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September 23, 2008

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Commissioner Sean Dilweg
Chair, NAIC Senior Issues Task Force
Guenther Ruch
Administrator, Regulation & Enforcement Division
Office of the Commissioner of Insurance
Post Office Box 7873
Madison, Wisconsin 53707-7873

Re: Waivers of Part A Deductibles in Medicare Supplement Plans

Dear Sirs:

A number of issuers of Medicare supplemental (Medigap) policies have entered into arrangements whereby hospitals have agreed to waive some or all of the required hospital inpatient deductible for Medicare beneficiaries with Medigap policies that cover that deductible. Questions have been raised about whether such arrangements are consistent with the standardization and other requirements of federal law. This letter will address those questions by demonstrating that nothing in the federal Medicare statute or the NAIC Model Medicare Supplemental Regulations prohibits such arrangements or would otherwise prevent a Medigap issuer from entering into such arrangements. Moreover, we will demonstrate how such arrangements are in the public interest by lowering the cost of Medigap insurance for all policyholders.

Background

Several years ago an issuer of Medigap policies throughout the country was approached by an organizer of a network of hospitals that were willing to reduce or waive the Medicare hospital inpatient deductible for policyholders of the Medigap insurer whose policies covered the inpatient deductible. Since this arrangement did not seem to fall within one of the anti-kickback safe harbors, the insurer sought an advisory opinion from the Office of Inspector General (“OIG”) of the U.S. Department of Health and Human Services on the legality of such an arrangement under the anti-kickback laws.

The OIG responded that the proposed arrangement would not constitute grounds for the imposition of sanctions under the anti-kickback statutes because (1) it presented a low risk of fraud, (2) it would not increase Medicare costs or decrease competition, (3) by providing a premium credit to beneficiaries for whom the deductible was waived, it would lower Medigap costs for affected policyholders, and (4) it had the potential to lower costs for all policyholders. Armed with this opinion (and a similar opinion subsequently issued to another insurer) several issuers of Medigap policies have entered into such arrangements which have successfully reduced costs for the beneficiaries.

It is important to note several features of these arrangements. First, the agreement to waive all or part of the deductible applies only to plans that are obligated to pay the deductible.. Holders of a Plan A policy (which does not cover the deductible) are not included within the discounting agreement. Second, there is no consequence to a policyholder who chooses to obtain services from a non-network hospital. His or her deductible is paid under the policy by the insurer, even though the deductible is not waived or discounted. This is not like Medicare Select or similar preferred provider plans under which a policyholder is subject to lesser coverage or increased deductibles or coinsurance if they receive services from a non-participating provider. Here, the arrangement is absolutely invisible to the policyholder. In other words, the benefits received by the policyholder are not different in any respect from those that are specified in whatever standardized plan he or she chooses.

Despite these facts, these arrangements have been questioned on two grounds. First, it has been alleged that these arrangements somehow violate the “standardization” requirements in the federal statute and the Model Regulations. Second, it has been alleged that such arrangements are a form of Medicare Select policy but that they fail to meet the requirements in the Model Regulations for such policies. We find no merit to either of these contentions. The standardization features of the Medigap requirement relates only to the benefit structure of the various plans, while these arrangements have no impact on the benefits provided under those plans. Nor are these arrangements similar to Medicare Select policies in that they do not restrict policyholders in any way to the use of network providers. A more complete analysis of these issues follows.

The Discounting Arrangement Does Not Violate Standardization Requirements

Section 1882 of the Social Security Act (SSA) establishes a comprehensive regulatory scheme governing the issuance of Medicare Supplement policies. The SSA permits states to approve Medicare Supplement policies, but only in accordance with a state regulatory framework that meets certain federal requirements and standards. The SSA specifically provides that no *benefit packages* may be offered under a Medigap policy unless it meets the NAIC standards. SSA § 1882(p)(4)(A). It is illegal to sell any Medicare Supplement policy that does not conform to one of the standardized packages developed by the NAIC in conjunction with CMS.

All of the NAIC Model Regulation standardized plans other than Plan A include a benefit for coverage of the Part A deductible amount incurred for inpatient hospital treatment. Section 8 of the Model Regulations, which details the standardized benefits, requires in part “coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period.” Section 9(B) of the Model provides that “no groups, packages or combinations of Medicare supplement benefits other than those listed in this section shall be offered...” Section 9(C) of the Model requires that benefit plans shall be

uniform in structure, language, designation and format to the standardized benefit plans...listed...and conform to the definitions in...this regulation... For purposes of this section ‘structure, language, and format’ means style, arrangement and overall content of a benefit.

All of the Medigap plans offered by the insurer that has entered into the deductible waiver agreement fully comply with these requirements. The benefits provided under each plan are exactly as specified in the Model Regulations. When the insurer entered into this arrangement, no change needed to be made to its benefit packages because in the case of all policies covering the inpatient deductible, that benefit continues to be provided without change. Nor is any restriction placed on the policyholder’s choice of which provider he or she could choose. If a non-network provider is chosen, the insurer pays the provider for the deductible on behalf of its policyholder. If the policyholder chooses a network provider, the discount negotiated by the insurer is applied to the deductible, and if any balance remains, it is paid by the insurer. In either case the policyholder is held harmless, and he or she has received the full benefit specified in the policy.

In establishing the various Medigap packages, the Model Regulations uses the term “standardization” only in conjunction with the term “benefits”. For example, Section 1 of the regulations states that “[t]he purpose of this regulation is to provide for the reasonable standardization of coverage and simplification of terms and benefits of Medicare supplement policies” In describing the various packages, the Model Regulation in each case states that “Standardized Medicare supplemental benefit plan [A through L] shall consist of the following:” and then goes on to list only the benefits that are required to be provided under each of the plans. Although the format of the various packages indicates the amount that each party (i.e., Medicare, plan, and insured) “pays” for the various covered services, that format is undoubtedly for the purpose of clarifying for the policyholder the amounts for which he or she is responsible. There is nothing in the standardized packages that indicates how each party must satisfy the amount for which it is liable.

The goal of standardization according to section 1882(p)(3)(B) of the SSA is to—

balance the objectives of (i) simplifying the market to facilitate comparisons among policies, (ii) avoiding adverse selection, (iii) providing consumer choice, (iv) providing market stability, and (v) promoting competition

Nothing in the arrangement into which the insurer has entered is inconsistent with those goals; in fact, the arrangement is likely to help achieve the goal of promoting competition. In short, an agreement with a participating hospital to reduce or waive the Part A deductible amount for which the insurer is responsible in no way violates standardization or the goal of standardization. The standardized benefit is always covered and the insured is never responsible for paying any of the deductible.

The Arrangement is Not Prohibited by the Medicare Select Requirements

This section of the letter will respond to allegations that the arrangement results in a Medicare Select policy which does not meet the requirements for such a policy under the applicable statute (SSA § 1882(t))¹ and Model Regulations.

Section 10 of the Model Regulation provides as follows:

(B) For the purposes of this section:

¹ SSA § 1882(t)(1) provides as follows:

If a Medicare supplemental policy meets the 1991 NAIC Model Regulation or 1991 Federal Regulation complies with the requirements of this section except that benefits under the policy are restricted to items and services furnished by certain entities (or reduced benefits are provided when items or services are furnished by other entities), the policy shall nevertheless be treated as meeting those standards if—

(A) full benefits are provided for items and services furnished through a network of entities which have entered into contracts or agreements with the issuer of the policy;

(B) full benefits are provided for items and services furnished by other entities if the services are medically necessary and immediately required because of an unforeseen illness, injury, or condition and it is not reasonable given the circumstances to obtain the services through the network

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(4) “Medicare Select policy” or “Medicare Select certificate” mean respectively a Medicare supplement policy or certificate that contains restrictive network provisions.

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(6) “Restrictive network provision” means any provision that conditions the payment of benefits, in whole or in part, on the use of network providers.

Quite simply, this regulation and the Medicare statutory provision on which it is based do not apply to the arrangement in question because the arrangement does not condition the payment of benefits, in whole or in part, or in any way, shape or form, on the use of network providers. Nor does the arrangement provide reduced benefits if a policyholder chooses to obtain covered items or services from non-network providers. Policyholders are completely free, without any consequence to themselves, to choose a non-network provider. If they do, the insurer will pay the benefit. Unlike Medicare Select, full benefits are covered without regard to the use of a network provider.

It has also been alleged that Medicare Select is the only permissible arrangement through which a Medigap insurer may enter into payment arrangements with a network of providers. This is simply not true. Nothing in the statute or Model Regulations prevents an insurer from entering into arrangements with a network of providers so long as the full benefits are provided under its Medigap plans without restriction. The fact that the statute and Model Regulations permit a particular form of network arrangement that requires policyholders to accept restricted access to providers or reduced benefits does not mean that an insurer cannot enter into payment arrangements with providers that have absolutely no bearing on the benefits provided or the choices available to policyholders.

The Arrangement Otherwise Fully Complies with the Law and Is in the Public Interest.

The only legal question that this arrangement raised was whether it was permissible under the Medicare anti-kickback prohibitions. In order to resolve those questions, the insurer in advance fully disclosed the terms of the arrangement in a formal advisory opinion request to the OIG. The OIG carefully evaluated the arrangement and then issued an advisory opinion² that the arrangement was permissible and did not warrant the imposition of sanctions under the anti-kickback laws.

² OIG Advisory Opinion 03-10, May , 2003

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In its opinion the OIG noted that, beyond its legality, the arrangement would be in the public interest by reducing the cost of Medicare supplement insurance for Medicare beneficiaries. Medicare supplement policyholders would benefit directly whenever they received a premium credit under the arrangement. Moreover, the arrangement offered the potential of reduced premiums for all policyholders because savings realized from the arrangement are reported to state insurance rate-setting regulators. We do not understand what objections could be raised to an arrangement that reduces costs for everyone yet provides the full range of benefits required in Medigap plans.

Conclusion

We appreciate the opportunity to share this analysis with NAIC's Senior Issues Task Force. We think you will agree that the deductible waiver arrangement under question fully complies with the standardization requirements of the Model Regulation and in no way implicates the Medicare Select provisions. Please let us know if we can address any further questions that you or members of the Task Force may have.

Sincerely,

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