TO: **NAIC Members**

FROM: **Commissioner Kevin McCarty**
Chair, Senior Issues (B) Task Force

DATE: **March 8, 2010**

RE: **Questions and Answers Regarding Implementation of Medicare Supplement Plan N Copayment, Deductible and Coinsurance**

As you know, Medicare supplement insurance plans and benefits have been updated in accordance with recent revisions to the NAIC Medicare supplement model regulation and the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). Section 9.1E(11) of the NAIC model provides that new Medicare supplement Plan N will include a copayment structure. As states and companies are working towards implementation of these new changes (which apply for policies with effective dates on or after June 1, 2010), a number of questions have arisen regarding implementation of the new Plan N copayment, deductible and coinsurance requirements.

> **Plan N Requirements:**
> **Section 9.1E(11) of NAIC Model Regulation 651 (as published in the Federal Register on April 24, 2009 (see page 18823) states:**
> **(11) Standardized Medicare supplement Plan N shall include only the following**: The basic (core) benefit as defined in Section 8.1B of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in Sections 8.1C(1), (3) and (6) of this regulation, respectively, with copayments in the following amounts:
>
> (a) the lesser of twenty dollars ($20) or the Medicare Part B coinsurance or copayment for each covered health care provider office visit (including visits to medical specialists); and
> (b) the lesser of fifty dollars ($50) or the Medicare Part B coinsurance or copayment for each covered emergency room visit, however, this copayment shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense.

In order to ensure consistent implementation of this new standardized benefit Plan N, the Senior Issues Task Force, in conjunction with the Centers for Medicare and Medicaid Services (CMS), has developed the following questions and answers as guidance. This information will also be provided to Medicare supplement carriers. References to CPT codes and Medicare procedures in this document have been reviewed by CMS, but are subject to change as Medicare rules and coding may change.

If you have any questions, you may contact Jane Sung at the NAIC for matters relating to the NAIC model regulation or related issues at (202) 471-3979 or jsung@naic.org, or Jay Dobbs at CMS for matters relating to Medicare procedures and coding at (410) 786-1182 or jay.dobbs2@cms.hhs.gov.

Questions and Answers:

Deductible

1. **Question:** Will payment of the Medicare Part B deductible by the beneficiary when the beneficiary has a Plan N policy operate the same way as FFS Medicare, in that the beneficiary pays coinsurance or a copayment for the Medicare-approved amount for services only after meeting the Part B deductible?
   Answer: Yes, the Plan N subscriber is responsible for meeting the deductible before any coinsurance or copayment is collected. Once the deductible is met, the subscriber is responsible for up to $20 per office visit and up to $50 for an emergency room visit.

Office Visit Coinsurance or Copayment

2. **Question:** Under Plan N, what constitutes an "office visit" for purposes of determining whether the subscriber is subject to the Part B coinsurance or copayment of up to $20?
   Answer: Services coded by providers in Part B billings as office visits, office consultations, or evaluation and management visits would be considered "office visits" for purposes of determining whether the subscriber is subject to the Plan N Part B coinsurance or copayment of up to $20. These include CPT-4 codes 99201 – 99205 and 99211 – 99215. (Note: consultation codes have been deleted from the 2010 Physician Fee Schedule.)

3. **Question:** When applying the Plan N physician office copayment or coinsurance, should the amount be applied only to the office visit charge and not to other charges such as laboratory, x-ray or durable medical equipment (DME)?
   Answer: Yes, the coinsurance or copayment should be applied only to CPT-4 codes 99201 – 99205 and 99211 – 99215, which are codes used to bill an office visit.

4. **Question:** If the Plan N subscriber presents for multiple Medicare-covered office visits in one day, is the coinsurance or copayment applicable to each office visit?
   Answer: Yes, the coinsurance or copayment is applicable to each Medicare-covered office visit.

5. **Question:** What are the CPT-4 codes applicable to physician specialty office visits for Plan N?
   Answer: There are no office visit codes used solely for visits to specialists. CPT-4 codes 99201 – 99205 and 99211 – 99215, which apply to non-specialty office visits, also apply to the Plan N specialty office visit coinsurance or copayment.

6. **Question:** Would online, telephone or telehealth services constitute "office visits" for purposes of determining whether a Plan N subscriber is subject to the Part B coinsurance or copayment of up to $20?
   Answer: No, providers do not code these services as office visits, office consultations or evaluation and management visits in their Part B billings. Therefore, these services would not be subject to the Plan N coinsurance or copayment.

Emergency Room Coinsurance or Copayment

7. **Question:** Does the Plan N emergency room (ER) coinsurance or copayment apply to the physician professional fee charges, the ER facility fees, or both the ER and the physician office visit coinsurance or copayment?
   Answer: The Plan N ER coinsurance or copayment applies to the total Medicare Part B coinsurance or copayment patient responsibility amount as shown in the remittance advice.

8. **Question:** Is a Plan N subscriber subject to both the Plan N physician professional fee charge coinsurance or copayment of up to $20 and the emergency room facility coinsurance or copayment of up to $50 as a result of a covered emergency room visit that does not result in an inpatient hospital admission?
   Answer: No, the beneficiary is subject to one Plan N emergency room coinsurance or copayment of up to $50 based on the total Part B coinsurance liability.

9. **Question:** When is the Part B emergency room coinsurance or copayment of up to $50 waived for a Plan N subscriber?
   Answer: If a Plan N subscriber is admitted to an inpatient facility subsequent to the ER visit, and the care is paid under a Medicare Part A hospital inpatient stay, then the Plan N ER coinsurance or copayment must be waived. If the emergency room visit, including physician and facility outpatient charges are paid under Part B, as they will be when the subscriber is not admitted to an inpatient facility, then the Plan N Part B coinsurance or copayment of up to $50 will apply.

10. **Question:** If the Plan N subscriber presents for multiple Medicare-covered ER visits in one day and is not admitted, is the ER coinsurance or copayment applicable to each visit?
    Answer: Yes, the Plan N ER coinsurance or copayment of up to $50 is applicable to each Medicare-covered visit.

11. **Question:** Is the Plan N ER or office visit coinsurance or copayment applicable to Urgent Care facilities?
    Answer: No. Since a visit to an Urgent Care facility is not coded as either an office visit or an ER visit and has a unique code, the Plan N copayment or coinsurance for either the office visit or ER visit does not apply to visits to an Urgent Care facility.

12. **Question:** Under Plan N, why is there a greater coinsurance or copayment for emergency room visits than for office visits?
    Answer: The intent of having a greater coinsurance or copayment for emergency room visits is to encourage office visits where they are appropriate and discourage unnecessary emergency room visits.