

STATE ALERT

TO: State Insurance Commissioners

FROM: Kevin McCarty
Chair, Senior Issues Task Force
Commissioner, Florida Office of Insurance Regulation

DATE: [AUGUST 10, 2010 DRAFT]

RE: Medicare Supplement Hospital Network Arrangements

States should be aware of arrangements engaged in by certain Medicare supplement (Medigap) insurance carriers involving network hospitals in a manner that may not be intended by federal law and may be in violation of certain state laws where, in many cases, without the review or approval of state insurance regulators. We are concerned that there may be efforts to such arrangements could misconstrue and misinterpret federal law and, at a minimum, should be reviewed for compliance with State insurance law ~~opinion about these arrangements.~~

In ~~recent~~ the last several years, a number of Medigap issuers have entered into arrangements with organized networks of hospitals. Under these arrangements, the network hospitals agree to waive the Medicare Part A deductible (currently \$1,100) for the Medigap issuer if the issuer's policyholder uses their facility. In exchange, the plan agrees to pay the network arrangement an administrative fee equal to 35% of the Part A deductible (\$385) each time the network hospital discounts or waives the Part A deductible. Policyholders who use a network hospital receive a \$100 credit on their next year's premium renewal or the next month's premium, but receive no credit if they use an out-of-network hospital. (In some arrangements, the policyholder receives a \$100 check.)

Over the last several years, ~~the~~ Senior Issues Task Force has raised concerns about these arrangements.¹ We believe that these arrangements are likely to have a negative impact on the concept and goals of Medigap standardization and simplification, and are inconsistent with the requirement that Medicare supplement policies may not be more restrictive than Original Medicare. In addition, we believe that these arrangements should be part of the Medigap issuer's rate filing as a return of premium or premium credit result from policyholders participating in the program. Finally, there may very well be state marketing and sales enforcement issues associated with this arrangement, especially in those instances where the Medigap products are being sold with this program acting as an inducement to purchase the product in an area where access to a network hospital may be restrictive or even non-existent. This would be likely occur in the rural parts of a state.

As you know, standardization is a cornerstone consumer protection feature of Medigap plans, and permits consumers to easily compare plans based on meaningful benefit differences in order to select the plan that best meets their needs. Federal law also requires that Medicare

¹ Letter from Mary Beth Senkewicz to CMS Acting Administrator Charlene Frizzera, Aug. 5, 2009, accessible at www.naic.org/committees_b_senior_issues.htm

beneficiaries be granted the choice of any provider qualified to provide Medicare services,² and the NAIC model prohibits Medicare supplement policies from being more restrictive than Medicare.³ The only carefully prescribed exceptions to these requirements permissible by federal and state law are plans approved by the state as a Medicare Select plan or benefits approved by the state as a “new or innovative” benefit. Original Medicare is a fee-for-service program and federal law requires that beneficiaries ~~may use~~have access to any provider that accepts Medicare reimbursement. This Medigap arrangement is a traditional network arrangement and requires policyholders to use this restricted network in order to obtain the premium credit.

These arrangements also raise several other areas of concern for regulators and consumers, including the potential discriminatory impact for policyholders in rural areas with limited providers, the discriminatory impact on policyholders of the same actuarially supportable class, the administration of the premium credit for policyholders, impact on loss ratio and premium calculations, and advertising and marketing practices.

In some cases, we understand that these arrangements between issuers and hospital networks are occurring without the knowledge and approval of state regulators. In other cases, issuers may be consulting state regulators but misconstruing the weight of federal opinion on this matter.

First, some organizations have misrepresented the weight of advisory opinion letters issued by the Department of Health and Human Services’ (HHS) Office of the Inspector General (OIG), claiming that these letters constitute “blessing” by the federal government of these new arrangements and, therefore, they do not require additional state review. Regulators should be aware that the OIG advisory opinions comment only on the narrow issue of the applicability of federal anti-kickback rules and do not address the issue of whether states should or can approve plans utilizing these arrangements. The advisory opinions specifically note that the OIG has no authority and does not express any opinion as to whether the arrangement complies with other federal laws and regulations, or with any state laws and regulations.

Second, the Centers for Medicare and Medicaid Services (CMS) recently responded to an inquiry from the Senior Issues Task Force about these arrangements.⁴ While CMS took a narrow view of standardization in its response and believed that it did not have authority to prohibit the sale of these policies based on federal law on benefit coverage standardization grounds. CMS also clearly validated the state’s role in approving or disapproving these policies in stating: “It is important to emphasize, however, that State regulators have the discretion to decline licensing of a Medigap product with this network arrangement if they conclude that it violates State law, or that sale of such products will have a detrimental impact on their respective markets, or will be discriminatory against certain providers or issuers.”

² Social Security Act, Section 1802(a).

³ Section 6.A, NAIC Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (Model #651).

⁴ Letter from CMS Acting Administrator Charlene Frizzera to Mary Beth Senkewicz, Dec. 3, 2009, accessible at www.naic.org/committees_b_senior_issues.htm

State regulators should be aware of these arrangements by Medigap issuers in the states and, if they believe necessary, consider taking appropriate regulatory action.

DRAFT