

CHAMBERLAIN ♦ MCHANEY
ATTORNEYS AT LAW

Reply to: P.O. Box 684158
Austin, Texas 78768-4158
301 Congress Avenue, 21st Floor
Austin, Texas 78701
(512) 474-9124
Fax (512) 474-8582
WRITER'S EMAIL: bdavidson@chmc-law.com

San Antonio Office:
310 South St. Mary's, Suite 1815
San Antonio, Texas 78205
(210) 227-3331
Fax (210) 227-3334

September 20, 2010

Commissioner Kevin M. McCarty
Chair, NAIC Senior Issues Task Force
Mary Beth Senkewicz
Deputy Insurance Commissioner
State of Florida
Office of Insurance Regulation
Edwin Larson Bldg.
200 E. Gaines St., Suite 312
Tallahassee, FL 32399

Dear Commissioner McCarty & Deputy Commissioner Senkewicz:

Thank you for the opportunity to provide comments on the Draft *State Alert* and *Bulletin* addressing Medicare Supplement Hospital Network Arrangements.

We are writing to you today on behalf of USA Senior Care, Inc, an operator of such a network to correct serious misstatements of fact and invalid arguments contained in the draft State Alert and Bulletin. USA Senior Care contracts with approximately 1300 facilities that agree to waive all or a portion of the \$1,100 Part A inpatient deductible, thereby reducing the overall cost of the inpatient admission. Approximately 50 Medigap carriers participate in USA Senior Care's network agreements, representing about 1.5 million policyholders.

While policyholders of Medicare Supplement (Medigap) insurance carrier clients of USA Senior Care can select any provider they wish for inpatient care, if they choose a contracted hospital the policyholder receives a \$100 credit toward future premium due each time a Part A deductible is waived. The balance of the \$1,100, minus the premium credit and other administrative expenses, is retained by the carrier as savings. This requires the carrier to reduce the severity of premium rate increases going forward. The program cuts premium costs for all policyholders, not just those that access participating facilities.

Background:

For over two years, the NAIC Senior Issues Task Force (the Task Force) has conducted an informal review of a series of longstanding contractual arrangements (arrangements) between a

number of Medigap carriers and USA Senior Care's network of in-patient facilities whereby, as noted above, such facilities agree to waive some or all of the Medicare Supplement Part A deductible, resulting in premium savings to Medigap enrollees.

We believe that the Medicare supplement Part A deductible waiver program offers a welcome opportunity for Medigap carriers to capture significant Part A claims costs savings. As a result of federal minimum loss ratio standards, these savings are passed along in the form of reduced premiums to *all* Medigap enrollees.

Last year the Task Force, under the direction of Mary Beth Senkewicz, Deputy Commissioner of the Florida Office of Insurance Regulation, sent a letter to CMS requesting an opinion that the arrangements violate federal law. CMS held just the opposite, completely exonerating the arrangements. The CMS opinion letter indicated that the arrangements do not violate the standardization of benefits provisions of the Social Security Act, and do not meet the definition of a Medicare Select Policy or "new or innovative" benefit. In fact, CMS determined such arrangements are not a benefit at all. This response is consistent with numerous Advisory Opinions published by the Office of Inspector General of the U.S. Department of Health and Human Services (OIG). The OIG clearly recognizes that the savings from the arrangements would have the potential to lower costs for all policyholders.

Despite CMS having primary responsibility for oversight of the Medicare laws, the Senior Issues Task Force has responded to the CMS letter by drafting a *State Alert* and *Bulletin*, dismissing the opinion letter and directing the states to ignore the CMS conclusion that the agreements do not violate standardization.

Comments:

We are unaware of any authority granted to the Senior Issues Task Force to opine on federal or state law. Nonetheless the Task Force reaches a legal conclusion in its communication to state commissioners. We believe this is an inappropriate action by an NAIC Task Force, particularly absent input from NAIC legal counsel or a hearing with testimony from interested and affected parties. We ask that the Task Force postpone issuing a *State Alert* and *Bulletin* absent such clear legal authority and due process.

We are pleased to comment on specific provisions in the Draft *State Alert* and *Bulletin*. The following are the statements made in the Draft, followed in **bold** by my client's response to that statement:

1. Arrangements engaged in by certain Medicare Supplement (Medigap) carriers involve network hospitals in a manner that may not be intended by federal law, and could misconstrue and misinterpret federal law and opinion...The Senior Issues Task Force believes that these arrangements are likely to have a negative impact on the concept and goals of Medigap standardization and simplification. **Response: The CMS letter of 12/03/2009 is clear in its opinion about the issue of standardization. CMS states,**

"Since the benefits in question (payment of the beneficiaries' Part A Deductible) are not impacted, this particular network arrangement does not violate the standardization provisions." In addition, Senior Issues Task Force members have not demonstrated a uniform position as is indicated by the Draft State Alert. In fact, in 2008 the Task Force reviewed the issue and decided not to act on issuing a State Alert and Bulletin to state regulators. Had the Task Force in fact acted in 2008, its guidance to states that arrangements violated standardization would have been an inappropriate *legal* conclusion, and as affirmed by the 2009 CMS opinion, would have been legally incorrect.

2. Medigap carriers have engaged in arrangements with network hospitals without the review or approval of state regulators. **Response: Medigap forms and rates are subject to state approval. These arrangements are not part of the form filing process because they are not "plans" and do not prohibit, restrict or affect policyholder benefits. However, informational filings have been done by certain carriers. When arrangements have been reviewed and suspended, the effect has been higher premiums for policyholders, as approved by state regulators, because claims incurred increased per the Part A deductible. The program has been highly visible to regulators, and has been used by major Medigap carriers for many years. It has also leveled the playing field for smaller and mid size carriers allowing them to compete on an even basis with the large carriers, because large carriers often negotiate waivers directly with facilities. This program has kept Medigap rate increases lower and the cost of Medicare Supplement coverage lower.**
3. A 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 Part A deductible. **Response: The arrangement is not a "plan." None of the contracted hospitals receive an administrative fee.**
4. Policyholders receive no premium credit if they use an out of network hospital. **Response: True, but all policyholders receive the advantage of the Part A deductible waiver via less severe future rate increases. There is no benefit differential whether a policyholder uses a network or non-network hospital.**
5. Federal law requires that Medicare beneficiaries be granted the choice of any provider qualified to provide Medicare services. **Response: The arrangements do not change this at all. Policyholder benefits do not vary based on network usage. There is no restriction in choice of provider.**
6. The arrangements are inconsistent with the requirement that Medicare supplement policies may not be more restrictive than Original Medicare. **Response: The Draft Alert references Section 6 A of the Model Regulation, which provides:**

Except for permitted preexisting condition clauses as described in Section 7A(1),

Section 8A(1), and Section 8.1A(1) of this regulation, no policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy if the policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare. [emphasis added]

Only provisions containing limitations or exclusion on coverage more restrictive than that of Medicare are prohibited. The arrangements do not limit or exclude coverage. Policyholders benefits will not vary based on network usage. The carrier will always cover the Part A deductible amount. Therefore, the arrangements are not more restrictive than Original Medicare and not inconsistent with Model or state requirements.

7. The only exception to Section 6 A of the Model Regulation permissible by federal law is plans approved by the state as a Medicare Select Plan or as a "new or innovative" benefit. **Response: CMS determined in its 2009 opinion letter that "since benefits are not restricted to a network of providers, this arrangement does not meet the definition of a Medicare Select policy..." CMS also opined that because this arrangement is not a benefit it is not an "innovative" benefit.**
8. These arrangements will have:
 - a. a potential discriminatory impact for policyholders in rural areas with limited providers **Response: There is no benefit differential whether a rural policyholder uses a network or non-network hospital. The carrier will always cover the Part A deductible for all policyholders. Approximately 40% of contracted in-patient facilities are considered rural. The arrangement is open for participation to all in-patient facilities both rural and urban, but some simply choose to not join. –**
 - b. an impact on loss ratio and premium calculations **Response: Rate filings submitted annually to state regulators reflect claims actually paid for Medigap benefits. Incurred claims are reduced by any savings a company realizes from participating in an agreement. The reduction in those claims will result in smaller future increases in order to satisfy federally mandated loss ratio requirements.**
9. CMS took a narrow view of standardization in its response and believed that it did not have the authority to prohibit the sale of these policies based on federal law on standardization grounds. **Response: CMS provided in its 2009 letter that neither the particular network arrangement nor the premium credit violates standardization provisions. The Task Force does not have the authority to opine on federal law. The Task Force misconstrues the arrangement as a "policy" for sale.**
10. 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 [Insert Name of State Insurance Department]. **Response: This section of the draft *Bulletin* again pertains to Section 6 A of the Model Regulation, which provides:**

“Except for permitted preexisting condition clauses as described in Section 7A(1), Section 8A(1), and Section 8.1A(1) of this regulation, no policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy if the policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare. [emphasis added]”

Only provisions containing limitations or exclusions on coverage more restrictive than that of Medicare are prohibited. The arrangements do not limit or exclude coverage. Policyholders benefits will not vary based on network usage. The carrier will always cover the Part A deductible amount. Therefore, the arrangements are not more restrictive than Original Medicare and not inconsistent with Model or state requirements.

11. We believe that these arrangements should be part of the rate filing as a return of premium or premium credits result from policyholders participating in this program. **Response: Medigap forms and rates are subject to state approval. These arrangements are not part of the form filing process because they are not "plans" and do not prohibit, restrict or affect policyholder benefits. These arrangements are not part of the rate filing process because policies are sold at a pre-established premium rates that are part of the carriers annual rate filing. These rates do not change until the next rate filing. Policyholders choosing to use contracted hospitals are simply allowed to participate in the hospital discounts and carrier savings via a premium credit but the premium rate at the time of policy purchase remains the same.**
12. 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 likely occur in the rural parts of a state. **Response: This arrangement is an after the sale program. It is designed and has been proven to increase persistency, not induce sales. It is not a sales tool and has no place in the sales presentation. The opportunity to use the USA Senior Care network is given to all existing policyholders and is only revealed to new policyholders after the sale. It is always the policyholder's option to use it. It does not, in any way, alter or change the policyholder's coverage. It keeps product pricing competitive and policies in force.**

Conclusion:

The arrangements provide all Medigap policyholders with welcome premium savings without affecting policy benefits. The Senior Issues Task Force should not make a legal pronouncement in the form of a *State Alert* or *Bulletin* without the proper authority and without a full review and hearing. This arrangement is beneficial to all stakeholders: consumers/policyholders, providers, carriers and the network manager and it benefits the public by reducing the cost of Medicare Supplement insurance. The Task Force is ill advised in focusing its attention on this very positive program. The public would be better served if the Task Force focused its efforts on helping senior consumers by ensuring that the states enforce laws like the Safeguard Our Seniors Act contained in Section 41 of Chapter 2010-175 of the Florida statues which establishes safeguards for inappropriate marketing actives relating to annuities, life insurance, commodities and options, and which cracks down on the practices of "twisting" or "churning."

USA Senior Care, Inc. thanks you for the opportunity to comment on this matter.

Sincerely,


William C. Davidson