous Medigap plan, the individual may purchase Medigap plans "A", "B", "C", or "F" from any insurer which

sells these plans in the State.

In these cases, the insurance company selling the policy may not:

- (1) deny or condition the sale of the policy,
- (2) discriminate in the pricing of the policy because of health status, prior history of claims experience, receipt of health care or medical condition, or
- (3) impose a preexisting exclusion for any condition.

However, the individual has only 63 days after coverage ends to select a Medigap insurer. Information and assistance is available from the SHIPs to assist in resolving situations like these. Their telephone numbers can be found in the back of the *Guide to Health Insurance for People with Medicare*.

Are There Any Other Times When These Protections Would Apply?

Yes. If a person moves outside of the M + C plan's service area or terminates enrollment for a good reason, these protections are in force for 63 days. Further information and assistance is available from the SHIP, which can tell people about the State rules that define the reasons a person may end enrollment in the M + C plan for a good reason, such as poor quality medical treatment.

Is There Any Other Time When You May Be Guaranteed Issuance of a Medigap Policy?

Yes. You are guaranteed issuance of *ANY* Medigap plan if:

- o you were 65 years old, *and*
- o first become eligible for Medicare, *and*
- o you enrolled in a M + C plan, *and*
- o you then disenrolled from that plan within 12 months of the effective date of your enrollment.

When Do the Rules on Guaranteed Issuance Take Effect?

The rules became effective July 1, 1998.

TERMINATION OF YOUR MANAGED CARE CONTRACT

What Happens If a Managed Care Plan Terminates Coverage Because it Does Not Continue in the Medicare Program?

If a health plan will no longer continue its contract with the Medicare program to provide health care to Medicare beneficiaries, the following alternatives are available:

1. Plan participants may remain enrolled in the non-renewing health plan until the end of the contract period. To choose this option, participants need take no further action; they will automatically be disenrolled from the plan and returned to the Original Medicare Plan as of the effective date of the health plan's termination. Until disenrollment from the non-renewing health plan is effective, participants must continue to use health plan providers.
2. Participants may join another managed care plan that contracts with the Medicare program. If an individual chooses this alternative before the end date of your coverage, he or she will automatically be disenrolled from the non-renewing health plan upon enrollment in the new HMO.
3. A person may disenroll from the non-renewing health plan and return to the Original Medicare Plan before coverage terminates. To choose this option, the person may disenroll by notifying the non-renewing health plan, or by notifying Social Security or (as applicable for railroad retirees) the Railroad Retirement office. Disenrollment is effective the first day of the month following the month in which it is requested. For example, if a person requests disenrollment on November 20th, he or she would be returned to the Original Medicare Plan effective December 1.

May a Person Who Returns to the Original Medicare Plan Purchase a Medigap Policy?

Yes. If a person returns to the Original Medicare Plan, that individual may wish to purchase a Medigap policy. A Medigap policy requires an additional monthly premium and will pay for some out-of-pocket costs which are not covered under the Original Medicare Plan. The non-renewing plan has a legal obligation to arrange for beneficiaries to be protected against any pre-existing condition exclusions under a Medigap policy for up to six months after the plan terminates coverage. The plan may do this in a number of ways. The plan must notify participants of what arrangements it has made for such coverage no later than November 2, 1998.

Some plans will identify a Medigap insurer which will waive the waiting period for

coverage of pre-existing conditions. Individuals may then enroll for the new policy between specific dates identified by the non-renewing managed care plan.

Must an Individual Accept a Medigap Policy Chosen by the Non-renewing Plan, or is it Possible to Shop for a Better Bargain?

A beneficiary is not bound by the non-renewing plan's choices of coverage. A beneficiary is free to shop for a Medigap policy that meets his/her needs and provides coverage at the lowest premium available.

Are There Any Protections for a Person Who Chooses a Medigap Policy Other than the One Chosen by the Non-renewing Plan ?

When the plan terminates, participants have certain rights, but must exercise them within 63 days after coverage terminates. If a person enrolls in a Medigap policy within 63 days, the seller or issuer of that policy may not:

- (1) refuse to sell the person any Medigap policy designated A, B, C or F that the issuer sells in the State;
- (2) discriminate in the pricing of such policy because of health status, claims experience, receipt of health care, or medical condition, or
- (3) impose a pre-existing condition exclusion

Further information is available from each State's insurance department or State Health Insurance Assistance Program.

How Does a Person Go about Finding a Medigap Insurer?

The person should begin inquiries as soon as he or she receives the non-renewing plan's notice of termination. This way, the individual will have time to find the best coverage and have it go into effect on the date following the effective date of the non-renewing plan's termination from the Medicare program.

The best course of action in such situations is to contact the State Health Insurance Assistance Program (SHIP) or State insurance department. SHIPs have been trained to assist people in resolving situations like these. The telephone number for the SHIP in each state is available on www.medicare.gov. To find out about a particular State's health insurance assistance program, check the State Government listing in the telephone book, and contact the State's Office on Aging or Insurance Commission.

Do These Special Protections Apply to All Medicare Beneficiaries?

Beneficiaries: Medigap rights are guaranteed to individuals age 65 and over whose prior coverage is terminated. In States where Medigap insurance is sold to individuals under age 65, beneficiaries eligible for Medicare due to disability or end stage renal disease have the same protections as the elderly.

Insurers: Medigap insurers must make plans "A", "B", "C", and "F" that the insurer sells to new enrollees, available to all beneficiaries whose Medicare managed care plans are terminated or not renewed. Issuers now offering these policies to beneficiaries entitled to Medicare due to disability must make the same policies available to disabled beneficiaries whose plans have terminated their Medicare contracts.

However, this provision does not require issuers to begin to offer Medigap policies that they do not currently sell. In addition, it does not require insurers which do not now sell policies to disabled beneficiaries under age 65 to begin selling to those individuals. The beneficiary protections included in the Medigap law do not distinguish between individuals eligible for Medicare based on age and those whose eligibility is based on disability or end stage renal disease.

Chart of the Ten Standard Medicare Supplement Plans

Medicare supplement insurance can be sold in only 10 standard plans. This chart shows the benefits included in each plan. Every company must make available Plan A. some plans may not be available in your state.

Basic Benefits: Included in All Plans

Blood: First 3 pints of blood each year.

Hospitalization: Part A coinsurance plus coverage for 365 days additional days after Medicare benefits end.

Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses).

A	B	C	D	E	F*	G	
Basic Benefit	Basic Benefit	Basic Benefit	Basic Benefit	Basic Benefit	Basic Benefit	Basic Benefit	
		Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	C
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	
		Part B Deductible			Part B Deductible		
					Part B Excess (100%)	Part B Excess (80%)	
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	
			At Home Recovery			At Home Recovery	
				Preventive Care			

*Plans F and J also have an option called a high deductible plan F and a high deductible plan J. These high deductible plans pay the same or offer the same benefits as plans F and J after the beneficiary has paid a calendar year deductible of \$1,500. Out of pocket expenses, in this instance, are expenses that would ordinarily be paid by a Medigap policy. These expenses include the Medicare deductibles for Parts A and B, but do not include, in plan J, the plan's separate prescription drug deductible of \$250, or in plans F and J, the plans' separate foreign travel emergency deductible of \$250.

FA

HEALTH CARE FINANCING ADMINISTRATION

**ADDRESSEE:***Chris Jennings*

PHONE: _____

FROM: *Nancy Ann (Corinne Martin)***OFFICE OF THE ADMINISTRATOR
200 INDEPENDENCE AVE., S.W.
ROOM 314G
WASHINGTON, DC 20201****PHONE: 202-690-6726****FAX : 202-690-6262 .****TOTAL PAGES:***C+9***ADDRESSEE'S FAX MACHINE NUMBER:***456-7431***DATE:***10/16/98***REMARKS:**

Nancy Ann wanted you to see this letter that we plan to send to the State Finance Commissioners on Monday. We're getting comments to Jack Hordley in Gary Claxton's office by noon on Monday.

-Corinne

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Dear Insurance Commissioner:

I am writing to inform you of new requirements, contained in the Balanced Budget Act of 1997 (the BBA), which apply to Medicare Supplement ("Medigap") insurance policies. These provisions were enacted in conjunction with the new Medicare+Choice program, which changes and expands beneficiary options for receiving their benefits. (However, it is now clear that the transition to the new program will be traumatic for some beneficiaries.) The welfare of beneficiaries is the first priority of the Health Care Financing Administration (HCFA). (We are committed to trying to protect beneficiaries from undue concern and unnecessary hardship as they make this transition.) However, we need your cooperation to protect these vulnerable individuals.

expanded
info on
strong
outreach
effort

As you probably know, HCFA has been notified by about 100 HMOs serving portions of 30 States and the District of Columbia that they will no longer serve some or all of their current Medicare enrollees. Medicare beneficiaries currently enrolled in these HMOs must therefore decide on new options for receiving their Medicare benefits. It is critical that they be able to make timely decisions, because their HMO coverage will end on December 31. Some beneficiaries will have the option of continuing in another HMO, but others will not. In either case, in order to ensure a seamless transition into a new Medicare+Choice plan or to obtain Medigap coverage in conjunction with returning to original Medicare, beneficiaries will need to make their decisions well before the end of the year.

add
request
for their
cooperation

Section 4031 of the BBA mandates several new situations in which Medicare beneficiaries are guaranteed issue of Medigap insurance. Two of these new protections apply to beneficiaries now enrolled in HMOs that are terminating contracts or reducing service areas.

Every beneficiary whose coverage is terminating has a key protection is the right to **guaranteed issue of any Medigap plans A, B, C, or F** that are offered to new enrollees by issuers in your State. In Massachusetts, Minnesota, and Wisconsin, section 1882(s)(3)(C) provides that issuers must provide guaranteed issue of policies that are comparable to plans A, B, C, or F. As an alternative, some beneficiaries may qualify to use a second protection guaranteed by the BBA. If they have been enrolled in their HMO less than 12 months and were never enrolled in any other Medicare HMO, they may return to their previous Medigap policy if the same issuer still sells the policy in the State. In either case, Medigap issuers may not (1) deny or condition the sale of the policy; (2) discriminate in the pricing of the policy because of the individual's health status, prior history of claims experience, receipt of health care or medical condition; or (3) impose an exclusion for any preexisting condition. (More details on these rights are in the attachment to this letter).

HMOs will very shortly be sending termination notices to all affected Medicare beneficiaries, who will begin contacting Medigap insurers and your Department about Medigap insurance options

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available to them as they make their decisions on their future Medicare coverage options.

Therefore, we urgently request your cooperation in alerting Medigap issuers in your State as soon as possible to the need to comply with the new Federal requirements.

As you address these new Federal requirements in your State, we want to advise you of two important considerations in interpreting the provisions in the BBA (more details are included in the attachment to this letter):

move to beginning

- The Medigap rights are guaranteed to "individuals" whose meet the statutory criteria (e.g., their prior coverage is terminated). **The statute does not distinguish between individuals eligible for Medicare based on age and those whose eligibility is based on disability or ESRD.** This is the case even for issuers who are not currently writing policies for individuals under 65. They must now make plans A, B, C or F (if offered to new enrollees) available to all Medicare beneficiaries who meet the statutory requirement.

It is also important to emphasize that the statute mandates that the premium charged to those under 65 must not be established in a way that discriminates based on health status.

Finally, the new guaranteed issue requirements for individuals under age 65 who meet the statutory criteria supersede any requirements, such as State filing and approval requirements, that might otherwise prohibit the sale. We request that you make this clear to issuers in your State as quickly as possible. Permitting issuers to sell existing policies to these individuals without prior State approval will not jeopardize the approval of your current State Medigap regulatory program.

add disability provisions here as separate bullet

- The BBA mandated a July 1, 1998, effective date for these requirements. Some confusion has resulted from the fact that the statute incorporates two parallel enforcement mechanisms. In order for your State to continue to have an approved regulatory program under section 1882(b) of the Social Security Act, State laws and regulations must conform to the new Federal requirements. If changes to your State laws and regulations are required in order for the State to enforce these provisions, the BBA deems your program to continue to be an approved program during a transition period of, in most cases, up to a year after the NAIC adopted its Model Regulation. However, regardless of when the State laws and regulations come into conformity with the Federal requirements, it is essential for Medigap issuers to understand that **the Federal guaranteed issue requirements added to section 1882(s) by the BBA, as well as the Federal civil money penalty enforcement authority in section 1882(s)(4), apply to all Medigap issuers as of the statutory effective date, July 1, 1998.**

We will be happy to work with you and your staff to bring these changes into effect, so that Medicare beneficiaries can benefit from the protections that have been afforded them. Staff from our Regional Offices will contact you shortly to follow up on any questions raised by these

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requirements. We encourage you to work with your servicing HCFA Regional Office to identify issues which may serve as barriers to the effective implementation of the Medicare beneficiary protections guaranteed under the Federal statute.

Sincerely,

Nancy Ann Min DeParle

Enclosures

[ATTACHMENT WHICH REFERS IN TURN TO 3 OTHERS (1) THE STATE-BY-STATE LIST OF PLANS, (2) THE MODEL NOTICE TO BENEFICIARIES, AND (3) SECTIONS OF THE NAIC MODEL REGULATION]

cc: All State Medicaid Directors
All HCFA Regional Offices
All HCFA ARMS, DMSO
APHSA
NGA
NAIC
NCSL
SHIPs

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ATTACHMENT

Prior to enactment of the BBA, the primary managed care option open to Medicare beneficiaries was to enroll in a health maintenance organization (HMO) or similar organization that had contracted with Medicare, under section 1876 of the Social Security Act, to provide Medicare covered services to beneficiaries in return for payment by Medicare. Most of these organizations had risk contracts that paid a monthly amount for each enrolled beneficiary. The remainder had cost contracts that reimbursed the organization's reasonable costs. The law eliminates the old risk contract program at the end of 1998 and replaces it with comparable under the new Medicare+Choice program enacted as part of the BBA. Beginning in 1999, the primary managed care option available to beneficiaries will be through organizations that enter into contracts under Medicare+Choice. (For simplicity, we will use the terms "HMO" and "managed care plan" interchangeably here.)

Plan Decisions to Terminate Contracts or Reduce Service Areas

HCFA has been notified by more than 100 HMOs that they will not enter into new Medicare+Choice contracts or that they will sign Medicare+Choice contracts for a reduced service area, effective December 31, 1998. Included are HMOs with risk contracts, HMOs with cost contracts, health care prepayment plans, and plans operating as part of the Medicare Choices demonstration. The beneficiaries currently enrolled in these plans will be seeking new options for receiving their Medicare benefits, effective on or before January 1, 1999. Included among these beneficiaries are some who will not have access to another managed care plan, primarily because they live in an area that is no longer served by any Medicare-contracting HMOs. A small number of beneficiaries who developed End Stage Renal Disease (ESRD) (permanent kidney failure) while enrolled in the terminating HMO will be precluded by law from enrolling in another HMO. We have enclosed a list of the counties and numbers of beneficiaries affected in each State (similar information is available on HCFA's Internet Website at www.hcfa.gov).

Information for Affected Beneficiaries

Most Medicare beneficiaries will be able to choose between enrolling in another HMO, or returning to the "Original" Medicare fee-for-service program. When an HMO terminates coverage because it leaves the Medicare program entirely, or reduces the service area covered by its contract, the individuals it has served have certain statutory rights to enroll with a new managed care plan, or to purchase Medigap insurance if they return to "Original" Medicare. However, these rights are time-limited. It is therefore critical that all affected beneficiaries be given sufficient information about their choices, as soon as possible, to allow them to make the best decision about how to cope with the change in their health care options.

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Part of this information will come from the managed care plans. First, under section 1876 of the Social Security Act, the terminating HMO is required to inform enrolled beneficiaries about other Medicare-contracting HMOs, if any, that will be available to them. However, the beneficiaries will generally be required to decide before the end of November whether they wish to enroll under one of these plans. Second, the HMO is still required under the law that pre-dated the new BBA protections to ensure that beneficiaries who wish to return to Original Medicare are protected against out-of-pocket costs related to pre-existing condition exclusions in Medigap policies. This right, which might in some cases be more attractive than the new BBA protections, is also likely to involve a deadline for making a choice.

Finally, the HMO is required by the Medigap provisions at section 1882(s)(3)(D) of the Social Security Act (added by the BBA) to inform beneficiaries of their new rights with respect to purchasing Medigap insurance. A copy of the letter approved by HCFA for use by the HMOs is enclosed for your information. This letter will likely be used by beneficiaries to demonstrate to Medigap issuers that the beneficiaries qualify for the new guaranteed issue protections. In that notice, HCFA is advising beneficiaries who have any problems with Medigap insurers in your State to contact your department.

Medigap Rights Extended by the Balanced Budget Act

The most important protection created by the BBA for Medicare beneficiaries enrolled with an HMO (of any type) that is terminating its contract with Medicare applies to all individuals who are enrolled in that plan at the time the contract terminates. These individuals have the right to **guaranteed issue of any Medigap plans A, B, C, or F** that are offered to new enrollees by issuers in your State. In the three States with waivers (Massachusetts, Minnesota, and Wisconsin), section 1882(s)(3)(C) provides that issuers must provide guaranteed issue of policies that are comparable to plans A, B, C, or F.

The above right applies to individuals by virtue of the involuntary termination of their coverage. However, certain Medicare beneficiaries in the terminating plans may have another, separate basis for entitlement to guaranteed issue of a Medigap policy. In particular, if an individual (1) has been enrolled for less than 12 months with the HMO that is terminating coverage; (2) was never enrolled in any other Medicare HMO; and (3) was previously enrolled in a Medigap policy; the individual may terminate enrollment with the HMO before the contract terminates, and return to the previous Medigap policy if the same issuer still sells the policy in the State. If the policy is no longer available from that issuer, the individual may purchase Medigap plans A, B, C, or F from any insurer which sells those plans in the State.

Note that, if an issuer does not market all four of the specified benefit packages, the Federal law does not require it to add the other policies.

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For either of these groups of beneficiaries, an issuer may not:

- (1) deny or condition the sale of the policy;
- (2) discriminate in the pricing of the policy because of the individual's health status, prior history of claims experience, receipt of health care or medical condition; or
- (3) impose an exclusion for any preexisting condition.

These rights are guaranteed to "individuals" who meet statutory criteria (e.g., their prior coverage is terminated). The statute does not distinguish between individuals eligible for Medicare based on age, and those whose eligibility is based on disability or ESRD. This is the case even for issuers who are not currently writing policies for individuals under 65. As a result of the BBA provision they must now make plans A, B, C or F (if offered to new enrollees) available to all Medicare beneficiaries who meet the statutory requirement. Finally, it is important to emphasize that the statute mandates that the premium charged must not be established in a way that discriminates based on health status.

In either of the above situations, the Medicare beneficiary must apply for the Medigap policy not later than 63 days after the date that HMO coverage terminates, unless your State law provides for a longer period. (The 63-day period will generally begin January 1, 1999, unless a beneficiary meets the criteria for re-enrolling in a previous Medigap policy. In that case, the 63-day period begins on the effective date of the individual's disenrollment.) However, most beneficiaries will prefer to apply before the beginning of this period. While issuers may not sell a policy with an effective date before a beneficiary's HMO coverage terminates, because that would be duplicate coverage, nothing in the law prevents an issuer from accepting applications in order to make the new coverage effective the day after the old coverage ends.

As with previous amendments to the Federal Medigap law, section 4031 of the BBA specifies that State law and regulations must comply with the requirements of section 1882 of the Social Security Act and with standards contained in the NAIC's Medicare Supplement Model Regulation. The Model Regulation, as revised to reflect the BBA amendments, tracks the statutory language of these protections. We are enclosing a copy of the relevant sections for your reference. As you may be aware, HCFA is working with the NAIC to correct an error in the drafting note that follows section 12.B(2) of the Model Regulation. This error, regarding the significance of the statutory reference to the year 2002, does not in any way affect the rights of beneficiaries whose current section 1876 managed care plans are terminating. It only pertains to beneficiaries who may, in the future, be covered by a Medicare+Choice organization.

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There may be some confusion on the part of Medigap issuers regarding the effective date of the guaranteed issue requirements described above. These requirements were added to section 1882(s) of the Social Security Act by section 4031(a) of the BBA. Section 4031(d)(1) mandated a July 1, 1998 effective date. The confusion results from the fact that the statute incorporates two parallel enforcement mechanisms.

First, in order for your State to continue to have an approved regulatory program under section 1882(b) of the Social Security Act, State laws and regulations must conform to the new Federal requirements. If changes to your State laws and regulations are required in order for the State to enforce these provisions, section 4031(e) of the BBA deems your program to continue to be an approved program during a transition period of, in most cases, up to a year after the NAIC adopted its Model Regulation.

However, regardless of when the State laws and regulations come into conformity with the Federal requirements, it is essential for Medigap issuers to understand that the Federal guaranteed issue requirements added to section 1882(s) by the BBA, as well as the Federal civil money penalty enforcement authority in section 1882(s)(4), apply to all Medigap issuers as of the statutory effective date, July 1, 1998.

Finally, we are aware that the NAIC Model Regulation specifies that issuers may not issue new policy forms without filing them for your approval, and that your State is required by federal law to incorporate the NAIC Model standards into your approved regulatory program. Approval of policy forms for beneficiaries under 65 who meet the specific statutory requirements is desirable if it can be done on an emergency basis. However, if this is not possible, we believe the guaranteed issue protections for these beneficiaries supersede any requirements of pre-existing Federal or State law (such as the prior approval rule) that would preclude issuing the policies. We request that you make this clear to issuers in your State as quickly as possible. Permitting issuers to sell existing policies to these individuals without prior State approval will not jeopardize our approval of your current State Medigap regulatory program.

The prohibition on discrimination in pricing also raises the issue of agent compensation. Some issuers have, in the past, attempted to circumvent statutory guaranteed issue requirements imposed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) by reducing or eliminating agent compensation for sales to individuals who meet the statutory requirements. If this were to happen, we assume that States would act as they did in the HIPAA context to address similar abuses.

HCFA's Outreach Campaign

DRAFT
10/16/98

HCFA has also initiated an outreach campaign to help Medicare beneficiaries understand their rights and options. This campaign will strive to inform Medicare beneficiaries affected by HMO withdrawals of all their rights and options - including the fact that they are automatically eligible for the Original Medicare Plan and that they have guaranteed access to Medigap policies that help fill coverage gaps. HCFA plans to enlist public and private partners who serve older Americans to provide their members with needed information through newsletters, conferences, and targeted information campaigns. In addition, HCFA is posting new information about HMO plan withdrawals on the Medicare Internet site (www.medicare.gov). By November 2, the Internet site will provide up-to-date information on the available coverage options in each local area.

DRAFT
10/21/98 - a.m.

Dear Insurance Commissioner:

I am writing to inform you of new requirements contained in the Balanced Budget Act of 1997 (the BBA) which apply to Medicare Supplement ("Medigap") insurance policies. These provisions were enacted at the same time as creation of the new Medicare+Choice program, which changes and expands health care options for Medicare beneficiaries. The new provisions strengthen the rights of beneficiaries who are involuntarily terminated from Medicare managed care plans (and certain beneficiaries who leave HMOs voluntarily) to obtain Medigap coverage if they return to original Medicare.

This protection will be particularly important in the next few months, because, as you probably know, the Health Care Financing Administration (HCFA) has been notified recently by a number of HMOs serving portions of 30 States and the District of Columbia that they will no longer serve some or all of their current Medicare enrollees. A small percentage of beneficiaries may be left with no HMO plan option and will need to transition back to original Medicare with Medigap, while a number of others who are losing their HMO coverage may also wish to return to original Medicare with Medigap.

(We are committed to trying to guard beneficiaries from undue concern and unnecessary hardship as they make this transition.] However, in order to protect these vulnerable individuals, **we urgently request your cooperation in immediately alerting Medigap issuers in your State to the need to comply with the new Federal requirements.**

I call your attention to two key issues, which are further explained below. First, the rights established by the BBA apply to most Medicare beneficiaries, including many who are eligible for Medicare based on disability or end stage renal disease (ESRD). Second, there are both State and Federal enforcement mechanisms that apply to these rights.

Section 4031 of the BBA mandates several new situations in which Medicare beneficiaries are guaranteed issue of Medigap insurance. Two of these new protections apply to beneficiaries now enrolled in HMOs that are terminating contracts or reducing service areas.

Most beneficiaries whose coverage is terminating have a key protection: **the right to guaranteed issue of any Medigap plans A, B, C, or F that are offered to new enrollees by issuers in your State.** In Massachusetts, Minnesota, and Wisconsin, section 1882(s)(3)(C) of the Social Security Act (added by the BBA) provides that issuers must provide guaranteed issue of policies that are comparable to plans A, B, C, or F. As an alternative, some beneficiaries may qualify to use a second protection guaranteed by the BBA: **if they have been enrolled in their HMO less than 12 months and were never enrolled in any other Medicare HMO, they may return to their previous Medigap policy if the same issuer still sells the policy in the State.**

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In either case, Medigap issuers may not: (1) deny or condition the sale of the policy; (2) discriminate in the pricing of the policy because of the individual's health status, prior history of claims experience, receipt of health care or medical condition; or (3) impose an exclusion for any preexisting condition. (More details on these rights are explained in the "Detailed Background" attachment that is enclosed with this letter).

HMOs will be sending termination notices to all affected Medicare beneficiaries by November 2. While some beneficiaries will have the option of continuing in another HMO, others will not. In order to ensure a seamless transition into a new Medicare+Choice plan or to obtain Medigap coverage in conjunction with returning to original Medicare, beneficiaries will need to make decisions on new options for receiving their Medicare benefits well before their current HMO coverage ends on December 31. Many of these beneficiaries will be contacting Medigap insurers and your Department about Medigap insurance options available to them as they make decisions on their future Medicare coverage options.

As you address these new Federal requirements in your State, we want to advise you of two important considerations in interpreting the provisions in the BBA (again, more details are included in the "Detailed Background" attachment to this letter):

Applicability. The Medigap rights are guaranteed to "individuals" who meet the statutory criteria (e.g., their prior coverage is terminated). **The statute does not distinguish between individuals eligible for Medicare based on age and those whose eligibility is based on disability or end stage renal disease (ESRD).** Issuers must now make plans A, B, C or F – if those plans are offered to new enrollees – available to all Medicare beneficiaries who meet the statutory requirement. This provision, however, does not require that issuers not now offering all four of the designated plans begin to offer them. Nor does it require that ^{issuers} plans not now selling these plans to disabled beneficiaries under 65 must start selling to those individuals. Where they are sold, it is important to emphasize that the statute mandates that the premium charged must not be established in a way that discriminates based on health status.

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not
stand

Enforcement. The BBA mandated a July 1, 1998, effective date for these requirements. Some confusion has resulted from the fact that the statute incorporates two parallel enforcement mechanisms – one State and one Federal.

HHS proposed addition - encourage States to do more (start offering new options) even though it's not req

- States clearly have the primary authority for enforcement of Medigap requirements under their approved regulatory programs. The law, however, recognizes that you may need to make changes to your Medigap regulatory program in order for it to continue to be an approved program under section 1882(b) of the Social Security Act. If changes are required in order for your State to enforce these provisions, the BBA deems your program to continue to be an approved program during a transition period of, in most cases, up to a

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year after the NAIC adopted its Model Regulation. Shortly, we will publishing a *Federal Register* notice transmitting this Model Regulation to the States.

- Regardless of when State laws and regulations come into conformity with the Federal requirements, section 1882(s)(4) contains a Federal civil monetary penalty that can be imposed independently of any State enforcement mechanisms. HCFA will be developing further guidance to specify these Federal requirements, including more detailed interpretations of the statutory provisions on guaranteed issue and nondiscrimination in pricing. It is essential for Medigap issuers to understand that **the Federal guaranteed issue requirements added to section 1882(s) by the BBA, as well as the Federal civil money penalty enforcement authority in section 1882(s)(4), apply to all Medigap issuers as of the statutory effective date, July 1, 1998.**

We stand ready to work with you and your staff to ensure that Medicare beneficiaries can benefit from the protections that have been afforded them. Staff from our Regional Offices will contact you shortly to follow up on any questions raised by these requirements. [In addition, through the regional offices, HCFA has initiated an ^{extensive} outreach campaign to help all Medicare beneficiaries understand their rights and options.] We encourage you to work with your HCFA Regional Office to identify issues that could serve as barriers to the effective implementation of the Medicare beneficiary protections guaranteed under Federal law.

Sincerely,

Nancy-Ann Min DeParle
Administrator

Enclosures [“DETAILED BACKGROUND,” WHICH REFERS IN TURN TO 3 OTHERS
(1) THE STATE-BY-STATE LIST OF PLANS AND (2) THE MODEL
NOTICE TO BENEFICIARIES – ALSO LIST OF REGIONAL OFFICE
CONTACTS]

NOTE: WE DROPPED REFERENCE TO THE SECTIONS OF THE NAIC
MODEL REGULATION

cc: All State Medicaid Directors
All HCFA Regional Offices
All HCFA ARMS, DMSO
APHSA

XXXXXXXXXXXXXXXXXXXX

NGA
NAIC
NCSL
SHIPs

DRAFT
10/21/98 - a.m.

DETAILED BACKGROUND

Before the BBA was enacted, the primary managed care option open to Medicare beneficiaries was to enroll in a health maintenance organization (HMO) or similar organization that had contracted with Medicare, under section 1876 of the Social Security Act, to provide Medicare covered services to beneficiaries in return for payment by Medicare. Most of these organizations had "risk" contracts that paid them a monthly amount for each enrolled beneficiary. Others had "cost" contracts or contracts as health care prepayment plans (for Part B services only) that reimbursed the organization's reasonable costs. The BBA eliminates the old risk contract program at the end of 1998 and replaces it with comparable managed care plans under the new Medicare+Choice program enacted as part of the BBA. Beginning in 1999, the primary managed care option available to beneficiaries will be through organizations that enter into contracts under Medicare+Choice. (For simplicity, we will use the terms "HMO" and "managed care plan" interchangeably here.)

Plan Decisions to Terminate Contracts or Reduce Service Areas

HCFA has been notified by more than 100 HMOs that they will not enter into new Medicare+Choice contracts or that they will sign Medicare+Choice contracts for a reduced service area, effective December 31, 1998. Included are HMOs with risk contracts, HMOs with cost contracts, health care prepayment plans, and plans operating as part of the Medicare Choices demonstration. The beneficiaries currently enrolled in these plans will be seeking new options for receiving their Medicare benefits, effective on or before January 1, 1999. Included among these beneficiaries are some who will not have access to another managed care plan, primarily because they live in an area that is no longer served by any Medicare-contracting HMOs. A small number of beneficiaries who have End Stage Renal Disease (ESRD) (permanent kidney failure) and are enrolled in the terminating HMO will be precluded by law from enrolling in another HMO. We have enclosed a list of the counties and numbers of beneficiaries affected in each State (similar information is available on HCFA's Internet Website at www.hcfa.gov).

Information for Affected Beneficiaries

Most Medicare beneficiaries will be able to choose between enrolling in another HMO, or returning to the "Original" Medicare fee-for-service program. When an HMO terminates coverage because it leaves the Medicare program entirely, or reduces the service area covered by its contract, the individuals it has served have certain statutory rights to enroll with a new managed care plan, or to purchase Medigap insurance if they return to "Original" Medicare. However, these rights are time-limited. It is therefore critical that all affected beneficiaries be given sufficient information about their choices, as soon as possible, to allow them to make the best decision about how to cope with the change in their health care options.

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Part of this information will come from the managed care plans. First, under section 1876 of the Social Security Act, the terminating HMO is required to inform enrolled beneficiaries about other Medicare-contracting HMOs, if any, that will be available to them. However, the beneficiaries will generally be required to decide before the end of November whether they wish to enroll under one of these plans. Second, the HMO is still required under the law that pre-dated the new BBA protections to ensure that beneficiaries who wish to return to Original Medicare are protected against out-of-pocket costs related to pre-existing condition exclusions in Medigap policies. This right, which might in some cases be more attractive than the new BBA protections, is also likely to involve a deadline for making a choice.

Finally, the HMO is required by the Medigap provisions at section 1882(s)(3)(D) of the Social Security Act (added by the BBA) to inform beneficiaries of their new rights with respect to purchasing Medigap insurance. A copy of the letter approved by HCFA for use by the HMOs is enclosed for your information. This letter will likely be used by beneficiaries to demonstrate to Medigap issuers that the beneficiaries qualify for the new guaranteed issue protections. In that notice, HCFA is advising beneficiaries who have any problems with Medigap insurers in your State to contact your department.

Medigap Rights Extended by the Balanced Budget Act

The most important protection created by the BBA for Medicare beneficiaries enrolled with an HMO (of any type) that is terminating its contract with Medicare applies to all individuals who are enrolled in that plan at the time the contract terminates. These individuals have the right to **guaranteed issue of any Medigap plans A, B, C, or F** that are offered to new enrollees by issuers in your State. In the three States with waivers (Massachusetts, Minnesota, and Wisconsin), section 1882(s)(3)(C) provides that issuers must provide guaranteed issue of policies that are comparable to plans A, B, C, or F.

The above right applies to individuals by virtue of the involuntary termination of their coverage. However, certain Medicare beneficiaries in the terminating plans may have another, separate basis for entitlement to guaranteed issue of a Medigap policy. In particular, if an individual (1) has been enrolled for less than 12 months with the HMO that is terminating coverage, (2) was never enrolled in any other Medicare HMO, and (3) was previously enrolled in a Medigap policy, the individual may terminate enrollment with the HMO before the contract terminates, and return to the previous Medigap policy if the same issuer still sells the policy in the State. If the policy is no longer available from that issuer, the individual may purchase Medigap plans A, B, C, or F from any issuer which sells those plans in the State.

Note that, if an issuer does not market all four of the specified benefit packages, the Federal law does not require it to add the other policies.

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For either of these groups of beneficiaries, an issuer may not:

- (1) deny or condition the sale of the policy;
- (2) discriminate in the pricing of the policy because of the individual's health status, prior history of claims experience, receipt of health care or medical condition; or
- (3) impose an exclusion for any preexisting condition.

These rights are guaranteed to "individuals" who meet statutory criteria (e.g., their prior coverage is terminated). The statute does not distinguish between individuals eligible for Medicare based on age, and those whose eligibility is based on disability or ESRD. As a result of the BBA provision, any issuer now offering plans A, B, C or F to beneficiaries over 65 must make these plans available to all Medicare beneficiaries who meet the statutory criteria described above. Issuers now offering these plans to beneficiaries entitled to Medicare due to disability must make the same plans available to disabled beneficiaries who met the statutory criteria. Finally, it is important to emphasize that the statute mandates that the premium charged in these circumstances must not be established in a way that discriminates based on health status.

In either of the above situations, the Medicare beneficiary must apply for the Medigap policy not later than 63 days after the date that HMO coverage terminates, unless your State law provides for a longer period. (The 63-day period will generally begin January 1, 1999, unless a beneficiary meets the criteria for re-enrolling in a previous Medigap policy. In that case, the 63-day period begins on the effective date of the individual's disenrollment.) However, most beneficiaries will prefer to apply before the beginning of this period. While issuers may not sell a policy with an effective date before a beneficiary's HMO coverage terminates, because that would be duplicate coverage, nothing in the law prevents an issuer from accepting applications in order to make the new coverage effective the day after the old coverage ends.

As with previous amendments to the Federal Medigap law, section 4031 of the BBA specifies that State law and regulations must comply with the requirements of section 1882 of the Social Security Act and with standards contained in the NAIC's Medicare Supplement Model Regulation. The Model Regulation, as revised to reflect the BBA amendments, tracks the statutory language of these protections. As you may be aware, HCFA has worked with the NAIC to correct an error in the drafting note that follows section 12.B(2) of the Model Regulation, and the NAIC issued a memorandum on October 16 explaining this change. A *Federal Register* notice, being published shortly, will transmit to the States the revised Model Regulation. This revised version is the Model Regulation that must be adopted by all States. (The error, regarding the significance of the statutory reference to the year 2002, does not in any way affect the rights

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of beneficiaries whose current section 1876 managed care plans are terminating. It only pertains to beneficiaries who may, in the future, be covered by a Medicare+Choice organization.)

There may be some confusion on the part of Medigap issuers regarding the effective date of the guaranteed issue requirements described above. These requirements were added to section 1882(s) of the Social Security Act by section 4031(a) of the BBA. Section 4031(d)(1) mandated a July 1, 1998 effective date. The confusion results from the fact that the statute incorporates two parallel enforcement mechanisms – one State and one Federal.

States clearly have the primary authority for enforcement of Medigap requirements under their approved regulatory programs. In order for your State to continue to have an approved regulatory program under section 1882(b) of the Social Security Act, State laws and regulations must conform to the new Federal requirements. If changes to your State laws and regulations are required in order for the State to enforce these provisions, section 4031(e) of the BBA deems your program to continue to be an approved program during a transition period of, in most cases, up to a year after the NAIC adopted its Model Regulation, which was April 29, 1998.

However, regardless of when the State laws and regulations come into conformity with the Federal requirements, it is essential for Medigap issuers to understand that the Federal guaranteed issue requirements added to section 1882(s) by the BBA, as well as the Federal civil money penalty enforcement authority in section 1882(s)(4), apply to all Medigap issuers as of the statutory effective date, July 1, 1998.

Finally, we are aware that some States have no approved policy forms for beneficiaries under 65 and that the NAIC Model Regulation specifies that issuers may not issue new policy forms without filing them for your approval. Approval of policy forms for beneficiaries under 65 who meet the specific statutory requirements is desirable if it can be done on an expedited basis. If this is not possible, however, we believe the guaranteed issue protections for these beneficiaries exist only for a policy "that is offered and is available for issuance to new enrollees by such issuer" (section 1882(s)(3)). We request that you make this clear to issuers in your State as quickly as possible.

The prohibition on discrimination in pricing also raises the issue of agent compensation. Some issuers have, in the past, attempted to circumvent statutory guaranteed issue requirements imposed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) by reducing or eliminating agent compensation for sales to individuals who meet the statutory requirements. If this were to happen, we assume that States would act as they did in the HIPAA context to address similar abuses.

Jim Bossenmeyer

DRAFT
10/21/98 - a.m.

HCFA's Outreach Campaign

Through our regional offices, HCFA has also initiated an outreach campaign to help Medicare beneficiaries understand their rights and options. This campaign will target those areas where Medicare beneficiaries are most affected by HMO withdrawals and inform them of their rights and options – both that they are automatically eligible for the Original Medicare Plan and what their Medigap rights and protections are. [As part of this plan, HCFA plans to enlist public and private partners who serve the Medicare population to provide their members with needed information through newsletters, conferences, and targeted information campaigns.] As part of this campaign, you should be aware that beneficiaries who are denied access are being instructed to contact their State's insurance department. They are also instructed to contact HCFA's regional offices if they have difficulty resolving their individual concerns. In those States with significant plan withdrawals, staff from our regional offices will contact your office to identify ways that we can work together to ensure that the correct information is shared with beneficiaries. In addition, HCFA will post new information on the Medicare Internet site (www.medicare.gov), so that beneficiaries in every local area have the most up-to-date information on available HMO coverage options.

7
Advised

State Information Campaign –
designed to use HCFA RD & other
Fed agencies for Medicare + Choice –
Alliance Network – to get info out

AOA

Fortune 500

Academics

Unions

over 100 ^{agencies} @
national level
additional groups
at local level

local outreach

targeted to sp. groups &
designed to be culturally competent
messages

2. What is currently available to disabled Medicare beneficiaries?

Still getting what they could have gotten before

In states where Medigap policies are available to the disabled, they have new protections available under the BBA. Most beneficiaries whose coverage is ending have two key protections provided by the Balanced Budget Act of 1997: 1) the right to guaranteed issue of any Medigap policies A, B, C, or F that are currently available to other disabled beneficiaries under 65 or 2) if disabled beneficiaries have been enrolled in their HMO less than 12 months and were never enrolled in any other Medicare HMO, they may return to the Medigap policy they had purchased before, if the same issuer still sells the same policy in the state.

In either case, Medigap issuers may not: 1) deny or condition the sale of the policy; 2) discriminate in the pricing of the insurance policy based on the individual's health status, prior history or claims experience, receipt of health care or medical condition; or 3) impose an exclusion for any preexisting condition. This means that insurers cannot consider an individual's health status when determining eligibility or how much to charge for premiums. Issuers must accept these applicants at the same premium rate provided to other new applicants with no health problems. Issuers that adjust rates for non-health status factors, such as age or geographic location, can apply those adjustments if done on a nondiscriminatory basis.

3. Does this mean that all disabled Medicare beneficiaries can buy a Medigap policy?

Only in states that currently require insurers to sell Medigap policies to individuals under 65 or in states where plans have been selling policies to disabled individuals under 65. In these cases, disabled and ESRD beneficiaries have all the protections outlined in the BBA. The statute does not distinguish between individuals eligible for Medicare based on age and those whose eligibility is based on disability or ESRD. Issuers must make any of the four plans available on a guaranteed issue basis without exclusions for preexisting conditions -- if those plans are offered to new disabled enrollees.

However, if a state has no requirements guaranteeing coverage to individuals under 65, or Medigap policies are not available to beneficiaries under 65, the insurers are under no obligation to sell to these individuals. Of course, we hope plans will extend that coverage to disabled and ESRD beneficiaries under the age of 65, even if not required. You should also remember that some disabled beneficiaries will still be able to join other HMOs in their county.

4. Why can't HCFA force carriers to sell Medigap policies to disabled beneficiaries and those with ESRD? What can HCFA do to make sure these disabled individuals can purchase Medigap insurance?

While by law HCFA generally cannot regulate state insurance coverage, it does have the authority to enforce laws passed by Congress.

While we asked for even stronger protections, Congress did strengthen some protections for many Medicare beneficiaries when it created Medicare+Choice in the BBA. On October 8, President Clinton directed HHS Secretary Donna Shalala to develop new legislation to protect

Medicare beneficiaries. We expect that additional beneficiary protections will be included in these legislative proposals.

HCFA is encouraging states to find ways to help these beneficiaries, for example, by urging plans to extend coverage voluntarily.

At the same time, we are concerned about the effect of requirements forcing Medigap carriers to insure individuals under 65 because it could result in some policies no longer be available to other beneficiaries. In Maryland, for example, the state recently enacted a regulation requiring carriers to provide Medigap policies C and I to individuals under 65 and two carriers decided to withdraw their I plans from the state.

5. What states offer additional protections to Medicare beneficiaries under 65?

About 18 states, including 12 of the 30 states where HMOs have announced they are non-renewing or reducing their service area, require that Medigap issuers sell policies to disabled beneficiaries. Other states may have some issuers who do offer Medigap coverage to this population as well.

6. What about coverage for prescription drugs? None of the guaranteed Medigap plans -- A, B, C, or F pay for prescription drugs?

Those are the Medigap policies designated in the BBA. We expect to recommend adding more Medigap policies -- including those that cover prescription drugs -- in our legislative proposals for next year.

Disabled beneficiaries should investigate all their options, such as seeing if other HMOs in their area offer some drug coverage. Information about the services and benefits HMOs will be offering in their areas will be available at the Medicare Compare site at www.Medicare.gov in early November.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

OCT 9 1998

The Honorable Bill Thomas
Chairman
Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives
Washington, D.C. 20515

Dear Chairman Thomas:

Thank you for your letter of October 6th in which you expressed your concern regarding the decision of many Medicare managed care plans to reduce their service areas or terminate their contracts. I share your concern and we are taking steps to ensure that beneficiaries have accurate and reliable information on their options. In addition, I have already taken actions to reduce regulatory burdens on plans. In your letter, you asked that I review five policies included in the June Medicare+Choice Interim Final Regulation. I have reviewed these policies and wanted to let you know how we plan to handle them.

Before I address your issues, I want to catalog the changes that we have already made to address concerns raised by plans concerning plan administration. Last week, after consulting with plans over a number of months, we released the interim final version of our quality standards. These standards were changed significantly from the December 1997 draft which we had widely circulated for public comment. Specifically:

- ▶ We reduced the number of quality improvement projects that plans must conduct -- two per year -- which is comparable to requirements of private sector accrediting organizations.
- ▶ We permit waivers of participation in our national quality improvement project, and allow plans to substitute ongoing projects of their own.
- ▶ We phase in quality improvement projects; plans have three years before they must achieve demonstrable improvement. In the first contract year, plans need only select a topic, establish performance indicators, and collect baseline data.
- ▶ We clarify the implementation of minimum performance level compliance. We intend to establish these levels in 1999, first measure compliance in 2000, and require plans to have achieved demonstrable improvement in 2001.
- ▶ We no longer mandate site visits to providers as part of credentialing.

Page 2 - The Honorable Bill Thomas

- We increase flexibility in required care coordination by allowing primary care providers, a team of providers, or an employee who is a health care professional, to conduct this function. Coordination need apply only to patients with complex health needs.

In addition to these changes, we are currently examining other policies in the June regulation based on comments that we have received. You raised five specific areas that deserve further review. Specifically, you ask about issues surrounding; service areas, risk adjustment, attestation, provider participation procedures and involuntary terminations.

Service Area

Last year, you suggested that plans be allowed to submit separate ACRs for portions of their service area that have differing reimbursement rates. Some plans took advantage of this flexibility. We believe that plans believe this flexibility is important, and therefore we will carefully consider allowing plans to follow the 1999 service area policy again in their ACRs for 2000.

Risk Adjustment

We were pleased that the BBA mandated that Medicare+Choice payments rates incorporate risk adjustment for enrollee health status beginning in 2000. Plans will now be paid more for treating enrollees with chronic and substantial complex health care needs than for healthy enrollees with minimal needs. Risk adjustment will reduce the disincentive for plans to enroll beneficiaries with serious health problems. As a result these beneficiaries will be able to benefit from the coordination of services that plans can provide. Risk adjustment will also eliminate the overpayment to plans due to favorable selection and thus aid the long term effort to assure the solvency of the Medicare trust funds.

The risk adjustment system we will implement will use inpatient data that plans can readily produce. As plans improve their capacity to provide more detailed data, we will move to a more sensitive risk adjustment methodology that includes outpatient data and data for non-hospitalized beneficiaries with serious chronic conditions such as diabetes or rheumatoid arthritis.

Recognizing the potential for significant changes in plan payment amounts, we will carefully consider your request for a transition and will construct our risk adjustment policy with the goal of maintaining stability in the Medicare+Choice program. We will fully inform you of our plans later this year. We will provide each plan with an estimate of risk adjustment's impact on their payments early next year.

Attestation

Your letter expresses concern that the June regulation requires 100 percent accuracy of encounter data. You point out that the integrity of these data, in many cases, is not under the control of

Page 3 - The Honorable Bill Thomas

Medicare+Choice organizations since they are submitted by physicians, hospitals and other providers who often make coding errors. Your discussion of attestation raises important issues, and, as you know, we have devoted significant effort over the past few months trying to resolve them. Language in the Medicare+Choice contracts will require that organization officers, contractors and subcontractors certify that the data that they are submitting are accurate, complete and truthful "to the best of their knowledge, information, and belief." This standard will apply not only to encounter data, but also to any other data affecting payment (e.g., enrollment data and community rating data). This contract language strikes a balance between program integrity concerns and the need to apply reasonable standards to Medicare+Choice organization officers responsible for signing these documents. The final regulation will reflect this clarification.

Provider Participation Procedures

Your letter points out that, while the BBA applies certain provider participation requirements in section 1852(j) only to physicians, HCFA extended these provisions to a number of other health care professionals pursuant to its authority to "establish" Medicare+Choice standards by regulation. We took this approach after our review of the National Association of Insurance Commissioners' model act and the laws of several states. In addition, a number of comments submitted to us on this issue support such an expansion. Nonetheless, a number of comments have made the case that this extension would create an undue burden. You also make the case that Congress' use of the term physician in connection with these requirements, while using the term health professionals in connection with other requirements in section 1852(j), signifies an affirmative intent to exempt non-physicians from these requirements. We intend to address this issue in the final rule.

You also suggest that the regulation's provider participation procedures are overly broad and would place a significant burden on plans by requiring notification and appeals processes for many operational decisions. Section 1852(j) of the Social Security Act mandates that Medicare+Choice organizations establish reasonable participation procedures within their agreements with physicians, and that these procedures include: notice of rules regarding participation; written notice of participation decisions that are adverse to physicians; and a process within the organization for appealing such adverse decisions. In the June regulation, we provided an illustrative list interpreting these rules of participation including utilization review, quality improvement programs, credentialing, data reporting, confidentiality, and other rules related to administrative policy. This list was premised upon interpreting "rules regarding participation" to refer to rules that must be followed by participating physicians, as opposed to rules affecting how or whether a physician can participate.

We now recognize, as a result both of your letter and comments we have received on the regulation, that our interpretation should be reconsidered. Therefore, we intend to adopt a narrower interpretation of the scope of what is included in "rules regarding participation" in the final rule

Page 4 - The Honorable Bill Thomas

Involuntary Terminations

Finally, your letter suggests that the June regulations are overly prescriptive in requiring Medicare+Choice organizations to provide information to beneficiaries about continuity of specialist care when an organization terminates its relationship either with a plan or a given specialist. You point out, first, that specialists would likely tell their Medicare patients they no longer participate in the Medicare+Choice plan but do participate in fee-for-service Medicare (or another Medicare+Choice plan); and second, that a more reasonable requirement would be for plans to inform patients of other available providers within the network. After considering your suggestions and a number of written comments that we have received on this issue, I agree with you and intend to change the final rule accordingly.

Thank you for taking the time to review the Medicare+Choice regulation and point out some areas of concern. We share the desire to balance protecting Medicare beneficiaries and minimizing regulatory burden. I appreciate your continued support as we move forward with implementing the Medicare+Choice program.

Sincerely,



Nancy-Ann Min DeParle
Administrator

SUBCOMMITTEE ON HEALTH

NANCY L. JOHNSON, CONNECTICUT
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JOHN BURNER, NEVADA
JOHN CHRISTENSEN, MINNESOTA
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AND HOLMSTON, NEW YORK
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COMMITTEE ON WAYS AND MEANS

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COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES
WASHINGTON, DC 20515

SUBCOMMITTEE ON HEALTH

October 6, 1998

Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration
200 Independence Ave., SW
Washington, D.C. 20201

Dear Nancy-Ann:

I am very concerned by the recent decision of Medicare managed care plans to discontinue their operations in several counties under the Medicare+Choice program. In discussions with several plan managers, it has come to my attention that there are several recent regulatory decisions by the Administration that they believe are adding to both the uncertainty and the costs of managing a Medicare managed care plan.

In reviewing the details of the Administration's regulation to implement the Medicare+Choice program, referred to as the "Mega-Reg," I was struck by several examples where the Administration went beyond the statutory language and has created policies that will place a significant burden on plans. I believe that it is very important for you to review these five areas with an eye toward review and revision:

1) Service Areas

During the past year, we have had several conversations about Medicare+Choice Service Areas. I supported your decision to allow plans in 1999 to continue to offer different packages in adjoining counties by required them to submit multiple Adjusted Community Rate (ACR's) proposals. In order to provide seniors with as many choices as possible, it is important to continue with this level of flexibility in 2000.

2) Risk Adjuster

The Balanced Budget Act of 1997 (BBA) requires the Health Care Financing Administration (HCFA) to implement a new risk adjuster in 2000. Moving from the

current risk adjuster to the new risk adjuster will cause significant changes in payments. The Congress gave the Secretary considerable authority in determining the specifics of the new risk adjuster. I would like to request that you phase in the new risk adjusters over several years to allow for a smooth transition.

3) Attestation

The Medicare+Choice "Mega-Reg" requires that in submitting encounter data to HCFA, Medicare managed care plans must attest to 100% accuracy of these data. Physicians, hospitals, and other providers, which are the source of much of the information, often make coding errors when they submit data to health plans. The plans, in turn, give this data to HCFA. In order for the plans to meet the new 100% accuracy requirements, they would have to invest significant resources in verifying every claim. It is my understanding that ensuring data accuracy is also a significant problem in the fee-for-service side of the program. It seems unreasonable to require a higher standard for plans. Therefore, I strongly recommend that plans be asked to make a "best faith" effort to submit data that is accurate. Health plans that are found to repeatedly provide incorrect data should be scrutinized by HCFA.

4) Provider Participation Procedures

The BBA language was written to provide physicians with clear rules regarding participation, notification of participation decisions, and a process for appealing such decisions. HCFA's interpretation, as embodied in the "Mega-Reg," goes well beyond the scope of this provision.

First, the BBA language specifically discusses physicians (the word "physician" is used 5 times in this one section). However, HCFA is applying the new rules to 15 other categories of health professionals. Second, HCFA states in the "Mega-Reg," that "we are adopting a broad definition of procedures that might affect participation in the plan or network." This broad definition would place a significant burden on plans by requiring written notification and an appeals process for virtually any type of operational decision that a plan may make, including: terms of payment, utilization review, quality improvement programs, credentialing, data reporting, confidentiality, guidelines or criteria for providing services, and other administrative policy rules.

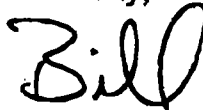
I strongly recommend that the Administration review the bill language and establish policies that are applied to physicians, not 15 other types of providers. These physicians should be given a process to appeal when they are denied participation by a plan. The process should be determined by the plan --not HCFA-- and the process should only apply to a plan's decision regarding participation, rather than the long list of items included in the "Mega-Reg" language.

5) Involuntary Terminations

The BBA provides for continuity of benefits, not continuity of providers, to seniors when a plan drops a physician from its network. The "Mega-Reg" includes very specific requirements for plans when a physician is dropped from a health plan network without cause. First, the plan must inform beneficiaries about the other health plans a dropped physician is affiliated with. Second, the health plan must inform beneficiaries of the process that they would have to go through to return to Medicare fee-for-service. It seems overly prescriptive because physicians would likely tell their Medicare patients that they are no longer in the plan, but do participate in other plans or fee-for-service Medicare. A more reasonable requirement, one that would provide protections for seniors, would be that managed care plans inform patients of the other available providers in the network.

Thank you for your attention to these important matters. I would appreciate a response by Thursday, October 8, 1998.

Sincerely,

A handwritten signature in cursive script that reads "Bill".

Bill Thomas
Chairman

DRAFT October 23, 1998 11:39AM

Fact Sheet on Non-Renewals

Background and General Information on Medicare Health Maintenance Organizations (HMOs) and Non-renewals:

- For many years, the law has allowed Medicare to contract with HMOs to enroll beneficiaries. Currently, about 6 million beneficiaries receive their Medicare benefits through Medicare-contracting HMOs. The law that governs Medicare-contracting HMOs through 1998 (the "older" law) is being replaced by a new law. This new law creates the Medicare + Choice program. The Medicare + Choice program allows HMOs as well as other health plans to contract with Medicare. Beginning January 1, 1999, if HMOs that had been operating under the older law want to continue their Medicare participation, they must contract under the new Medicare + Choice program. Some currently-contracting HMOs have decided to continue under the Medicare + Choice program; others have decided not to continue.
- Under both the older law and the new Medicare + Choice program, Medicare HMOs must make annual business decisions about whether or not to continue to participate in the Medicare program. Under the older law, a decision not to participate was generally referred to as a non-renewal, because the HMO was deciding not to "renew" its existing contract with HCFA. This year, however, since under the Medicare + Choice law existing HMO contracts cannot be renewed, a "non-renewal" represents a decision by an HMO not to enter into a new Medicare + Choice contract for 1999. Non-renewal decisions can apply to a plan termination or to a service area reduction.
- For plans that want to contract with HCFA to enroll Medicare beneficiaries, HCFA initially approves the plan for its contract and then conducts periodic monitoring reviews. However, HCFA has no control over the annual business decisions of plans to continue participating in Medicare, that is, HCFA cannot require plans to enter into a Medicare + Choice contract for 1999 or maintain their existing service area under such a contract.
- Regulations governing contracts under the older law require HMOs to notify HCFA 90 days before the contract ends (i.e., October 2) of a decision to nonrenew and to notify affected enrollees 60 days prior to the end of the contract (i.e., November 2).

Information for Medicare Enrollees In Nonrenewing Plans:

1. **In General.** Non-renewing HMOs will continue to provide services to their Medicare enrollees through December 31, 1998; that is, current enrollees can remain in their HMO through December 31, 1998. They can also disenroll prior to that time and either (1) return to the original Medicare plan or (2) enroll in another Medicare-contracting HMO or other Medicare + Choice plan if one is available in their geographic area (see item 3 below on effective dates and exceptions regarding who is eligible to enroll in another plan). All beneficiaries have the option of returning to the Original Medicare Plan. Non-renewing HMOs are required to send all affected enrollees an information package by November 2, 1998. This package will provide information on enrollees' options with respect to either (1) returning to the original Medicare plan with supplemental coverage or (2) enrolling in another Medicare-contracting HMO or other Medicare + Choice plan.
2. **Returning to the Original Medicare Plan.** Individuals can return to the Original Medicare Plan in one of two ways: (1) they can remain enrolled in the nonrenewing plan until December 31, 1998 and be automatically returned to the Original Medicare Plan starting January 1, 1999; or (2) they can return to the original Medicare plan before December 31, 1998, by (a) submitting a written request to disenroll to the nonrenewing plan or (b) contacting the Social Security Office or Railroad Retirement Board Office. The member will be disenrolled effective the first day of the first month following the month the request for disenrollment was made. For example, if the individual requested disenrollment on November 20, he/she will be returned to the Original Medicare Plan effective December 1, 1998.

Individuals should understand that, until their disenrollment is effective, they must continue to comply with plan rules when seeking medical services.
3. **Choosing Another Medicare HMO.** Individuals may be able join another Medicare-contracting HMO or other Medicare + Choice plan. Beginning January 1, 1999, beneficiaries can enroll in any Medicare + Choice plan that serves their geographic area if they are entitled to Medicare Parts A and B and do not have permanent kidney failure (End Stage Renal Disease). If individuals choose to enroll in another plan before December 31, 1998, they will automatically be disenrolled from their current plan. Medicare-contracting HMOs and other Medicare + Choice plans that will be available in their geographic area will be required to accept enrollments in November 1998 to be effective January 1, 1999. It should also be noted that some of these plans may also accept enrollments during the month of December. Be sure to enroll no later than December 31, 1998 for your coverage to begin January 1999.
4. **Supplemental Insurance through Medigap.**

Requirements for Medigap Insurers:

- As long as individuals apply for a Medigap policy no later than 63 days after the coverage with the nonrenewing plan terminates, they are guaranteed the right to buy any Medigap plan designated "A", "B", "C" or "F" that is offered in the State. Accordingly, if individuals who remain enrolled until the nonrenewing plan terminates their coverage on December 31, 1998 apply for one of these Medigap policies no later than March 4, 1999, companies selling these policies cannot place conditions on the policy (such as an exclusion of benefits based on a pre-existing condition) or discriminate in the price of the policy because of health status, claims experience, receipt of health care or medical condition.

CAUTION: While individuals can apply for a Medigap policy before December 31, 1998, the protections described here will NOT be guaranteed if they voluntarily disenroll before the HMO contract terminates December 31, 1998. Individuals must keep a copy of their plan's termination letter to show a Medigap insurer as proof of loss of coverage under this plan.

- If individuals dropped a Medigap policy to join the nonrenewing plan and they were never enrolled in a similar managed care plan since starting Medicare, they may be able to return to the Medigap policy that was dropped if (1) the Medigap policy dropped is still being sold by the same insurance company; (2) they disenroll from their current HMO before December 31, 1998; (3) they have been enrolled in their current HMO for no more than 12 months; and (4) they apply for the Medigap policy no later than 63 days after their coverage from their current HMO terminates.

If the previous Medigap policy is no longer available, the individual is still guaranteed the right to buy from any Medigap carrier a Medigap Plan designated "A", "B", "C", or "F" that is offered in that state (as described above).

CAUTION: If the previous policy is no longer available, the individual is still guaranteed the right to buy from any Medigap carrier any Medigap plan designated A, B, C or F that the carrier offers in that State (as described above.). However, in this situation the 63-day period for filing your the new Medigap application will begin on the effective date of disenrollment.

The individual should therefore make sure the old policy is still available from the original insurer before disenrolling from the non-renewing plan. If it is not

available, the individual will have more time to make a decision about Medigap options by simply remaining enrolled until the current health plan terminates coverage on December 31. The individual will then have 63 days from the last day of coverage under the current plan to apply for a plan designated A, B, C or F.

Requirements for Plans: By law Medicare HMOs must arrange for individuals to be protected against any pre-existing condition exclusions under a Medigap policy for up to six months after a plan terminates coverage. Plans will provide individuals with specific information regarding the arrangements that will be made available to beneficiaries in the information package that nonrenewing plans must send by November 2, 1998.

5. **Do These Special Protections Apply to All Medicare Beneficiaries?**

Beneficiaries: Medigap rights are guaranteed to individuals age 65 and over whose prior coverage is terminated. In States where Medigap insurance is sold to individuals under age 65, beneficiaries eligible for Medicare due to disability or end stage renal disease have the same protections as the elderly.

Insurers: Medigap insurers must make plans "A", "B", "C", and "F" that the insurer sells to new enrollees, available to all beneficiaries whose Medicare managed care plans are terminated or not renewed. Issuers now offering these policies to beneficiaries entitled to Medicare due to disability must make the same policies available to disabled beneficiaries whose plans have terminated their Medicare contracts.

However, this provision does not require issuers to begin to offer Medigap policies that they do not currently sell. In addition, it does not require insurers which do not now sell policies to disabled beneficiaries under age 65 to begin selling to those individuals. The beneficiary protections included in the Medigap law do not distinguish between individuals eligible for Medicare based on age and those whose eligibility is based on disability or end stage renal disease.

6. **Supplemental Coverage Through a Former Employer.** Beneficiaries who have coverage with a Medicare HMO through their former employer should consult with their former employer's retirement office before making any changes.
7. **Possibility of Seeing the Same Doctor as Before.** Beneficiaries who choose to return to the Original Medicare Plan may be able to continue to see the same physicians that they had seen through the HMO because most HMO physicians (except those in staff or group model HMOs) also provide services under the Original Medicare Plan. If there are other Medicare-contracting HMOs or other Medicare + Choice plans in their geographic area, some of

their current physicians may also participate with those plans.

8. **Information on Other Medicare HMOs.** On November 2, comparative information on Medicare-contracting HMOs and other Medicare + Choice plans that plan to contract with Medicare for 1999 will be available on the worldwide web at www.medicare.gov under "Medicare Compare". Information can be accessed by zip code or by state and county. Some plans are available only in certain counties within a state or zip codes within a county. Many libraries and senior centers can help beneficiaries obtain information from this source.
9. **General Assistance for Medicare Beneficiaries on Health Insurance Matters.** Beneficiaries can contact their State Health Insurance Assistance Program (SHIP) for assistance; they can also contact the U.S. Administration on Aging (AoA) central toll-free number (1-800-677-1116) to be referred to their local area agency on aging.

Status of Medicare Managed Care Non-Renewals as of October 21, 1998

SUMMARY OF RISK CONTRACTS

- 42 risk contracts (health plans paid on a prepaid capitation basis) are non-renewing their Medicare contracts, affecting 201,047 beneficiaries. These plans have participated in the program for 1 to 5 years, with an average of about three and one-half years.
- 53 risk contracts are reducing their service areas, affecting 219,318 beneficiaries. These plans will continue to serve other parts of their current service areas.
- A total of 420,365 beneficiaries (about 7 percent of total risk enrollment) are affected by non-renewals and service area reductions in 372 counties. Of these, 39,096 beneficiaries are in 123 rural counties. There are 3,223 counties in the country, of which 1,122 currently have risk contracts. A total of 28 states and the District of Columbia are affected by these risk contract non-renewals and service area reductions.

AREAS WITH NO MANAGED CARE OPTIONS

- 75 counties will have no other risk (or cost) plans available, affecting 50,974 beneficiaries -- less than 1 percent of current risk enrollment. Of these, 50 counties are rural, affecting 12,705 beneficiaries.
- At this time, there are three pending applications that will serve some of these areas.

PENDING APPLICATIONS

- There are 48 pending risk applications (43 Health Maintenance Organizations, 1 Preferred Provider Organization, 3 Provider Sponsored Organizations (PSO), and 1 PSO with an approved Federal waiver to state licensure). In addition, 25 current risk plans have requested an expansion of their service areas.

OTHER NON RENEWAL ACTIVITIES

- 5 cost contracts (health plans paid on a cost reimbursement basis) in 5 states are non-renewing in 40 counties, affecting 15,914 beneficiaries.
- 15 Health Care Prepayment Plans (Part B-only health plans) are non-renewing, affecting 18,014 beneficiaries.

- 2 Choices Demonstrations in 2 states are non-renewing, affecting 23,178 beneficiaries.

DRAFT October 23, 1998 11:35AM

Non-Renewal Questions and Answers

The Health Care Financing Administration (HCFA) is the Federal governmental entity that administers the Medicare program. This includes administration of Medicare risk-based contracts with health maintenance organizations (HMOs). Some of these plans have decided not to renew their contracts with HCFA to provide Medicare services to Medicare beneficiaries in certain states and selected counties.

The following discussion is designed to assist you in answering the most commonly asked questions arising from managed care plan non-renewals and service area reductions.

Q1 HMO plans are leaving Medicare. How do beneficiaries get information about whether this is true?

A1 Individuals affected by a termination will be receiving notification from the HMO no later than November 2, 1998.

Q2 Why are HMOs terminating their contracts with HCFA?

A2 HMOs are independent businesses that make business decisions to either participate or not participate in a contract with HCFA. HMOs voluntarily choose to enter into contracts with HCFA to serve Medicare enrollees. Each year HMOs have to make a choice to continue their contracts, adjust premiums and/or benefits, or not renew the contracts. Some HMOs have made business decisions to terminate their Medicare contracts in certain areas. In some cases, the termination of the contract was the result of the merger between the two plans where only one corporate entity will continue in the Medicare program.

Q3 Can the Health Care Financing Administration (HCFA) force Medicare HMOs to continue their contracts to provide services to Medicare beneficiaries?

A3 No. While HCFA is responsible for ensuring that contracting HMOs meet their contractual obligations, we do not influence their core business decisions, nor can we force them to stay in the Medicare program.

Q4 How are HMOs paid by the Federal government?

A4 HCFA pays HMOs a monthly amount for each enrolled Medicare member in exchange for providing all Medicare covered services to these members. The amounts vary from county to county and are determined based on a methodology prescribed in the statute. HCFA will make monthly payments to plans terminating their contracts through December, 1998. NOTE: \$379.84 is the lowest Federal government reimbursement rate for the aged allowed for 1999 by the Balanced Budget Act (BBA) of 1997. These rates are only the base rate and the actual payments to HMOs reflect adjustments to the base rate for factors like age, sex, etc.

Q5 **Are there any other HMOs in the affected areas that Medicare beneficiaries can join?**

A5 In most instances, there is at least one other managed care option available. Beneficiaries will receive a notification from the terminating HMO with a list of options along with an available Medicare supplement (Medigap) option no later than November 2, 1998.

Q6 **Are all HMOs terminating?**

A6 No. The changes for January 1999 only affect certain Medicare contracts.

Q7 **After a plan terminates, what health care coverage will be available for Medicare beneficiaries who were enrolled in these plans?**

A7 Many beneficiaries who are currently members of the terminating HMOs will be able to enroll in other Medicare managed care plans available in their area. Also, the Original Medicare Plan continues to be available to all Medicare-eligible individuals. Beneficiaries who return to the Original Medicare Plan and wish to purchase a Medicare supplement (Medigap) policy will have specific rights, discussed below. Each terminating HMO will be mailing a list of all health care options to its members by November 2, 1998.

Q8 **Is there anything that will be made available to individuals being terminated from an HMO, such as a Medicare supplemental (Medigap) insurance policy?**

A8 Plan enrollees have certain rights to new coverage, but these are time limited. The managed care plan is required to provide certain information to assist in making decisions about continuing managed care enrollment, or switching to original Medicare with Medigap to supplement the coverage. In general, individuals who are enrolled with a managed care plan that terminates its contract with Medicare have the right to guaranteed issue of any Medigap plans "A", "B", "C",

or "F" that are offered to new enrollees by issuers in the State. (Minnesota, Massachusetts and Wisconsin have special waivers that allow them to provide guaranteed issue of policies that are comparable to plans "A", "B", "C", and "F".

These rights apply to individuals by virtue of the involuntary termination of their coverage. However, certain Medicare beneficiaries in the terminating plans may have another, separate basis for entitlement to guaranteed issue of a Medigap policy. If a person had been enrolled in the managed care plan for fewer than 12 months, was never enrolled in any other Medicare HMO, and had a previous Medigap policy, that individual may return to the former Medigap plan if the previous Medigap insurance company still sells the policy in the State.

If coverage is not available under the previous Medigap plan, the individual may purchase Medigap plans "A", "B", "C", or "F" from any insurer which sells these plans in the State.

In these cases, the insurance company selling the policy may not:

- (1) deny or condition the sale of the policy,
- (2) discriminate in the pricing of the policy because of health status, prior history of claims experience, receipt of health care or medical condition, or
- (3) impose a preexisting exclusion for any condition.

However, the individual has only 63 days after coverage ends to select a Medigap insurer. Members should contact their State Health Insurance Assistance Program (SHIP) for further information.

Q9 What health coverage is available for members who are under the age of 65, and eligible for Medicare because of a disability?

A9 Beneficiaries: Medigap rights are guaranteed to individuals age 65 and over whose prior coverage is terminated. In States where Medigap insurance is sold to individuals under age 65, beneficiaries eligible for Medicare due to disability or end stage renal disease have the same protections as the elderly.

Insurers: Medigap insurers must make plans "A", "B", "C", and "F" that the insurer sells to new enrollees, available to all beneficiaries whose Medicare

managed care plans are terminated or not renewed. Issuers now offering these policies to beneficiaries entitled to Medicare due to disability must make the same policies available to disabled beneficiaries whose plans have terminated their Medicare contracts.

However, this provision does not require issuers to begin to offer Medigap policies that they do not currently sell. In addition, it does not require insurers which do not now sell policies to disabled beneficiaries under age 65 to begin selling to those individuals. The beneficiary protections included in the Medigap law do not distinguish between individuals eligible for Medicare based on age and those whose eligibility is based on disability or end stage renal disease.

Terminating HMOs must only make arrangements for Medigap insurance based on what is available in the local marketplace. Members should contact their local State Health Insurance Assistance Program (SHIP) for further information.

Q10 What if I dropped a Medigap policy before I joined this plan? Can I return to this Medigap policy? What happens if I do this before December 31, 1998?

A10 If a beneficiary was previously enrolled in a Medigap policy and this was the first managed care plan the beneficiary enrolled in since starting Medicare, the beneficiary has the right to return to the Medigap policy if:

1. the Medigap policy dropped is still being sold by the same insurance company;
 2. the beneficiary has not been enrolled in this managed care plan for more than 12 months;
 3. the beneficiary disenrolls from this plan before December 31, 1998;
- and
4. the beneficiary reapplies for that previous policy no later than 63 days after coverage from this plan terminates.

If the previous policy is no long available, the beneficiary is still guaranteed the right to buy a Medigap Plan designated "A", "B", "C", or "F" that is offered in that State. Before the beneficiary disenrolls, he or she should make sure the policy is still available from the original insurer before disenrolling from the plan.

Q11 Will members be able to keep prescription drug coverage, or is new coverage being made available?

A11 If a member currently has prescription drug coverage through a terminating HMO, this coverage will also end December 31, 1998. Members have the option to enroll in other managed care plans available in their area which may cover prescription drugs. However, the Medigap policies that must be made available to members of terminating HMOs (plans "A", "B", "C" and "F") do not include prescription drug coverage. Similarly, the requirement that terminating HMOs make certain supplemental coverage available does not require them to make arrangements that include prescription drug coverage. Medicare supplemental plans that contain prescription drug coverage are available, but members must seek them out on their own. These plans may refuse to sell a policy based on health status, and may impose waiting periods for pre-existing conditions.

Q12 How soon will a decision need to be made for new health care coverage?

A12 Members may remain enrolled in their HMOs until December 31, 1998, or they may disenroll from their HMOs and return to the original Medicare plan before December 31, 1998 (As noted above, this decision may affect which Medigap options are available). It is recommended that members apply for a Medicare supplemental (Medigap) plan as soon as possible, in order to have Medigap coverage begin when the beneficiary returns to the Original Medicare Plan on January 1, 1999. However, as long as members apply within 63 days after HMO coverage terminates on December 31, 1998, their rights to get a new Medigap policy will be protected.

Members currently enrolled in an HMO who have Part B only and who wish to enroll in another Medicare managed care plan must do so no later than December 1 in order to ensure they can continue to be enrolled in a Medicare managed care plan option. The Balanced Budget Act does not allow beneficiaries with Part B-only coverage to enroll in a Medicare + Choice health plan option.

Q13 What are the benefits under the Original Medicare Plan?

A13 Beneficiary focused information, including an explanation of Medicare benefits, is
available at www.medicare.gov.

Q14 Will members be able to go to their same doctors?

A14 For those members returning to the Original Medicare Plan it is very likely

that they will be able to continue seeing the same doctors and other providers as they had seen through the HMO. Most physicians also participate in the Original Medicare Plan. Members need to check with their doctor and other providers to find out. If the providers participate in Medicare, there is no need for a change. If a member chooses to enroll in a new Medicare HMO, he or she may need to select a new primary care physician (PCP) and begin using a new network of providers. Before making a decision to enroll in a new health plan option, the member should check with each managed care plan.

Q15 What happens if a currently enrolled member, who is hospitalized prior to January 1, 1999, is still a hospital inpatient after January 1?

A15 Most participating acute care hospitals are paid by Medicare based on the Prospective Payment System (PPS); non-PPS hospitals operate only in the state of Maryland. Other hospitals, like rehabilitation hospitals, free-standing psychiatric hospitals, and long-term care hospitals, are paid on a cost basis and not under PPS. For PPS hospitals, the HMOs will continue to be responsible after December 31, 1998, for inpatient hospital charges until the member is discharged. For non-PPS hospitals and for other charges, such as physician charges, related to inpatient PPS hospital stays after December 31, 1998, the original Medicare plan will be responsible for payment, minus normal deductible and copayment amounts. Members with Medicare supplemental insurance may have these deductible and copayment amounts paid by their Medigap policy.

Q16 What if a currently enrolled member is receiving other services at home? How can he or she receive assistance during this transition?

A16 Members who are currently receiving ongoing care, such as home health care, or who are using medical equipment, such as oxygen or wheelchairs, need to call the phone number shown on their HMO identification card and ask for Utilization Management (UM) when they are ready to change insurance plans. UM will help members make the change to receive care under the Original Medicare Plan or under a new managed care option. Members who select a new HMO should contact that HMO as soon as possible and ask for the UM department. Members who elect to return to the Original Medicare Plan should instruct their providers to bill Medicare directly after January 1, 1999.

Q17 What happens if a member needs to get additional information after January 1, 1999?

A17 HCFA requires HMOs to provide appropriate assistance to their members for

as long as necessary. Individuals can also contact their State Health Insurance Assistance Program (SHIP) for additional assistance.

Q18 Does a current member of a terminating HMO have to wait until January 1, 1999 to change his or her Medicare coverage?

A18 No. If a member chooses to enroll in another Medicare managed care plan prior to January 1, 1999, that enrollment will automatically disenroll the member from his or her HMO. If a member chooses to disenroll and go to the Original Medicare Plan before January 1, 1999, the member must submit a request to disenroll in writing to the plan or go to the local Social Security District Office; disenrollment will be effective through the end of the month in which the plan or Social Security Office receives the request. If the member takes no action, the member will be returned to the Original Medicare Plan on January 1, 1999.

Q19 How can members receive additional assistance or more information about their choices?

A19 Individuals can contact their State Health Insurance Assistance Program (SHIP). The following agencies can also give beneficiaries information on Medicare supplemental insurance plans and help with other health care decisions.

- County Aging Services
- Senior Centers
- Area Agencies on Aging
- State Insurance Departments
- The U.S. Administration on Aging
- HCFA Regional Offices

DRAFT October 23, 1998 11:42AM

MEDICARE SUPPLEMENTAL INSURANCE

Questions and Answers about Managed Care Plans Non-Renewals

A Medicare supplement policy, also known as Medigap insurance, is an insurance policy offered by a private entity (insurance company or association) to individuals entitled to have benefits paid by the Original Medicare Plan. Medigap pays for certain expenses incurred for services or items for which payment may be made by the Original Medicare Plan but which are not reimbursable because of deductibles or coinsurance. A Medigap policy may also pay for certain items or services not covered by Medicare at all, such as prescription drugs. Medigap only works with the Original Medicare Plan. It will not cover out-of-pocket expenses, such as copayments, in a managed care plan.

The following is designed to assist you in answering the most commonly asked questions arising from managed care plan terminations and service area reductions.

What Happens If Your Managed Care Plan Terminates Coverage in Your Area Because it Does Not Continue in the Medicare Program?

If your health plan will no longer continue its contract with the Medicare program to provide health care to Medicare beneficiaries, the following alternatives are available to you:

1. You may remain enrolled in the non-renewing health plan until the end of the contract period. If you choose this option, you need take no further action; you will automatically be disenrolled from the plan and returned to the Original Medicare Plan as of the effective date of the health plan's termination. Until your disenrollment from the non-renewing health plan is effective, you must continue to use health plan providers.
2. You may join another managed care plan in your area that contracts with the Medicare program. If you choose this alternative before the end date of your coverage, you will automatically be disenrolled from the non-renewing health plan when you enroll in the new HMO. Health plan(s) in your area that have contracts with Medicare will be identified for you. They are required to accept your enrollment. Contact these plans concerning benefits and premiums in order to make the best selection for your personal needs.
3. You may disenroll from the non-renewing health plan and return to the Original Medicare Plan before your coverage terminates. If you choose this

option, you may disenroll by notifying the non-renewing health plan. You may also disenroll by writing to or visiting your local Social Security office or your local Railroad Retirement office if you are a railroad retiree. You will be disenrolled effective the first day of the month following the month in which you requested disenrollment. For example, if you request disenrollment on November 20th, you will be returned to the Original Medicare Plan effective December 1.

If I Choose to Enroll in the Original Medicare Plan, Can I Purchase a Medigap Policy?

Yes. If you return to the Original Medicare Plan, you may wish to purchase a Medigap policy. A Medigap policy requires an additional monthly premium and will pay for some of your out-of-pocket costs which are not covered under the Original Medicare Plan. Your non-renewing plan has a legal obligation to arrange for you to be protected against any pre-existing condition exclusions under a Medigap policy for up to six months after the plan terminates your coverage. The plan may do this in a number of ways. The plan must notify you of what arrangements it has made for such coverage no later than November 2, 1998.

Some plans will identify a Medigap insurer, and the insurer will waive (i.e., not apply) the waiting period for coverage of pre-existing conditions. You may then enroll for the new policy between specific dates identified by the non-renewing managed care plan. Your Medigap insurance will have an effective date that should coincide with the ending of the plan's Medicare contract so that you will have continuous coverage.

May I Shop Around for a Medigap Policy Rather Than Accept the One Chosen by the Non-renewing Plan?

Yes. A beneficiary is free to shop for a Medigap policy that meets his/her needs and provides coverage at the lowest premium available.

Are There Any Protections for a Person Who Chooses a Medigap Policy Other than the One Chosen by the Non-renewing Plan ?

When the plan terminates, participants have certain rights, but must exercise them within 63 days after coverage terminates. If a person enrolls in a Medigap policy within 63 days, the seller or issuer of that policy may not:

- (1) refuse to sell the person any Medigap policy designated A, B, C or F that the issuer sells in the State;

(2) discriminate in the pricing of such policy because of health status, claims experience, receipt of health care, or medical condition, or

(3) impose a pre-existing condition exclusion

Further information is available from each State's insurance department or State Health Insurance Assistance Program.

How Do I Go about Finding a Medigap Insurer?

Begin your inquiries as soon as you receive the non-renewing plan's notice of termination. This way, you will have time to find the best coverage to meet your needs and have it go into effect on the day following the effective date of your non-renewing plan's termination from the Medicare program.

Your best course of action in such situations is to contact your State Health Insurance Assistance Program (SHIP) or State insurance department. Your SHIP has been trained to assist you in resolving situations like these. The telephone number for the SHIP in your state is available on www.medicare.gov. To find out about your state's health insurance assistance program, check the State Government listing in your telephone book, and contact your State's Office on Aging or Insurance Commission.

Do These Special Protections Apply to All Medicare Beneficiaries?

Beneficiaries: Medigap rights are guaranteed to individuals age 65 and over whose prior coverage is terminated. In States where Medigap insurance is sold to individuals under age 65, beneficiaries eligible for Medicare due to disability or end stage renal disease have the same protections as the elderly.

Insurers: Medigap insurers must make plans "A", "B", "C", and "F" that the insurer sells to new enrollees, available to all beneficiaries whose Medicare managed care plans are terminated or not renewed. Issuers now offering these policies to beneficiaries entitled to Medicare due to disability must make the same policies available to disabled beneficiaries whose plans have terminated their Medicare contracts.

However, this provision does not require issuers to begin to offer Medigap policies that they do not currently sell. In addition, it does not require insurers which do not now sell policies to disabled beneficiaries under age 65 to begin selling to those individuals. The beneficiary protections included in the Medigap law do not distinguish between individuals eligible for Medicare based on age and those whose eligibility is based on disability or end stage renal disease.

Health Care Financing Administration's Beneficiary Information and Outreach Strategy for Managed Care Plan Service Terminations and Service Area Reductions

To ensure that each managed care beneficiary facing the non-renewal of his or her current health plan is informed of the available health plan options, HCFA has developed an aggressive Beneficiary Information and Outreach Strategy structured around six strategies used in the National Medicare Education Program (NMEP). In addition, HCFA has prepared a model letter that non-renewing health plans must disseminate to all affected beneficiaries.

The six NMEP strategies included in HCFA's managed care information and outreach strategy are: meeting the needs of individual beneficiaries, enlisting and training partners, providing toll-free telephone service, conducting special information campaigns, and utilizing print media and the Internet as a means of distributing information.

HCFA's actions include:

- distributing a model notification letter to non-renewing health plans for dissemination to all affected beneficiaries. The notification letter includes information regarding: how beneficiaries may return to the Original Medicare Program; other Medicare managed care options (where applicable) and enrollment processes; potential referrals for additional information, (i.e., State Health Insurance Assistance Programs, the HCFA Regional Offices, an automated Medicare Special Information Number); and Medigap.
- distributing managed care termination and service area reduction information and a set of questions and answers which address enrollment and supplemental insurance for beneficiaries affected by plan changes on the Medicare Internet site, www.medicare.gov.
- providing information to partners, including the Social Security Administration, the State Health Insurance Assistance Programs, and other NMEP partners regarding managed care termination issues. HCFA has scheduled a meeting of the NMEP coordinating committee and advocacy groups on October 8, 1998.
- educating all call center personnel, including Medicare + Choice Call Center personnel, about beneficiary issues resulting from managed care terminations and service area reductions. The Medicare Call Center will become operational in the five pilot states (i.e., Arizona, Florida, Ohio, Oregon, and

Washington) on November 2, 1998.

- updating the Medicare Compare Data Base with fiscal year 1999 Medicare health plan data during the first week of November. The Medicare Compare data base is located on the Internet at www.medicare.gov.

DRAFT October 23, 1998 11:45AM

MEDICARE SUPPLEMENTAL INSURANCE

GENERAL INFORMATION

What Is Medicare Supplemental Insurance?

A Medicare supplement policy, also known as Medigap insurance, is an insurance policy offered by a private entity (insurance company or association) to individuals entitled to have benefits paid by the original Medicare plan. Medigap pays for certain expenses incurred for services or items for which payment may be made by the original Medicare plan but which are not reimbursable because of deductibles or coinsurance. A Medigap policy may also pay for certain items or services not covered by Medicare at all, such as prescription drugs. Medigap only works with the original Medicare plan. It will not cover out-of-pocket expenses, such as copayments, in a managed care plan.

Coverage sponsored by an employer or labor union may also supplement Medicare, but is not Medigap insurance. Medigap also does not include managed care entities, or new forms of Medicare + Choice coverage.

Why Do Beneficiaries Want or Need Medigap?

On average, Medicare covers about 45 percent of health expenditures of the elderly.

Under the original Medicare plan, beneficiaries are subject to the following out-of-pocket costs:

- o **Medicare Premiums.** (All beneficiaries must pay for Part B, unless they are eligible for a State Medicaid program to cover the premium. Some beneficiaries must also pay a premium for Part A.)
- o **Cost-sharing** (Under Original Medicare, this refers to the Medicare coinsurance and deductibles. These apply when Medicare covers an item or service, but does not pay for the entire cost.
- o **Non-covered services.** (These are services which Medicare does not cover at all. These include prescription drugs; emergency coverage outside the U.S., eyeglasses, hearing aids, routine physicals, inpatient

hospital costs after the maximum number of days of Medicare coverage has been exceeded, and the costs of long term care.)

All Medigap policies pay for some or all beneficiary cost-sharing expenses, and certain Medigap policies will pay for specific non-covered services. Medigap policies do not pay for Medicare premiums, and they only cover certain types of non-covered services. For example, no Medigap policy pays for long term care.

When Do Beneficiaries Enroll?

All Medicare beneficiaries are entitled to a one-time, six-month open enrollment period during which they have the right to purchase any Medigap policy sold in their State, regardless of any health problems they have. In most cases this period begins when the beneficiary turns 65 and enrolls in Part B. For beneficiaries who enrolled in part B based on disability, the open enrollment period begins when they reach age 65. For beneficiaries who postpone enrollment in Part B after age 65 because they are still employed, the open enrollment period begins when they enroll for Part B. All Medigap policies are guaranteed renewable. This means that they continue in force as long as the premiums are paid.

There are also more limited periods during which certain beneficiaries are guaranteed the right to buy certain Medigap policies. These are triggered by specific events, such as termination of a beneficiary's other health coverage. These rights are discussed in detail below. Outside of these specific open enrollment and guarantee issue periods, federal law does not prohibit a Medigap insurer from refusing to sell policies to individuals based, for example, on their health status.

What are the Standard Medigap Policies?

Except as provided below, there are 10 standard Medigap plans. In other words, there are ten different combinations of benefits that Medigap policies may include. Each combination, or Medigap "plan", is designated by one of the letters "A" through "J". For any particular Medigap plan, all insurance companies must use the same format, language and definitions. However, premiums can vary greatly from one insurance company to the next for the same grouping of benefits. Premiums vary with age, type of plan, the State in which the policy is purchased, and insurance carrier claims experience.

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administratively;

we could say if they're offered to anyone, we could say they have to give to disabled. (possible; Bob Williams) (defined times only)

narrower interpretation in the letter.

We weren't referencing DVST Medigap; we were referencing this particular instance re: dropping.

Chip → BC/BC & HIAA → they think our position is okay now.

① we don't have authority to create market where none existed

② even if we did, we'd need
a reg.

PHOTOCOPY
PRESERVATION

Robert Kuttner

Bad Medicine for The Elderly

Health maintenance organizations began signing up large numbers of elderly people in the 1990s. The government agreed to pay these Medicare HMOs 95 percent of what an average senior citizen cost conventional Medicare. In return, the Medicare HMO provided additional coverage such as drug benefits.

How could the HMO provide more benefits for less money? Supposedly by carefully coordinating care, an HMO could outperform conventional Medicare (which allows free choice of doctor and hospital) and still earn a profit.

But now, HMOs are abandoning seniors in droves. They're either dropping their Medicare programs outright or getting rid of the unlimited drug benefits. What happened?

It turned out that HMOs were not really all that much more efficient at treating the sick. Cancer is cancer; a stroke is a stroke, and these conditions are expensive to treat, in whatever venue. Mainly, Medicare HMOs were highly efficient at targeting relatively healthy oldsters. They used devices such as health clubs and commercials showing youthful, vigorous 65-year-olds. The fiction was that the health club represented the HMOs' commitment to preventive care.

The reality was that the health club was a near-perfect market-stratification device. Not too many 90-year-olds with multiple illnesses seek health clubs.

Another problem is that the Medicare program allows seniors to switch back and forth between HMOs and conventional Medicare. Many seniors found their HMOs were making it difficult for them to get the treatment they needed. So when they became seriously ill, they switched back to conventional Medicare. Many for-profit HMOs cynically encouraged this out-migration of the sick.

Government's conventional Medicare program, in effect, was getting stuck with the sickest and most costly group of oldsters, while for-profit HMOs were making tidy

**"Not too many
90-year-olds with
multiple illnesses seek
health clubs."**

profits from the healthier ones. So in the 1997 Balanced Budget Act, Congress put a stop to the gravy train and cut back what it paid Medicare HMOs. Many HMOs, in response, decided to cut benefits or to dump senior coverage entirely.

Now what?

Tens of millions of the elderly will be left with conventional Medicare, a good program as far as it goes, but which has significant gaps such as a lack of drug coverage. Many seniors with serious medical conditions get costly prescriptions from their doctors—that they can't afford to fill. Millions of sick, elderly people choose between medicine and food.

So-called Medigap insurance covers what Medicare doesn't, but it is too expensive for most elderly people. Other seniors will be marooned in the remaining Medicare HMOs that rigidly restrict what care they will provide and now no longer pay for crucial benefits such as prescription drugs.

It gets worse. Congress, prodded by insurance industry lobbyists, agreed to further complicate the Medicare program. The same Balanced Budget Act allowed industry to devise an even wider proliferation of insurance "products" aimed at seniors, to be underwritten by Medicare. And after the year 2003, the senior citizen who selected one of these plans will be locked in, no longer able to switch back to conventional Medicare.

Unfortunately, the intricacies of health insurance are already far too complex. Many old people, even the healthy ones let alone the sick and those with memory lapses, have inordinate difficulty keeping track of insurance intricacies. It is almost sadistic to complicate their lives further.

A recent study in the journal *Health Affairs* surveyed old people to test their understanding of the differences between conventional Medicare and Medicare HMOs. On many questions, the survey reported, the accuracy of responses was less than what would have been produced by random guesses.

For example, only 33 percent of respondents who had Medicare could accurately answer the question, "In a life-threatening situation, a patient can go to the nearest hospital emergency room and the visit will be covered. Does this best describe regular Medicare, an HMO, both or neither?" (The correct answer is both, but the HMO is likely to have stricter definitions of a covered emergency.)

The solution is to stop this fragmentation and profiteering and improve universal Medicare. For \$20 billion, Medicare could cover prescription drugs. Amazingly, this is resisted by the pharmaceutical industry, which fears Medicare coverage will bring steep price discounts (which it would and should).

Basically, the Medicare-HMO experiment has failed. It was always more an enterprise in market-targeting than integrated case management.

Old folks do need careful management by a primary-care doctor, but they can get that under regular Medicare. Ironically, managed care under for-profit auspices often has increased the system's fragmentation. We've learned once again that profiteering and good medicine just don't mix.

The writer is co-editor of The American Prospect.

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