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BULLETIN 91-7

TO: ALL INSURERS WRITING ACCIDENT AND HEALTH INSURANCE

FROM: Earl R. Pomeroy, Commissioner

DATE: December 19, 1991

SUBJECT: Physician's Limiting Charge - Medicare Beneficiaries

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The Insurance Department recently has become aware that some insurers are failing to meet their obligations to Medicare beneficiaries under Medicare supplement insurance contracts in the area of excess physician charges (sometimes called balance billing).

Many Medicare supplement insurance policies provide coverage for some or all of the difference between the amount Medicare recognizes as allowable and the amount the physician actually bills the patient. In the Omnibus Budget Reconciliation Act of 1989 (OBRA 1989), Congress established new limits on physician balance billing in conjunction with Medicare physician payment reform, called "limiting charges." These charge limitations phase-in between 1991 and 1993. In 1991, the limiting charge is calculated separately for each physician for each service. By 1993, when the Medicare fee schedule will be in effect, the limiting charge will be more easily calculable as a specified percentage in excess of the amount determined by the schedule.

Unfortunately, some insurers are attempting to restrict their liability for excess charges through erroneous interpretations of the new Medicare charge limitations. The following is a list of practices in this area that the Department has determined to be improper:

1. Limiting payments to the insured by capping reimbursement at 125 percent or 140 percent of the "Medicare approved amount" shown on the Explanation of Medicare Benefits ("EOMB").

   Explanation: This is improper for two reasons. First, this is an incorrect calculation of the limiting charge. The limiting charge currently must be calculated separately for each physician and service. [The limiting charge in 1991 is generally the same percentage (but no more than 25 percent) above the prevailing

charge for nonparticipating physicians as the percentage by which the physician's 1990 maximum actual allowable charge ("MAAC") exceeded the 1990 prevailing charge for nonparticipating physicians. 42 U.S.C. Sec. 1395w-4(g)(2). The limiting charge is not a simple multiple of the amount shown on the EOMB. The second reason is that the charge limitations are not enforced in a manner that ensures that patients will not be liable for amounts in excess of the limiting charge. This is discussed more below.

2. Limiting payment to the insured on the basis that the insured is not legally obligated to pay more than the limiting charge amount to the physician.

   Explanation: According to the Health Care Financing Administration (HCFA), which is the federal agency that administers the Medicare program, this is an incorrect interpretation of the limiting charge. OBRA 1989 establishes penalties for physicians who knowingly and repeatedly charge beneficiaries above the limiting charge. The statute, however, does not necessarily prevent physicians from charging in excess of the limiting charge in some instances and does not relieve the beneficiary of the legal obligation to pay the additional amount. HCFA is reconsidering this position, but currently there is no clear statement from the federal government limiting beneficiary liability to the limiting charge amount.

3. Limiting payment to the insured on the basis that the usual and customary amount is the limiting charge.

   Explanation: The limiting charge is based on a complicated formula which considers Medicare payment rules and the physician's historic Medicare billing practices. It is not necessarily related to the usual and customary charges for the service in the area.

The Insurance Department believes that insurers should not be using the limiting charge to limit payment for excess physician charges unless the insurance policy makes specific reference to the limiting charge. The practices listed above not only have the untenable consequence of placing Medicare beneficiaries in the middle of a technical dispute between their insurer and their physician about federal law, but in many instances deny beneficiaries of benefits promised in their policies.

These practices appear to constitute unfair claims settlement practices and/or unfair trade practices under the North Dakota Century Code. The Insurance Department is directing insurers to cease these practices in this state. Insurers that have erroneously relied on the Medicare limiting charge to restrict reimbursement are directed to search their claims files and correct any errors in past claims.

Insurers with questions about this bulletin should contact Vance Magnuson of the North Dakota Insurance Department.

ERP/njb