

BULLETIN

TO: Insurers Selling Medicare Supplement (Medigap) Insurance in [State]
FROM: [Insert Name and Title of State Insurance Commissioner]
DATE: [July 12, 2010 DRAFT]
RE: Medicare Supplement Hospital Network Arrangements

The [Insert Name of State Insurance Department] has become aware that a growing number of Medicare supplement (Medigap) insurance carriers have entered into arrangements with organized hospital networks without proper review or approval of state insurance regulators. In accordance with provisions of the [INSERT STATE CITATION TO NAIC MODEL REGULATION TO IMPLEMENT THE NAIC MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS MODEL ACT (MEDIGAP MODEL REGULATION)], these arrangements should be reported to, and approved by the [Insert Name of State Insurance Department].

Under the arrangements in question, network hospitals typically agree to waive the Medicare Part A deductible (currently \$1,100) if the policyholder uses their facility. In exchange, the plan typically 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 typically then receive a \$100 credit on the next year's 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 check.

We find it troubling that, in communications with insurers and state regulators, there have been efforts to misconstrue and misinterpret two pieces of federal opinion related to these arrangements.

First, some organizations have misrepresented the weight of advisory opinion letters issued by the United States 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 state review. Insurers 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 National Association of Insurance Commissioners' (NAIC) Senior Issues Task Force about these arrangements. It is accurate that CMS' response took a narrow view of the Task Force's immediate question regarding standardization of benefits and CMS believed it did not have authority to prohibit the sale of these policies based on federal law on benefit coverage standardization grounds. However, 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.”

These arrangements implicate a number of important concerns. Medigap standardization and simplification, as required by state and federal law, is intended to permit consumers to easily compare plans based on meaningful benefit differences.

In addition, federal law requires that Medicare beneficiaries be granted the choice of any provider qualified to provide Medicare services, and [INSERT STATE CITATION FOR SECTION 6A OF THE NAIC MEDIGAP MODEL REGULATION] prohibits Medicare supplement policies from being more restrictive than Medicare.

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. Plans seeking state approval as a Medicare Select plan or as a “new or innovative” benefit must meet the requirements for these provisions.