



National Association of Insurance Commissioners

August 5, 2009

Charlene Frizzera
Acting Administrator
Centers for Medicare and Medicaid Services
200 Independence Avenue SW
Washington DC 20201

Dear Acting Administrator Frizzera:

The National Association of Insurance Commissioners (NAIC) Senior Issues Task Force urges you to examine an issue that has come to our attention involving hospital network arrangements engaged in by certain Medicare supplement (Medigap) insurance issuers. Certain issuers are utilizing these new arrangements in a manner not intended by federal law and without the review or approval of state insurance regulators. Therefore we urge you to consider issuing guidance to issuers clarifying that such arrangements should not be entered into without state approval as a Medicare Select plan.

We understand that a number of Medigap issuers have entered into arrangements with networks of hospitals who have agreed to waive the Medicare Part A deductible (currently \$1,068) if the policyholder uses their facility. The plan agrees to pay the network hospital an administrative fee equal to 35% of the Part A deductible each time the network hospital discounts or waives the Medicare Part A deductible. Policyholders who use the network hospitals receive a \$100 credit on the next year’s renewal premium, but receive no credit if they use an out-of-network hospital.

The Senior Issues Task Force has several concerns about these arrangements. Most troubling, these arrangements do not meet the requirements of Medigap standardization. As you know, federal and state law require that Medigap plans be standardized so that Medicare beneficiaries can more easily compare benefits and select the plan that best meets their needs. Medigap standardization requires issuers to offer identical and easily comparable plans, in order to help consumers choose amongst meaningful variations in plan benefits and designs. However, allowing some issuers to utilize these arrangements gives an advantage to issuers who vary from standardized products and disrupts the benefits of Medigap standardization, violating the intent of federal law.

In addition, issuers have not submitted these arrangements for state approval as a Medicare Select plan. Federal law provides for two mechanisms to allow states to approve non-standardized Medigap plans and benefits: one is Medicare Select plans and the other is “new or innovative” benefits. In both of these cases, state regulators carefully review and approve/disapprove the proposed arrangement or benefit based on whether these variations are beneficial to Medicare beneficiaries and whether they otherwise meet the requirements of federal law. Using Medicare Select issuers can offer plans that use provider networks if they are otherwise in compliance with the requirements of federal law. However, these new questionable hospital arrangements have not been submitted for approval as Medicare Select plans.

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To add to the confusion, some issuers have misrepresented the weight of advisory opinion letters issued by the Department of Health and Human Services' (HHS) Office of Inspector General (OIG), claiming that these letters constitute a blanket "blessing" by the federal government of these new arrangements and, therefore, they do not require additional state review. The OIG advisory opinions comment on the narrow issue of the applicability of federal anti-kickback rules; however, these letters do not address (nor should they) the issue of whether or not states should or can approve plans utilizing these arrangements. While we do not disagree with the content of these advisory opinions as they pertain to federal anti-kickback rules, we believe they have led to a misunderstanding regarding the weight of these advisory opinions on broader issues. We understand that several such advisory opinion letters have been issued, and that additional requests for similar letters are pending.

We are also concerned that these arrangements may create an unlevel playing field between rural and urban hospitals, provide incentives for steering beneficiaries towards certain facilities, and may provide favorable treatment to carriers with the largest networks at the expense of smaller carriers who may not be able to contract with as many facilities. The provision of premium credits may also have an impact on third year loss ratios and these policies may not take into consideration the fact that they may not be renewed, leaving the policyholder without the credit that is supposed to be provided.

There are also laws in many states that require companies that act as administrators to hold a Third Party Administrator license. The hospital facilities that are being paid administrative fees may need to have a license to act as an administrator.

Further, the premium credits that are being given may be in violation of state laws. Those individuals who use the network hospitals, but do not renew their contracts for some reason, do not receive the credit even though they would receive it if they continued the coverage. This has the potential effect of causing an insured to stay with one of these companies when they might not if they were not going to receive the credit.

We urge you to examine this issue and consider providing guidance to issuers in this area. We look forward to working with you on this issue. If you should have any further questions, please do not hesitate to contact me.

Sincerely,



Mary Beth Senkewicz
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Chair, Senior Issues Task Force
National Association of Insurance Commissioners