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8th Annual Health Law Primer

The A, B, C and D's of Medicare

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Outline of Presentation

- Introduction
- The Four Parts of Medicare
  - Eligibility
  - Benefits
  - Payment and Reimbursement Issues
- Medicare Secondary Payer Rules
- Federal Preemption

Introduction to Medicare

- Social Security Act Amendments of 1965
  - Created Medicare Part A and Part B
  - To cover the cost of hospital and medical care for aged and disabled
- Balanced Budget Act of 1997
  - Created Medicare Part C
- Medicare Prescription Drug, Improvement, and Modernization of 2003 (MMA)
  - Created Medicare Part D

Medicare Funding

- Part A – Hospital Insurance
  - Hospital Insurance Trust Fund from payroll taxes
  - Beneficiary deductible
- Part B – Supplementary Medical Insurance
  - Supplementary Medical Insurance Trust Fund from individual premiums, general tax revenues, and earned interest income.
  - Beneficiary monthly premium
  - State premiums

Medicare Funding

- Part C – Medicare Advantage
  - Funded from both Hospital and Supplementary Medical Insurance Trust Funds
  - Beneficiary premiums (if any) paid to Medicare Advantage organizations
  - 25% rebate from Medicare Advantage organizations under the bid process
- Part D – Prescription Drug Benefit
  - Medicare Prescription Drug Account is funded by federal appropriations, payments from states for their dual eligibles, and the 25% rebate from Part D plan sponsors under the bid process.
  - Beneficiary premiums (if any) paid to Part D plan sponsors
  - Risk sharing with Part D plan sponsors

Medicare Terminology

- Provider vs. Supplier
  - "Provider" is a Part A term and includes:
    - Hospital
    - Skilled nursing facility ("SNF")
    - Comprehensive outpatient rehabilitation facility ("CORF")
    - Home health agency ("HHA")
    - Hospice
    - Critical access hospital ("CAH")

Medicare Terminology

- Supplier
  - "Supplier" is a Part B term, and includes:
    - Physicians
    - Durable medical equipment prosthetic orthotic suppliers ("DMEPOS")
    - Ambulatory Surgery Center ("ASC")
    - Independent Diagnostic Testing Facility ("IDTF")

Part A - Entitlement

- Automatic enrollment at 65 *if eligible* for monthly Social Security retirement or survivor benefits or railroad retirement benefits
- Individuals under 65 are entitled if they are entitled to (1) Social Security or railroad retirement disability benefits or (2) end-stage renal disease benefits
- Individuals 65 or over who don't meet either of the above, can enroll in Part A by paying monthly premium
  - Must be US resident and either (1) US citizen or (2) permanent resident

Part A – Basic Benefits

- Inpatient hospital care
  - General/acute care hospitals; and specialty hospitals, such as long term acute care hospitals, critical access hospitals, psychiatric hospitals, rehabilitation hospitals, etc.
  - Limited to 90 days per “spell of illness”
  - Beneficiary responsible for deductible and coinsurance payments for days 61-90 and larger deductible and coinsurance payments for days 91-150

Part A – Basic Benefits

- Skilled nursing facility (SNF) care
  - "Skilled" nursing care to beneficiaries (vs. "custodial")
  - Limited to 100 days per "spell of illness"
  - Requires "qualifying hospital stay" (i.e., hospital inpatient for at least three consecutive calendar days) prior to SNF admission
  - Admitted to SNF within 30 days after discharge from hospital

Part A – Basic Benefits

- Home health care
  - Services and supplies furnished in a beneficiary's "home"
  - Beneficiary must be:
    - Confined to the home or outpatient setting;
    - Receiving treatment from a physician, under a plan of care and needs (1) intermittent skilled nursing care, physical therapy, or speech language therapy, or (2) continuing need for occupational therapy.
  - Can be covered under both a Part A and Part B:
    - Part A covers the first 100 HHA visits **if** the beneficiary was discharged from a 3 day or longer hospital or SNF stay and was discharged from that stay within 14 days of the first HHA visit.
    - Part B covers visits over 100 and if Part A criteria not met
  - Can also be covered under only Part A or only Part B

Part A – Basic Benefits

- Hospice care
  - Services provided to terminally ill
  - Requires:
    - Written beneficiary election (except for certain pre-election services – see 42 U.S.C.A. 1395d(a)(5))
    - Physician determination that beneficiary is terminally ill
    - Establishment of plan of care
  - Covered in “benefit periods”
    - two 90 day periods
    - unlimited 60 day periods
  - Coverage includes: nursing care; medical social services; physicians' services; counseling services; home health aide; medical appliances and supplies, including drugs and biologicals; and physical and occupational therapy.

Part A Provider Conditions of Participation

- Providers seeking payment for services to Medicare or Medicaid beneficiaries must enter into an agreement with the Secretary or the state Medicaid agency, as appropriate.
  - Essential terms of Medicare participation agreement are at 42 C.F.R. § 489.20 *et seq*
- Medicare will only pay for services rendered in facilities that meet Medicare conditions of participation or conditions for coverage. The determination as to whether a facility meets Medicare requirements is made by the Secretary of HHS. However, the Secretary is required to make an agreement with any state that is willing and able to do so under which the state will certify whether a facility meets Medicare standards.

Part A Provider Reimbursement

- From its inception until 1983, Medicare reimbursed hospitals for inpatient services based on reasonable costs of services rendered.
- Reasonable cost reimbursement system was replaced with prospective payment system (PPS)
  - Provides a single payment amount for each type of case, identified by the diagnosis-related group (DRG) into which each case is classified

Part A Provider Reimbursement Issues

- Generally, PPS applies to all short term, acute-care hospitals, except that certain hospitals and units are specifically excluded including the following:
  - Psychiatric hospitals and units
  - Rehabilitation hospitals and units
  - Children's hospitals and units
  - Long-term care hospitals and units
  - Cancer hospitals and units
- See 42 C.F.R. § 412.422

Part A Provider Reimbursement Issues

- PPS inpatient operating costs include:
  - Routine services such as the costs of room, board and routine nursing services (see 42 C.F.R. §413.53(b));
  - Ancillary services, such as radiology and laboratory services furnished to hospital inpatients;
  - Intensive care type unit services (see 42 C.F.R. §413.53(b));
  - Malpractice insurance costs related to services furnished to inpatients; and
  - Preadmission services otherwise payable under Medicare Part B furnished to a beneficiary during the three calendar days immediately preceding the date of the beneficiary's admission to the hospital, commonly referred to as the three-day payment window. (see 42 C.F.R. §412.2(c).

Part A Provider Reimbursement Issues

- Other PPS-Paid Providers:
  - Inpatient Rehabilitation
  - Long Term Care Hospitals
  - Psychiatric Facility or Unit
  - SNF
  - Hospice
  - Home Health

Part A PPS

5 steps for determining payment a hospital will receive for providing inpatient services to a patient:

1. Assignment of DRG and DRG weight
2. Multiplying DRG weight by the standardized amount for that DRG
3. If applicable, percentage add-on for disproportionate share and/or teaching activities
4. If applicable, additional payments for “outliers” -designed to protect the hospital from large financial losses due to unusually expensive cases
5. Other special payment adjustments

http://www.cms.hhs.gov/AcuteInpatientPPS/02_stepspps.asp#TopOfPage

Part B Eligibility

- Part B is a voluntary program
- Individual is eligible for enrollment in Part B program if the individual
  - is entitled to Part A benefits or
  - has attained the age of 65 and is (a) a resident of the United States and is (b) either a citizen of the United States or permanent resident

Part B Benefits

- Part B benefits supplement and extend the benefits provided by the Part A program:
  - medical and other health services
  - home health services
  - comprehensive outpatient rehabilitation facility services
  - ambulatory surgical services

Part B Benefits

- Medical and other health services include:
  - physicians' services
  - outpatient hospital services
  - drugs and biologicals that cannot be self-administered
  - physical, occupational, and speech therapy services
  - durable medical equipment
  - ambulance service
  - prosthetic devices
  - braces, trusses, and artificial limbs and eyes
  - certified registered nurse anesthetist (CRNA) services
  - nurse-midwife services
  - qualified psychologist and clinical social worker services
  - preventive screening services and tests (e.g., pap smears, mammograms, prostate, colorectal, diabetes, glaucoma, etc.)

Part B Participation

- Deficit Reduction Act of 1984 established a voluntary participating system
  - Physicians and suppliers are encouraged to sign a "participation" agreement with Medicare binding them to accept assignment for all services provided to all Medicare patients for the following year.
  - A physician or supplier that does not participate in the program may accept assignment on a case-by-case basis.
  - For an assigned bill, the Medicare Administrative Contractor (MAC) pays the physician or supplier directly, and the physician or supplier is responsible for collecting the coinsurance from the beneficiary (or the beneficiary's Medicare supplement insurer). Where there is no assignment, the MAC pays the beneficiary, and the physician or supplier looks to the beneficiary for the entire payment.

Part B Reimbursement

- Generally, the Part B Medicare payment amount is 80% of the Medicare approved charge. The beneficiary pays the other 20% as a coinsurance.
- The Medicare approved charge is normally the fee schedule amount for the item or service. Part B fee schedules include:
  - ambulance services
  - durable medical equipment and prosthetic devices
  - clinical diagnostic laboratory tests
  - physician services and other health care practitioner services
- Items and services not paid under a fee schedule are either priced by the MAC according to prices in its locality, or based on Medicare's "reasonable charge" methodology.

Part B Reimbursement

- The “limiting charge” is a restriction on the amount that nonparticipating physicians, other health care practitioners, and suppliers are allowed to charge Medicare beneficiaries
  - limiting charge is 115% of the Medicare recognized payment amount
  - Medicare recognized payment amount for any service from nonparticipating physicians, practitioners, and suppliers is 95% of the amount approved for that service when it is provided by participating physicians, practitioners, or suppliers

Medicare Part C

- Medicare Part C - Federal managed care program to deliver Medicare benefit.

- Balanced Budget Act of 1997 created Part C (known then as Medicare+Choice), but Medicare Modernization Act of 2003 amended the program and renamed it Medicare Advantage

Part C Goals

- Save Medicare managed care by offering incentives for organizations to participate and compete against each other.
- Provide Medicare beneficiaries with more choices for less costly, comprehensive coverage.
- Reduce Government expenditures by transferring financial risk to MA organizations.

Types of Part C Plans

- Four Basic Types of Plans
  - Coordinated Care Plans
    - HMO with or without point of service (POS)
    - Provider Sponsored Organization (PSO)
    - PPO (local or regional)
    - Special Needs Plan
  - Private Fee-for-Service Plan
  - MSA – high deductible plan and contribution to Medical Savings Account
  - Religious Fraternal Benefit Plan

Part C Coordinated Care Plans

- Common feature of CCPs is a network of contracted providers
- HMO – is most restrictive form of CCP
  - Limits utilization to network providers except for emergency or urgent situations
  - May have primary care “gatekeeper” feature that requires members to get PCP referral for services
  - May have POS feature to ease restrictions on access

Part C Coordinated Care Plans

- HMO/Point-of-Service (POS) Option
  - Allows members to obtain services without complying with plan's typical referral/authorization requirements
  - Direct access to non-network providers
  - Higher member cost-sharing for going out of network
  - Different from PPO - POS plan may be limited to certain services and may impose dollar cap on out-of-network benefit

Part C Coordinated Care Plans

- Regional PPO
  - Service areas consist of 26 regions defined by CMS
    - 11 single state regions
    - 15 multi-state regions
    - Slightly different from the Part D regions
  - Regional PPO must service the entire region and have a uniform benefit package across the region.

Part C Special Needs Plans

- Special Needs Plan – created by MMA
  - A CCP that either exclusively enrolls special needs individuals or enrolls a "disproportionate share"
  - Disproportionate SNPs have proliferated with a significant number of members not having the special condition. Effective for the 2010 plan year, all beneficiaries must qualify as having a special need to enroll in SNP.
  - Special needs individuals
    - Dual eligibles (also entitled to Medicaid)
    - Institutionalized
    - Other high-risk groups of chronically ill or disabled individuals (e.g., ESRD, diabetes, COPD)

Part C Private Fee-For-Service Plans

- Pay providers on a fee-for-service basis – no provider risk-sharing.
- Can pay less than Medicare fee-for-service, but must have contracted provider network.
- Can't limit members to network providers, but can charge higher cost-share for non-network provider services. Member can go to any provider that is eligible to be paid by Medicare and "accepts" plan's terms and conditions.

Part C Private Fee-For-Service Plans

- Provider that renders services to a PFFS member is one of the following:
  - Direct-contracting provider
  - "Deemed-contracting" provider
    - Provider is aware prior to rendering service that patient is PFFS member,
    - Provider has reasonable access to plan's terms and conditions of participation, and
    - Service provided is covered by the plan
  - Non-contracting provider

Medicare Improvements for Patients & Providers Act of 2008 (MIPPA) Changes to PFFS Plans

- In the Individual Market, PFFS plans operating in a "network area" can only meet CMS access standards through a contracted provider network and not in whole or in part through "deeming."
  - "Network area" to be identified by CMS as having at least two network-based plans:
    - Coordinated care plan
    - Network-based MSA plan
    - Reasonable cost reimbursement plan
  - Regional PPO plans that don't rely on a contracted provider network are not network-based plans.
- No similar exception for the Employer Market.
- Effective plan year 2011.

MIPPA Changes to PFFS Plans

- Why Were PFFS Plans So Popular to Offer?
  - Attractive CMS payment rates
  - No provider network requirement
  - Ability to offer national plan
  - Offering Part D benefit optional
  - If Part D benefit offered, CMS access requirements satisfied without having a contracted pharmacy network
  - Quality improvement program requirements not applicable

Part C Eligibility

- Must be eligible for Part A
- Must be enrolled in Part B
- Must not have ESRD unless enrolling in an ESRD special needs plan
- Must reside in plan service area or continuation area

Part C Enrollment

- Initial coverage election period
  - Begins 3 months before individual's first entitlement to **both** Medicare Parts A and B and ends on the last day of the individual's Part B initial enrollment period.
  - The initial enrollment period for Part B is the 7 month period that begins 3 months before the month an individual meets the eligibility requirements for Part B, and ends 3 months after the month of eligibility.
- Annual election period
  - November 15 through December 31
  - MA eligible individuals may enroll in or disenroll from an MA plan.

Part C Enrollment

- Open enrollment period
  - January 1 through March 31
  - MA plans are not required to be open for new enrollments but must accept disenrollments.
  - Elections must be made to the same type of plan (regarding Medicare prescription drug coverage) in which the individual is already enrolled
- Special election period
  - Change in residence, Medicaid eligibility, etc.
  - Contract violation by MA organization
  - Contract non-renewals and terminations
  - “Exceptional” conditions determined by CMS

Part C Benefits

- MA organization must provide members with all original Medicare-covered services (Parts A and B), except hospice.
- All benefits must be
  - health-related
  - offered uniformly to all members
  - priced in the bid filed with CMS
  - mentioned in marketing vehicles
- Uniformity – MA plan must have a uniform premium, and uniform benefits and cost-sharing throughout the service area.

Part C Benefits

- Terminology
  - Basic benefits – all Medicare-covered services except hospice
  - Mandatory supplemental benefits – not covered by Original Medicare, but member is required to purchase. Paid for by member premium, cost-sharing or rebate dollars.
  - Optional supplemental benefits - not covered by Original Medicare, and member may choose whether to purchase them. Rebate dollars may not be used.

Part C Benefits

- Cost-sharing structure cannot:
  - Discriminate against beneficiaries
  - Promote discrimination
  - Discourage enrollment or encourage disenrollment
  - Steer specific subsets of Medicare beneficiaries to particular MA plans (except SNPs)
  - Inhibit access to services
- MA organization cannot:
  - Design cost-sharing differential so as to preclude member choice of provider

Part C Payments

- Annual submission of monthly aggregate bid amount
- Must be actuarially sound and reflect cost of:
  - Parts A and B benefits
  - Part D benefits (if applicable)
  - Supplemental benefits (if any)
  - Administrative and other costs
- CMS may negotiate reasonableness of assumptions and proportional attribution

Part C Payments

- Advance monthly payments
  - Amount of payment is determined by the relationship of the plan bid to the “benchmark” amount
  - If plan A/B bid < plan A/B benchmark, then 75% of that difference is “rebate” that must be used to offer mandatory supplemental benefits or reduce cost sharing or premium. Remaining 25% is retained by the Trust Funds.
  - If plan A/B bid > plan A/B benchmark, then plan must charge a basic beneficiary premium for A/B benefits. Premium = standardized bid - standardized benchmark.
  - CMS payments are adjusted by the individual enrollee's risk factor.

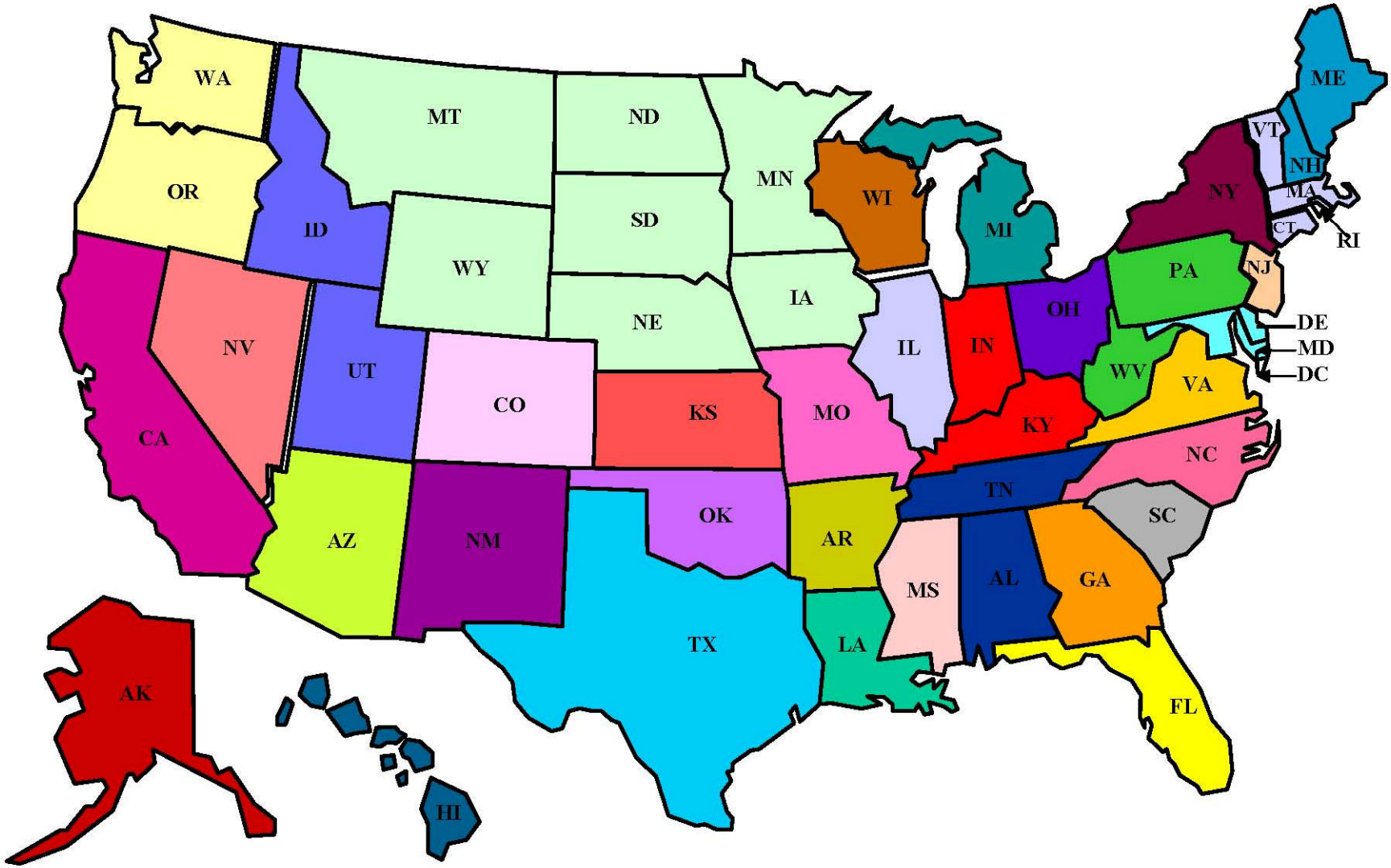
Medicare Part D

- Title I of the MMA
  - Added Sections 1860D-1 through 1860D-42 of the Act
- Two types of Medicare prescription drug plans:
  - Standalone PDPs
  - MA-PDs (e.g., HMOs, PPOs)
- Enrollment is voluntary
- Dual eligibles no longer have drug coverage through Medicaid
- Financed via premiums, general revenues, and "phased-down State contribution"

Part D Eligibility

- Entitled to benefits under Part A and enrolled in Part B
- Lives in a Part D plan service area

PDP Regions



Note: Each territory is its own PDP region.

Part D Benefit

CMS Part D Standard Benefit Plan (2008)

- **Initial Deductible: $275**
  - **Beneficiary pays 25% of the next $2,235 (*i.e.*, $558.75)**
  - **Plan pays 75% of the next $2,235 (*i.e.*, $1,676.25)**
- **Initial Coverage Limit: $ 2,510**
  - **Sum of amounts paid by beneficiary and plan (*i.e.*, $275 + $558.75 + $1,676.25)**
- **"Donut Hole": $3,216.25**
  - **Beneficiary pays 100% of the costs of covered drugs between $2,511 and $5,726.25**
- **Out-of-Pocket Threshold: $4,050**
  - **$275 + $558.75 + $3,216.25**
- **Minimum Cost-sharing in the Catastrophic Coverage Portion of the Benefit (2008):** $2.25 for generics and $5.60 for other drugs, or a flat 5% coinsurance, whichever is greater

Standalone PDPs vs. MA Plans

- Standalone Prescription Drug Plans
  - Offered to enrollees in Parts A and B
  - Provide prescription drug coverage only
- Medicare Advantage – Prescription Drug Plans
  - Generally subject to the same requirements as PDPs (*e.g.*, bidding, beneficiary protections)
  - Also provide Part A and Part B benefits in addition to drug coverage
  - MA-PD plans can use Medicare Part A and Part B payments to reduce the cost of the Part D benefits.

Part D Payments

- CMS pays Part D plan sponsors and MA organizations offering MA-PD plans monthly subsidies:
  - Payments equal to the plan's approved standardized bid, adjusted for health status (risk adjusted), minus the base beneficiary premium and adjusted for any difference between the standardized plan bid and the national average monthly bid amount.
  - CMS also makes reinsurance and low-income cost-sharing subsidy payments

Part D Payments

- Part D Payment Reconciliation
  - Process required to settle prepaid to actual enrollment, risk adjustment, low-income subsidy, and reinsurance payments (in that order) prior to calculation of risk sharing.
  - CMS may issue lump-sum payments or adjust monthly payments in the subsequent payment year based on the relationship of the Part D plan's adjusted allowable risk corridor costs to predetermined risk corridor thresholds in the coverage year.
  - Payment reconciliations resulted in recoveries by CMS of $4 billion for 2006 and $18 billion for 2007

Network Pharmacy Requirements - Network Adequacy/Access Standards

- Network Adequacy/Access Standards
  - Part D Plan Sponsors must establish a pharmacy network sufficient to ensure access to covered Part D drugs for their enrollees. Plan Sponsors must demonstrate that they provide:
    - Convenient access to retail pharmacies for all enrollees;
    - Adequate access to home infusion pharmacies for all enrollees;
    - Convenient access to LTC pharmacies for enrollees residing in LTC pharmacies; and
    - Convenient access to I/T/U pharmacies for American Indian/Alaska Native (AI/AN) enrollees.

Retail Pharmacy Access

- Plan Sponsors must secure the participation in their pharmacy networks of a sufficient number of pharmacies that dispense drugs directly to patients (other than by mail order) to ensure convenient access to covered Part D drugs by Part D plan enrollees. CMS convenient access rules require Plan Sponsors to establish pharmacy networks in which:
  - In urban areas, at least 90% of Medicare beneficiaries in the Plan Sponsor's service area, on average, live within 2 miles of a participating retail pharmacy;
  - In suburban areas, at least 90% of Medicare beneficiaries in the Plan Sponsor's service area, on average, live within 5 miles of a participating retail pharmacy; and
  - In rural areas, at least 70% of Medicare beneficiaries in the Plan Sponsor's service area, on average, live within 15 miles of a participating retail pharmacy.

Level Playing Field Between Mail-Order and Retail Pharmacies

- Plan sponsors that include mail-order pharmacies, must allow members to obtain covered drugs from a network retail pharmacy
  - Plan sponsor may hold member responsible for higher cost-sharing for obtaining covered drugs from network retail rather than network mail-order pharmacy.
  - Higher cost-sharing is limited to the mail-order cost-sharing plus any differential in contracted rates between retail and mail-order.

Limited Access and "Specialty" Drugs

- Part D sponsors may not require network pharmacies to qualify as a "specialty" pharmacy in order to dispense any drug that requires special attention if the network pharmacy is capable of appropriately dispensing the particular Part D drug.
  - "Specialty" pharmacies may be used to supplement network pharmacy access when necessary and not otherwise restrict the network.

Access to Negotiated Prices

- Plan Sponsor must provide enrollees with access to negotiated prices for covered Part D drugs at the point of sale.
  - Access to negotiated prices must be provided even when no benefits are otherwise payable (e.g., deductible or donut hole)
  - Negotiated prices take into account negotiated price concessions for covered Part D drugs that are passed through to enrollees at the point of sale, such as:
    - Discounts;
    - Direct or indirect subsidies;
    - Rebates; and
    - Other direct or indirect remunerations
  - Negotiated prices must include any applicable dispensing fees

Any Willing Pharmacy Requirement

- Plan Sponsor must permit the participation of any pharmacy – including non-retail pharmacies such as mail-order pharmacies – that is willing to accept the sponsor's standard terms and conditions.
  - Standard terms and conditions must be "reasonable and relevant."
  - Whether Plan Sponsor has permitted a pharmacy an opportunity to participate in its network, or whether a pharmacy can meet or has met contract terms are fact-specific questions "that are generally best left between the parties."

Standard Terms and Conditions

- Standard terms and conditions, particularly for reimbursement terms, may vary to accommodate geographic areas or types of pharmacies, provided that all similarly situated pharmacies are offered the same standard terms and conditions.
  - Standard terms and conditions are the “floor” of minimum requirements that all similarly situated pharmacies must abide by.
  - Part D sponsors may modify some of their standard terms and conditions to encourage participation by particular pharmacies.

Preferred vs. Non-Preferred Pharmacies

- Plan Sponsor may establish distinctions between "preferred" and "non-preferred" pharmacies within their pharmacy networks.
- Pharmacy can only be designated as preferred if it offers enrollees a lower level of cost-sharing than a non-preferred pharmacy.
- Cost-sharing requirements for low income subsidy ("LIS") enrollees are not affected.
- Cost differential cannot deter beneficiaries in certain areas from enrolling.

Medicare Secondary Payer

- Purpose of Medicare Second Payer (MSP) law is to shift costs from the Medicare program to private sources of payment.
- MSP law prohibits Medicare from making payment if payment has been made or can reasonably be expected to be made by a primary plan.
- If payment has not been made or cannot be expected to be made promptly by a workers' compensation plan, liability insurance, or no-fault insurance, Medicare may make a conditional payment, under some circumstances, subject to Medicare payment rules.

Medicare Secondary Payer

- Primary Plans
  - Group Health Plans
    - Working aged
      - Medicare benefits are secondary to benefits payable under GHPs for individuals age 65 or over who have GHP coverage as a result of:
        - » Their own current employment status with an employer that has 20 or more employees; or
        - » The current employment status of a spouse of any age with such an employer.
      - Employers with 20 or more employees are required to offer the same (primary) coverage to their age 65 or over employees and the age 65 or over spouses of employees of any age that they offer to younger employees and spouses

Medicare Secondary Payer

- Group Health Plans (cont.)
  - Disability
    - Medicare benefits are secondary to large group health plans (LGHP) for individuals under age 65 entitled to Medicare on the basis of disability and whose LGHP coverage is based on the individual's current employment status or the current employment status of a family member.
  - ESRD
    - Medicare benefits are secondary to benefits payable under a GHP for individuals eligible for or entitled to benefits on the basis of ESRD during a period of up to 30 months if Medicare was not the proper primary payer for the individual on the basis of age or disability at the time that the individual became eligible or entitled to Medicare on the basis of ESRD

Medicare Secondary Payer

- Other Primary Payers:
  - Workers' compensation plans
  - Liability insurance - Insurance (including a self-insured plan) that provides payment based *on alleged legal liability* for injury, illness or damage to property. Includes automobile liability, uninsured and under-insured motorist, homeowner's liability, malpractice, product liability and general casualty insurance. Includes payments under State wrongful death statutes that provide payment for medical damages.
  - No-fault insurance - Insurance that pays for medical expenses for injuries sustained on the property or premises of the insured, or in the use, occupancy, or operation of an automobile, regardless of who may have been responsible for causing the accident. Includes but is not limited to automobile, homeowners, and commercial plans. Includes medical payments coverage, personal injury protection, or medical expense coverage.

Federal Preemption

- Expanded Federal Preemption under MMA
  - The standards established under Part C supersede any state law or regulation (other than State licensing laws or State laws relating to plan solvency) for Medicare Advantage plans offered by Medicare Advantage organizations. 42 U.S.C. § 1395w-26(b)(3).
  - Medicare Advantage is a federal program operated under Federal rules. State laws, do not, and should not apply, with the exception of state licensing laws or state laws related to plan solvency." H.R. Conf. Rep. No. 108-391, at 557 (2003).
  - Also applies to Part D program. 42 U.S.C. § 1395w-112(g).

MIPPA - Greater Involvement of States in Marketing

- New requirements to strengthen states' ability to act in collaboration with CMS to address fraudulent or inappropriate marketing practices:
  - Must use agents and brokers who have been licensed under state law to sell MA and PD plans.
  - Must comply with state appointment law (if any).
    - CMS had previously decided state appointment laws do not apply
  - Must report to the state all terminations (including reason for termination) of agents and brokers.
  - Must comply with "**any request**" by state for information regarding agent, broker or third party performance as part of state investigation of agent, broker or third party.
- Effective for plan years beginning January 1, 2009.