

DRAFT 09/12/08

**MEMORANDUM ON
HOSPITAL NETWORKS AND STANDARDIZED MEDIGAP INSURANCE POLICIES**

A managed care network organization has proposed to use hospital networks to operate with standardized Medigap (other than MedicareSELECT) insurance products. Hospitals in these networks would waive the Medicare Part A deductible (currently \$1024). Policyholders would receive a \$100 credit on their next renewal premium if they use hospitals in the network, but would receive no credit when using out-of-network hospitals.

The Part A deductible is covered in either case--by the insurer for out-of-network, and by hospital waiver for in-network. Where a policyholder uses an in-network hospital and the Part A deductible is waived, the Medigap insurer must pay the network organization a fee of \$358.

The managed care network organization has indicated that the U.S. HHS Office of the Inspector General ("HHS-OIG") issued an opinion letter in 2003 to an insurance company that this arrangement in connection with a standardized Medigap policy (that **is not** a MedicareSELECT policy) does not violate the Medicare "anti-kickback" rules. Another similar advisory opinion was issued by the HHS-OIG in 2007 to another Medigap insurer.

The managed care network organization asserts that this waiver of the Part A deductible is a discount arrangement that is outside the policy form contract of insurance, much like discounts for health clubs or other similar "add on" benefits to the policy. The managed care network organization asserts that the Part A deductible waiver is based on an agreement between the Medigap insurer and a hospital network and is not part of the Medigap insurance policy.

Issues

The purpose of this memorandum is to discuss the following: (1) the applicability and scope of the HHS-OIG opinion letter and the Medicare-Medicaid anti-kickback law to Medigap and MedicareSELECT insurance products; and (2) possible state regulatory issues in connection with Medigap and MedicareSELECT insurance products that would utilize the Part A deductible waiver with a hospital network arrangement.

Discussion

The managed care network organization argues that some "de minimus" exception exists that permits network arrangements for all Medigap insurance products. However, as discussed below, the federal anti-kickback law presents issues and standards that are separate and distinct from Medigap and MedicareSELECT product regulation issues and standards.

Importantly, satisfaction of the federal anti-kickback rules does not satisfy any other state and federal standards and requirements for Medigap and MedicareSELECT insurance products. MedicareSELECT is a Medigap product that is subject to additional and specific standards under federal and state law that specifically permits use of a provider network.

I. Medicare-Medicaid Anti-Kickback Law

The Medicare “anti-kickback” statutes makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive “any remuneration” to improperly induce or reward referrals of items or services that are reimbursable by Medicare or any other federal health care program. The term “remuneration” is defined broadly to include the transfer of anything of value, directly or indirectly, overtly or covertly, in cash or in kind.

Waiver of the Medicare Part A deductible in exchange for patient steerage under the arrangement is technically a violation of the anti-kickback rule.

In OIG Advisory Opinion No. 03-10 (issued on May 8, 2003), and OIG Advisory Opinion No. 07-15A (issued December 3, 2007) the HHS-OIG determined that the inclusion of certain standardized Medigap policyholders in a hospital network involving waiver of the Medicare Part A deductible would not violate the anti-kickback rule and would present a low risk of fraud or abuse.

This is because the HHS-OIG concluded that the specific facts and information presented by the requestors of the advisory letters fit into a *statutory* exception, and that a waiver: (1) would not affect Medicare payments; (2) should not increase utilization; (3) should not affect competition among hospital providers; and (4) should not affect professional medical judgment.

In the Advisory Opinions, the HHS-OIG noted that, although the pass-through of premium savings was technically different from the statutory exception for waiver of the deductible amount, the purpose and effect was the same. The advisory opinions are only applicable to the companies requesting the letter; and are limited to the facts as described in the letters. These opinions may not be relied upon by any persons other than the parties requesting the opinions.

Statutory Exception for Plan Design

The HHS-OIG concluded that even though the waiver of the Medicare Part A deductible would improperly induce beneficiaries to choose particular providers, there is a statutory exception for differentials in coinsurance and deductible amounts that are part of a plan's benefit design.

Specifically, this statutory provision declares that the term “remuneration” does not include the waiver of coinsurance and deductible amounts if the differentials in coinsurance and deductible amounts is part of a benefit plan design and the differentials have been disclosed in writing to all beneficiaries, third party payers, and health care providers. See, Social Security Act section 1128A(i)(6)(C).

This statutory exception is intended to permit health plan enrollees to pay different cost-sharing amounts depending upon whether they use network or non-network providers.

Specific Regulatory Safe-Harbors

In addition to the statutory exception discussed above for “network” arrangements, the opinion letter discusses a separate *regulatory* “safe harbor” for the waiver of beneficiary coinsurance and deductible amounts for inpatient hospital services.

This regulatory “safe harbor” applies where: (1) the amounts are owed to a hospital and the hospital does not later claim the waiver as “bad debt” or does not shift the burden to other payers; (2) the hospital’s waiver is offered without regard to the reason for admission, length of stay, or DRG for which a claim for Medicare reimbursement is filed; and (3) the waiver is made a part of an agreement with a beneficiary that is *specifically* enrolled in a MedicareSELECT policy (must be issued under the terms of section 1882(t) of the Social Security Act). See 42 CFR 1001.952(k)(1)(i)-(iii).

Accordingly, this regulatory “safe harbor” is *restricted* to MedicareSELECT arrangements. This is because the regulation references only a Medicare Supplemental policy issued under the terms of section 1882(t)(1) of the Social Security Act. A MedicareSELECT policy is a specific “type” of Medigap policy form whose benefits are limited to use of a provider network arrangement. It is distinct from other standardized Medigap policies.

In 2002, the HHS-OIG issued a proposed rule to establish a regulatory “safe harbor” for the waiver of beneficiary coinsurance and deductible amounts under both Medicare Part A and Part B. See 67 Fed. Reg. at 60202 (September 25, 2002). The proposed rule would amend the existing “safe harbor” for MedicareSELECT. Accordingly, the “safe harbor” would be specifically limited to MedicareSELECT arrangements.

To date, however, the HHS-OIG has not issued a final rule for this Part B waiver “safe harbor”.

Analysis

The HHS-OIG Advisory Opinions rely upon the *statutory* exception and **not** the regulatory exception because the circumstances do not involve a MedicareSELECT insurance policy that has an explicit *regulatory* “safe harbor” in the anti-kickback rules. MedicareSELECT arrangements enjoy a separate and explicit regulatory “safe harbor” under the anti-kickback rules.

II. State Regulatory Issues for Medigap Standardized Plan Types

While the HHS-OIG advisory opinion resolves the issue of liability under federal anti-kickback law with respect to the issue of impermissible “remuneration,” the next issue is whether a Medigap policy that is NOT a MedicareSELECT policy can enter into a network agreement with a hospital provider to waive the Part A deductible amount.

The federal anti-kickback law requirements are separate and distinct from Medigap and MedicareSELECT product regulation issues and standards. Satisfaction of the federal anti-

kickback rules does not satisfy any state and federal standards and requirements for Medigap and MedicareSELECT insurance products.

MedicareSELECT Medigap Insurance Products

MedicareSELECT is a Medigap product that is subject to additional and specific standards under federal and state law because it involves a restricted delivery system for standardized Medigap benefits.

A MedicareSELECT insurance product is, in all other respects, a standardized Medigap product with the exception that both the Social Security Act and the NAIC Model Medigap Regulation provide standards that *explicitly* permit the restriction of full Medigap benefits (usually discounts or waivers of the Part A deductible) under the policy to a specified network. Policyholders would be subject to greater out-of-pocket cost-sharing (standard Medicare cost-sharing) when using a non-network hospital.

Federal law provides that if a Medigap policy otherwise meets the standardization requirements, under a MedicareSELECT arrangement it must also meet six additional statutory requirements.

These additional requirements are: (1) full benefits are furnished through a network that is based upon contracts or agreements with the issuer; (2) full benefits are provided by other entities if the services are medically necessary and immediately required in an emergency; (3) the network offers sufficient access; (4) the issuer has arrangements for an on-going quality assurance program; (5) the issuer provides, at the time of enrollment, an explanation of the restrictions on benefit payments, out of area coverage, and emergency care; and (6) the issuer also makes available a non-MedicareSELECT Medigap insurance policy. See, Social Security Act section 1882(t).

The NAIC Model Regulation provides that a Medigap insurance policy may not be advertised as a MedicareSELECT policy unless it meets the requirements of the Model Regulation. An issuer must meet the requirements of the Social Security Act and must specifically file a plan of operation for a MedicareSELECT policy.

The MedicareSELECT plan must be approved by the commissioner of insurance. See, NAIC Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act, Section 10. States require a separate policy form to be filed for MedicareSELECT plans, and rates and experience must be filed specifically for MedicareSELECT plans. See, NAIC Medicare Supplement Insurance Model Regulation Compliance Manual (June 12, 2005).

Standardized Medigap Insurance Products

Issuers offering non-MedicareSELECT Medigap insurance policies are limited to offering only the standardized plan types as described in the NAIC Model Medigap Regulation. In 2002, CMS took the position that, because of benefit standardization, preferred or limited provider networks may be provided only in the MedicareSELECT context. See, Letter from Thomas A. Scully, Administrator, to all Insurance Commissioners (dated August 27, 2002).

Apart from MedicareSELECT, the only other avenue for offering standardized Medigap policies with “managed care” features might possibly be in states where such a network feature is approved as a “new or innovative” benefit to one of the standardized plan types.

Federal law provides that, with the approval of a state, the issuer of a Medigap policy may offer “new or innovative” benefits, in addition to the standardized benefits of a particular plan type. Each state has discretion to approve such features so long as the “new or innovative” benefit is cost-effective and offered in a manner that is consistent with standardization. See, Social Security Act section 1882(p)(4)(B).

Few, if any state regulators have exercised the authority to approve “new or innovative” benefits to standardized Medigap plan types. In view of the CMS position that “managed care” features can only be offered in connection with a Medigap policy that is a MedicareSELECT plan it seems highly unlikely that a state would approve a network feature as a “new or innovative” benefit addition to a standardized Medigap plan type.

It is also likely that state regulators would not consider a network arrangement to be a “benefit” that is “new or innovative” because it is not an actual health care item or service. See, Draft NAIC Medicare Supplement Insurance Model Regulation Compliance Manual (“What are New or Innovative Benefits?”).

Finally, of note, federal law permits an issuer of a Medigap policy to provide “discount” arrangements with vendors for the purchase of items and services NOT COVERED under Medigap policies. For example, this could include services like dental or vision care, or items like eyeglasses and, prior to the Medicare Modernization Act, prescription drugs. See, Social Security Act section 1882(p)(7).

Analysis

Only MedicareSELECT arrangements are explicitly authorized to incorporate a hospital network feature under the Social Security Act. The managed care organization's proposal to utilize a network for the Part A deductible waiver arrangement for Medigap insurance products is not permissible under the federal Medigap product standards established under the Social Security Act.

Under this Part A waiver arrangement, the “benefit” is a reduction in a policyholder's renewal premium for each time a network hospital is used in a “benefit period”. If a policyholder does not use a network hospital, there is no “benefit” of a reduction in the policyholder's renewal premium. As a result, even though the Part A deductible is covered under the policy, the full benefit of the arrangement depends upon the use or non-use of the hospital network.

Silent PPO Issue. There is also a concern that this arrangement could be a “silent PPO” circumstance where, unbeknownst to a hospital, a managed care organization has sold or rented its network to a third party (such as a Medigap insurer). If a hospital contests a discount for a

non-MedicareSELECT Medigap policyholder, the beneficiary may be held liable for the deductible although the beneficiary thought it was "waived."

Marketing and Premiums. Other issues could include marketing violations if this feature, and a list of network providers, was not noticed to policyholders in marketing materials, policy documents, and membership cards. Another issue could be premium adequacy concerns if the waiver was included in the determination of the premium charged for the policy because under one arrangement policyholders are credited \$100 on the next renewal premium for each time they use a network hospital in a "benefit period".

Rules of Statutory Construction. Some argue that because the rule for non-MedicareSELECT plans is "silent" on using a provider network, that it is not prohibited. The better rule of statutory construction says that when federal law specifies that only a MedicareSELECT Medigap policy may use a provider network than other non-MedicareSELECT Medigap plans may not.

If non-MedicareSELECT plans could use hospital networks than Congress would not have established the specific and express use of networks for MedicareSELECT within the same section of the Social Security Act. Where Congress explicitly enumerates certain exceptions to a general rule, additional exceptions are not to be implied.

An inference drawn from Congressional silence cannot be credited when it is contrary to other textual and contextual evidence of Congressional intent. That Medigap plans may not generally use a network is evidenced by the MedicareSELECT provisions and the "new or innovative" benefit provisions of the federal statute.

Add-on Discounts. Some argue that the waiver of the Medicare Part A deductible is an "add on" that is outside the contract of insurance. However, coverage of the Part A deductible is a specific, standardized "covered" benefit of standardized Medigap policies B through L. Add-on discounts such as for health clubs, for example, are not specific benefits of a standardized Medigap policy. However, a "discount" for the Part A deductible would not qualify for permitted vendor discounts as a "covered" benefit.

Plan A Core Benefits. Adding this Part A deductible waiver as a benefit to standardized Medigap policy plan A would clearly breach the standardization for this plan type.

Conclusion

The HHS-OIG advisory opinions relate only to the federal anti-kickback law, and do not relate to federal and state Medigap policy standards. Only a MedicareSELECT Medigap insurance product is explicitly authorized to utilize a network arrangement for benefits under the policy as provided by federal and state law and regulations. The waiver of the Part A deductible is not an "add on" discount that is outside the policy of insurance because coverage of the Part A deductible is specifically addressed as a benefit of standardized Medigap policies.