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Title: Medigap Bulletin Series – INFORMATION

Subject: Medigap Coverage of Outpatient Mental Health Services That Are Subject to the Mental Health Payment Reduction

Market: Medigap

I. PURPOSE

This bulletin clarifies a Medigap issuer's coinsurance obligation with respect to Medicare Part B outpatient mental health services that are subject to the mental health payment reduction required by section 1833(c) of the Social Security Act (the Act). In doing so, it explains why the Medigap issuer is generally responsible for 50 percent of the Medicare "allowed amount" for these services.

II. BACKGROUND

A. Evolution of NAIC Model Standards

Congress first established voluntary Federal Medigap standards in 1980. In order to meet these standards, which were set forth in the National Association of Insurance Commissioners (NAIC) Model Regulation and incorporated by reference into the Federal statute, [i] all Medigap policies were initially required to pay "the 20 percent coinsurance" for Part B Medicare eligible expenses (after the Part B deductible was satisfied). However, under those standards, policies were permitted to contain an exclusion for "mental or emotional disorders, alcoholism and drug addiction."

In December 1989, pursuant to the Medicare Catastrophic Coverage Repeal Act of 1989 (MCCRA), the NAIC changed the Model Regulation to delete the reference to "20 percent," and to require Medigap issuers to pay "the" coinsurance amount for all Part B Medicare eligible expenses.[ii] This change was made at CMS's (then HCFA's) request, to reflect that Medicare does not always pay 80 percent of Part B Medicare eligible expenses.

In July 1991, Congress enacted **mandatory** Federal Medigap standardization requirements as part of the Omnibus Budget Reconciliation Act of 1990 (OBRA'90). The NAIC modified the model in accordance with the statute, and eliminated a number of exclusions that were previously permitted in Medigap policies.[iii] Among these was the exclusion for mental or emotional disorders. The NAIC also created the 10 standard Medigap plans, which are described in section 8 of the NAIC Model Regulation, as adopted in July 1991. Plan A contains a set of core benefits that must be included in all the other plans. One of the core benefits is payment of "the" coinsurance amount for all Part B Medicare eligible expenses. Subsequently, a technical

correction was also made to the outline of coverage to reflect that Medicare "generally" pays 80 percent of the Medicare approved amount; that the policy "generally" pays 20 percent of the approved amount, and that the policyholder always pays $0 (zero dollars).

For transitional purposes, in 1991, the NAIC retained the existing section 7 of the most recent version of the Model Regulation (as adopted on December 13, 1989) to govern policies issued prior to implementation of the OBRA'90 standards. Section 7.B (6) thus incorporates the 1989 benefit description that requires payment of "the" coinsurance amount for Part B Medicare eligible expenses.

B *Medicare Payment for Outpatient Mental Health Services*

1. Payment Reduction Overview

For most covered Part B expenses, pursuant to section 1833(a) of the Act, Medicare pays 80 percent of the Medicare allowed amount, leaving the beneficiary responsible for the remaining 20 percent. However, section 1833(c) of the Act requires an intermediate step for certain outpatient mental health services.[iv] After the allowed amount is calculated, the Medicare carrier or fiscal intermediary applies the statutorily mandated payment reduction, leaving only 62 ½ percent of the allowed amount, to which it then applies the general 80 percent payment rule.[v] The result is that Medicare pays only 50 percent of the allowed amount. [vi]

Due to this reduction, the beneficiary is responsible, after the Part B deductible has been met, for 50 percent of the Medicare allowed amount. In addition, the beneficiary is responsible for any balance billing above the Medicare allowed amount up to the limiting charge for physician services that are not under assignment.[vii]

2. Relevant Provisions & Terminology

Some of the confusion about this issue arises because there are several relevant provisions, all of which use somewhat different terminology. All standardized Medigap policies issued since 1992 are required to cover "the coinsurance amount of Medicare eligible expenses under Part B."[viii] The term "coinsurance" is not defined in the NAIC model regulation, or in Medicare law or regulations, and therefore, as discussed below, can be given its common meaning – the beneficiary's liability.[ix]

The term "Medicare eligible expenses" is defined in section 5G of the NAIC Model Regulation as "expenses of the kinds covered by Medicare, to the extent recognized as reasonable and medically necessary by Medicare." Thus there are three elements to determining the Medicare eligible expense: (1) The service must be a kind of service that is coverable under Medicare's coverage rules; (2) a payment methodology is applied by a Medicare carrier or fiscal intermediary to determine the Medicare "allowed amount" (at the time the NAIC Model was drafted, this was generally based on a "reasonable" charge, although it is now commonly based on a fee schedule); and (3) the service must be determined by a Medicare carrier or fiscal intermediary to be medically necessary for the particular individual.[x]

The allowed amount is the amount that would be paid by Medicare, but for the application of deductibles and coinsurance or other payment limitations. This is the amount that is paid to a provider who accepts assignment. If a provider who does not accept assignment charges more

than this amount, it is referred to as "balance billing" of the "excess charges" (over and above the allowed amount).

The NAIC Model Regulation also requires standardized policies to include a prescribed "outline of coverage" that allows beneficiaries to compare policies. As was noted above in Section II of this bulletin, the outline of coverage uses the term "approved amount" to refer to the Medicare "allowed amount." In the case of medical expenses under Part B, the outline of coverage says –

Remainder of Medicare Approved Amounts [After payment of first $100 of Medicare Approved Amounts]	Medicare Pays	Plan Pays	You Pay
	Generally 80%	Generally 20%	0

Therefore, for most Medicare covered Part B medical expenses, Medicare pays a full 80 percent of the allowed amount, and the coinsurance is the remaining 20 percent of the allowed amount. However, the result is different in the case of certain outpatient mental health services. For those services, section 1833(c) of the Act requires the carrier or intermediary to apply a special payment reduction **after** it calculates the allowed amount, but **before** it takes 80 percent of the result in order to determine the actual Medicare payment amount.

Regardless of what Medicare actually pays, under the NAIC Model the Medigap issuer's obligation to the policyholder is to pay "the coinsurance amount of Medicare eligible expenses under Part B." In this case, it is the allowed amount (not the reduced amount) that meets the NAIC definition of a Medicare eligible expense. This is because outpatient mental health services are a "kind" of expense covered by Medicare and the allowed amount is what Medicare determines to be "reasonable and medically necessary." **Therefore, for purposes of this bulletin, the allowed amount, the approved amount, and Medicare eligible expenses all refer to the same thing. Because the allowed amount is determined before the payment reduction is applied, then regardless of the label, the portion of Medicare eligible expenses that is not paid by Medicare becomes the coinsurance amount.**

The Medicare regulations make clear that this is the way the reduction is applied. The outpatient mental health limitation appears in 42 CFR 410.155. Subparagraph (c) provides an example that clearly lays out the steps. Step 2 of the example shows that the approved (allowed) amount is calculated before the payment reduction is taken. The beneficiary liability is clearly 50 percent of the allowed amount.

III. COINSURANCE PAYMENT RESPONSIBILITIES OF STANDARDIZED POLICIES

All Medigap policies issued pursuant to the OBRA'90 revisions to the NAIC Model (i.e., generally those issued after July 30, 1992) must cover mental health services because exclusions for "mental or emotional disorders" are no longer permitted. For the reasons explained in this bulletin, such policies must pay, as a standardized benefit, the entire beneficiary share, generally 50 percent of the total Medicare allowed amount for outpatient mental health services after the Part B deductible has been met.[xi] This means that the Medigap issuer is responsible for paying **both** the 37.5 percent of the allowed amount that results from the application of the mental health payment reduction **and** the 12.5 percent that remains after Medicare applies the 80 percent payment rule to the reduced amount.

In those states that implemented the July 30, 1991 NAIC standards prior to July 30, 1992, all Medigap policies issued on or after the date the state implemented the NAIC standards must comply with the requirements. Issuers may also have filed standardized policies prior to state adoption of the OBRA'90 standards and are thus subject to this rule by virtue of their policy language. Standardized policies that cover the Part B deductible and/or Part B excess charges, must, of course, also pay these benefits per the terms of the policy.

IV. COINSURANCE PAYMENT RESPONSIBILITIES OF PRESTANDARDIZED POLICIES

Medigap policies issued prior to the implementation of the 1991 NAIC standards may have contained exclusions for "mental or emotional disorders," if permitted under state law. If the policy does not expressly exclude coverage for services for mental or emotional disorders then the issuer is responsible for the Part B coinsurance amount, as interpreted under state law.

V. EMPLOYER GROUP HEALTH PLANS, EMPLOYER AND LABOR SUPPLEMENT POLICIES

Group health plans, employer supplements, and labor organization supplement plans are not true Medigap plans. They are not subject to Federal Medigap standards. Policies under these plans are governed by the terms of their particular contracts and may exclude coverage for outpatient mental health services.

VI. ENFORCEMENT

In the event CMS receives a complaint about an issuer engaging in practices that may constitute a violation of section 1882 of the Act, we will cooperate with the state involved in investigating the complaint and pursuing any necessary enforcement activity. The standardization requirements of section 1882(p) of the Act carry with them civil money penalties that could be imposed on an issuer that sells a non-standardized policy. If an issuer claims that its policy does not provide for payment of the 50% mental health coinsurance, this could raise a question about whether the policy was originally sold with a non-standard benefit.

Where to get more information:

If you have any questions regarding this bulletin, contact the Private Health Insurance Group, the Centers for Medicare & Medicaid Services, formerly the Health Care Financing Administration, via e-mail at *phigmedigap@cms.hhs.gov* or by phone at 1-877-267-2323, ext. 61565.

You may obtain an electronic copy of this bulletin and other technical Medigap regulatory resources at http://*www.cms.hhs.gov/medigap*. You can sign up to receive future bulletins and other updates at the Medigap website. Consumer-oriented Medigap materials can be obtained at *www.medicare.gov*

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[i] On June 9, 1980, Congress enacted section 1882 of the Act. Section 1882(g)(1) incorporated by reference the NAIC Model Regulation to Implement the Individual Accident and Sickness Insurance Minimum Standards Act, as it applied to Medicare supplement policies. The NAIC had adopted this Model Regulation on June 6, 1979. In December 1980, subsequent to congressional action, the NAIC created a separate NAIC Medicare Supplement Insurance Minimum Standards Model Act and an associated Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum

Standards Model Act (the NAIC Model Regulation). This regulation has been amended a number of times to add new Federal requirements each time Congress has enacted new legislation.

[ii] Section 1882(m)(1)(A) of the Act, as amended by MCCRA'89, permitted the NAIC the opportunity "to improve such regulation and otherwise to reflect the changes made by[MCCRA'89]." The NAIC availed itself of this opportunity to add a number of new consumer protections that were not directly required by the new statute. The deletion of the reference to "20 percent" in the description of the Part B coinsurance benefit was one of these consumer protections.

[iii] Pursuant to OBRA'90, the NAIC undertook a comprehensive review of the model regulation in order to eliminate or revise any provisions that would be inconsistent with the new standardization requirements. In order to ensure that there were no discrepancies, the NAIC decided to mirror Medicare's exclusions, and to no longer permit exclusions, such as for mental or emotional disorders, that were not permitted by Medicare. See the legislative history for Section 6 of the NAIC Model Regulation, entitled "Policy Provisions."

[iv] Federal regulations at 42CFR 410.155(b)(2)(i) through (v) provide a list of outpatient mental health services that are not subject to this payment reduction. These services are: (i) services furnished to a hospital inpatient; (ii) brief office visits for the sole purpose of monitoring or changing drug prescriptions used in the treatment of mental, psychoneurotic or personality disorders; (iii) partial hospitalization services not directly provided by a physician; (iv) diagnostic services, such as psychological testing that are performed to establish a diagnosis; and (v) medical management, as opposed to psychotherapy, furnished to a patient diagnosed with Alzhiemer's disease or a related disorder.

[v] From the beginning of the Medicare program in 1965, until 1990, outpatient mental health services were subject to both a low annual payment cap and a payment reduction. Consequently very few outpatient mental health services were ever claimed. Under OBRA'87 and OBRA'89, the annual cap on benefits was gradually raised and finally removed, effective in 1990, but the 62.5 percent payment reduction amount was maintained. During this same time period, the types and numbers of mental health professionals who could bill Medicare directly was expanded from physicians/psychiatrists to include psychologists and clinical social workers. Various types of outpatient settings were also recognized. Thus, provision of outpatient mental health services has become a much more common feature of the Medicare program. As a result of the increased volume of claims for such services, questions have arisen relating to the responsibilities of supplemental payers.

[vi] That is, where *N* = the Medicare allowed amount, Medicare pays *62.5%N x80% = 50%N*). Federal regulations at 42 CFR 410.155 explain how the reduction is calculated and provide several examples of assigned and unassigned claims and situations in which the Part B deductible has been unmet, partially met, or met. However, the process may be briefly described as follows:

1. The carrier or intermediary calculates the Medicare allowed amount (generally based on a fee schedule).
2. Next Medicare multiplies the allowed amount by the 62.5 percent mental health payment limitation.
3. Then Medicare subtracts any unmet Part B deductible amount.
4. The remainder is then subjected to the general 80 percent payment rule.
5. The resulting figure is what Medicare actually pays.

[vii] Psychologists and clinical social workers are required to take mandatory assignment. However, physicians, including psychiatrists, are permitted to balance bill for services paid for under the physician fee schedule if they have not signed a participation agreement with Medicare. Therefore, some outpatient mental health services may reflect balance billing. However, a limiting charge of 115 percent of the non-participating physician fee schedule (which is 95 percent of the participating physician fee schedule) applies.

[viii] This language appears in section 8 of the NAIC Model Regulation, and is incorporated by reference under section 1882 of the Act.

[ix] The term “coinsurance” is not defined in the NAIC Model Regulation. Medicare law and regulations also contain no definition of this term. The Act only uses the term “coinsurance” with respect to Part A cost sharing for hospital services. Since the NAIC Model Regulation does not cross reference the payment rules in section 1833(a) and (c) of the Act, CMS takes the position that the term, as used in the model, has the commonly understood meaning in the industry and in common parlance (i.e., the beneficiary’s liability after Medicare payment is made).

[x] In some cases, such as the extended hospital care benefit, Medigap coverage is contingent on whether the services would have been medically necessary but for the fact that Medicare Part A hospital benefits have been exhausted.

[xi] These policies are those issued in a state on or after the date the state implements the 1991 NAIC Model Regulation as required by OBRA’90.