



August 25, 2009

BY ELECTRONIC MAIL

Mary Beth Senkewicz
Deputy Insurance Commissioner, State of Florida
Chair, Senior Issues Task Force
National Association of Insurance Commissioners

RE: Network Arrangements and Medicare Supplement Insurance

Dear Ms. Senkewicz:

California Health Advocates recently became aware of your letter to the Centers for Medicare and Medicaid Services (CMS) concerning several Office of Inspector General (OIG) advisory opinions issued at the request of Medigap issuers about the application of anti-kick back rules to discounted Medicare Part A hospital deductible payments. On November 21, 2008, California Health Advocates also wrote to CMS about the OIG advisory opinions, and the underlying issues that we believe would fundamentally alter the nature of Medigap standardization and simplification. We have not received a reply from CMS to our letter. However, we recently read letters in response to our letter and yours by Darrel J. Grinstead (from the D.C. law firm of Hogan and Hartson.) Mr. Grinstead's letters were on the NAIC website, and were written to CMS apparently representing issuers who wished to offer Medigaps with a discounted Part A deductible.

In our letter to CMS we noted, as you did in your letter, that the OIG advisory opinions only address the issue of whether such an arrangement violates the anti-kick back statute. The opinions do not address other regulatory concerns such as the subtle undermining of Medigap standardization and simplification, the effect on loss ratios and refund calculations, discrimination issues related to small rural hospitals, or the potential shifting of Medicare-covered costs to larger urban centers to the detriment of smaller rural providers¹ and the consumers who live in rural areas.

California Health Advocates (CHA) is a non-profit organization dedicated to education and advocacy efforts on behalf of Medicare beneficiaries in California. CHA provides support, including technical assistance and training, to the State Health Insurance Program (SHIP), known in California as the Health Insurance Counseling and Advocacy Program (HICAP).

¹ "In general, smaller hospital facilities historically have been less profitable, and many struggle to meet a 1% to 3% margin. This is related to lack of economies of scale, poor payor mix, higher overhead costs, fewer high margin specialty service lines and an overall lower revenue base." A.M. Best Special Report: Weak Margins Threaten Survival of Smaller Not-for-Profit Hospitals; Insurance Broadcasting, 8/18/09
21 Locke Way Scotts Valley, CA 95066

We urged CMS to make perfectly clear to insurers that any changes they attempt to make to the standardized benefits, benefit packages, or benefit payments are preempted by federal law, except for those differences allowed in Medicare Select plans, and any innovative benefits described in the Model Regulation that have been approved under individual state laws.

We believe if insurers are allowed to offer Medigap policies that supplement Medicare's fee-for-service payments with benefit payments based on which providers delivered the policyholders Medicare covered services the overall consequences are negative and far-reaching. Further, federal law appears to be quite explicit that Medicare Supplement insurance policies are required to meet *all* of the standards and requirements of the NAIC Model Act and Regulation, and a state's voluntary certification program for Medicare Supplement policies must meet or exceed those standard and requirements.

The NAIC Models include two ways Medicare supplement benefits and the payment of Medicare explicit deductibles, co-payments, and coinsurance to a provider or beneficiary can vary from the standardized packages. An issuer may seek state approval of an innovative benefit, which under the Model Regulation must be for a benefit that is not otherwise available, is cost-effective, and offered in a manner that is consistent with the goal of simplifying Medicare supplement policies. Or, an issuer may provide benefits through a network of providers as a Medicare Select plan and benefit payments may vary as a result.

The Models envision no other way of modifying benefits that are payable for the exact amounts providers can charge for the Part A deductible, hospital and skilled nursing co-payments, the Part B deductible, the Part B coinsurance, and the Part B excess charge; all of these amounts are specified by the Medicare program, and most are required benefits in various combinations in Medicare supplement policies. The discount promised by these issuers is nothing more than a refund of approximately 10 percent of what the issuer would otherwise pay a hospital for a covered individual. And, despite the fact that a beneficiary may see no difference in their benefits, providers are being shortchanged at a time when many hospitals complain that Medicare payments fail to cover the full cost of the care they provide. Discounts, in this case more than \$1,000 per hospitalization, are *always* offset somewhere else and contribute to cost shifting from one payer to another, or from one center of operation to another.

As far as we know, the issuers who have sought these advisory opinions have not revealed to what extent premiums would be reduced beyond the small cash discount to an individual who is hospitalized in a network hospital. Nor is it clear in the case of multiple hospitalizations within a single year whether the discount applies cumulatively or singly. Since the issuer pays a cost to the network organizer, it is also not clear how that expense or the application of the discount will be handled within the context of the loss ratio and premium refund calculation. Further, if the block of business to which these discounts apply is not credible, there may be other compliance and actuarial issues to consider.

In addition, other factors that should be considered in calculating premium savings on a particular policy form are the Medigap packages offered by an issuer that include this discount; the regions of the country or parts of a state in which the plan is available; whether the discount is available in a guaranteed issue package or only those packages that are not; the age and

gender mix of targeted applicants; and the underwriting criteria used to issue coverage with this feature. All of these factors can affect the amount of premium charged and any reduction in premiums that might accrue to all policyholders as a result of a promised discount applied to a narrow set of circumstances. However, if differentials in payment of Medigap benefits that trigger small refunds are allowed, along with vague promises of overall premiums reductions, other issuers will inevitably seek to include this and other subtle differences, and standardization and simplification will eventually be defeated.

If large numbers of issuers adopt this premium discount methodology, hospital care costs that insurers are supposed to pay could begin to shift to providers in urban areas, or to select groups of providers. The number of rural non-network hospitals may further decline, thus limiting access to care. Such a shift can in fact increase Medicare costs since urban providers are often reimbursed at higher rates than providers in rural areas. Medicare covered costs could increase if individuals with these policies are more willing to be hospitalized in those higher cost areas in return for promised premium discount.

A number of marketing issues arise anytime a change is introduced that makes one product different from others. The prospect of a \$100 discount on the following year's premium can be an enticement to sell or replace existing coverage and can contribute to churning or inappropriate replacement. Since 1992 issuers have been unable to inappropriately add bells and whistles to make their product stand out from others. This proposal, and others like it that are sure to emerge will gradually begin to erode the standardized packages and simplification that has dramatically lowered the rate of abusive sales practices, and allowed consumers to easily compare one Medigap with another.

We join the NAIC in its concern that this premium discount proposal, and other variations that could arise in the future, endangers the intent and the practical application of standardization and simplification, and we support the NAIC's request for clarification from CMS on this important topic.

Sincerely,



Bonnie Burns

Cc: Charlene Frizzera, Acting Administrator, Centers for Medicare and Medicaid Services

Commissioner Steve Poizner, California Department of Insurance

Congressman Pete Stark

Senator Max Baucus