NAIC NATIONAL MEETING
FALL 2022

Draft: 11/1/22

2022 Fall National Meeting
Tampa, Florida

SENIOR ISSUES (B) TASK FORCE
Tuesday, December 13, 2022
2:30 – 3:30 p.m.
HB Plant Ballroom E & F - Level 2 - JW Marriott

ROLL CALL

Marlene Caride, Chair	New Jersey	Kathleen A. Birrane	Maryland
Jon Pike, Vice Chair	Utah	Gary D. Anderson	Massachusetts
Mark Fowler	Alabama	Anita G. Fox	Michigan
Lori K. Wing-Heier	Alaska	Grace Arnold	Minnesota
Peni Itula Sapini Teo	American Samoa	Chlora Lindley-Myers	Missouri
Evan G. Daniels	Arizona	Troy Downing	Montana
Alan McClain	Arkansas	Eric Dunning	Nebraska
Ricardo Lara	California	Barbara D. Richardson	Nevada
Michael Conway	Colorado	Mike Causey	North Carolina
Andrew N. Mais	Connecticut	Jon Godfread	North Dakota
Trinidad Navarro	Delaware	Judith L. French	Ohio
Karima M. Woods	District of Columbia	Andrew R. Stolfi	Oregon
David Altmaier	Florida	Michael Humphreys	Pennsylvania
John F. King	Georgia	Larry D. Deiter	South Dakota
Colin M. Hayashida	Hawaii	Carter Lawrence	Tennessee
Dean L. Cameron	Idaho	Cassie Brown	Texas
Amy L. Beard	Indiana	Kevin Gaffney	Vermont
Doug Ommen	Iowa	Tregenza A. Roach	Virgin Islands
Vicki Schmidt	Kansas	Scott A. White	Virginia
Sharon P. Clark	Kentucky	Mike Kreidler	Washington
James J. Donelon	Louisiana	Allan L. McVey	West Virginia
Timothy N. Schott	Maine	Nathan Houdek	Wisconsin

NAIC Support Staff: David Torian

AGENDA

1. Consider Adoption of its Oct. 17 and Summer National Meeting Minutes—*Commissioner Marlene Caride (NJ)* — Attachment One

2. Consider Adoption of Letters to the U.S. Congress and the U.S. Department of Labor (DOL) Regarding Medicare and the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)—*Commissioner Marlene Caride (NJ)*

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3. Discuss the Summary of Work Conducted by the Now-Disbanded Long-Term Care Insurance Model Update (B) Subgroup—*David Torian (NAIC)*

4. Hear a Federal Legislative Update—*David Torian (NAIC)*

5. Hear an Improper Marketing Update—*Martin Swanson (Nebraska Department of Insurance)*

6. Discuss Any Other Matters Brought Before the Task Force —*Commissioner Marlene Caride (NJ)*

7. Adjournment

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AGENDA ITEM #1

Draft: 10/26/22

Senior Issues (B) Task Force
Virtual Meeting
October 17, 2022

The Senior Issues (B) Task Force met Oct. 17, 2022. The following Task Force members participated: Jon Pike, Vice Chair (UT); Lori K. Wing-Heier represented by Sarah Bailey (AK); Mark Fowler represented by Willard Smith (AL); Evan G. Daniels represented by Jon Savary (AZ); Ricardo Lara represented by Tyler McKinney (CA); Andrew N. Mais represented by Paul Lombardo (CT); Trinidad Navarro represented by Frank Pyle (DE); David Altmaier represented by Chris Struk (FL); John F. King represented by Paula Shamburger (GA); Colin M. Hayashida represented by Lisa Zarko (HI); Dean L. Cameron represented by Shannon Hohl (ID); Vicki Schmidt represented by Craig VanAalst (KS); Sharon P. Clark represented by Stephanie McGaughey-Bowker (KY); James J. Donelon represented by Ron Henderson (LA); Gary D. Anderson represented by Kevin Beagan (MA); Kathleen A. Birrane represented by Jamie Sexton (MD); Timothy N. Schott represented by Marti Hooper (ME); Anita G. Fox represented by Renee Campbell (MI); Chlora Lindley-Myers (MO); Troy Downing represented by Ole Olson (MT); Mike Causey represented by Ted Hamby (NC); Jon Godfread represented by Yuri Venjohn (ND); Eric Dunning represented by Martin Swanson (NE); Barbara D. Richardson represented by Jack Childress (NV); Judith L. French represented by Tynesia Dorsey (OH); Glen Mulready represented by Andrew Schallhorn (OK); Andrew R. Stolfi represented by Lisa M. Beck (OR); Michael Humphreys represented by Shannen Logue (PA); Carter Lawrence represented by Brian Hoffmeister (TN); Cassie Brown represented by Dannette Smith (TX); Scott A. White represented by Julie Blauvelt (VA); Kevin Gaffney represented by Mary Block (VT); Mike Kreidler represented by Ned Gaines (WA); Nathan Houdek represented by Diane Dambach (WI); and Allan L. McVey represented by Joylynn Fix (WV). Also participating were: Eric Anderson (IL); Bogdanka Kurahovic (NM); Martin Wojcik (NY); Patrick Smock (RI); and Tana Howard (WY).

1. Adopted its 2023 Proposed Charges

Director Lindley-Myers made a motion, seconded by Ms. Campbell, to adopt the Task Force's 2023 proposed charges (Attachment One). The motion passed unanimously.

2. Heard a Discussion About Medicare and COBRA

Commissioner Pike asked Bonnie Burns (California Health Advocates—CHA) to summarize her previous presentations on this issue for the Task Force. Ms. Burns said the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal law giving one the legal right to keep their employer's health benefits that might otherwise end due to job loss, divorce, or death. She said employers of a certain size are required to offer COBRA when one retires or leaves an employer, and this is the same health plan coverage one had while working. Yet, federal health benefit payment rules that apply while one is working and eligible for Medicare are not the same after one stops working and is eligible for COBRA and Medicare at the same time.

Ms. Burns provided as an example a 76-year-old client who left employment and signed up for Medicare Part A at age 65 but did not sign up for Part B as he was still working. She said the employer, a large group health benefits consultant, provided eight months free of COBRA as part of his separation agreement, and he was provided with a lot of verbal instruction. She said the COBRA carrier, a large group health benefits company, paid the COBRA primary benefits, but at six months, the carrier discovered eligibility for

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Medicare but was not enrolled for benefits. She said the client had large medical expenses, and the carrier sought recovery for $80,000 of primary COBRA paid benefits.

Ms. Burns said COBRA is the same primary health benefits as when employed. She said the former employee pays 100% of premium plus an administrative fee. She said with or without Medicare benefits, Medicare Secondary Payer (MSP) rules do not apply. She said COBRA is automatically secondary, and added there is a disconnect between Social Security and Medicare.

Ms. Burns said the *Coordination of Benefits Model Regulation* (#120) exception pertaining to people who are eligible or who could be eligible for Medicare benefits is unfairly discriminatory. She said the NAIC should delete the exception for Medicare Part B in Model #120, as there is no rationale for this exception in the NAIC historical record, and it unfairly penalizes and discriminates against Medicare beneficiaries. She said the action specified in the exception, "is or could have been covered," produces a result that is expressly prohibited in the same subsection for any other form of health benefits. She recommended changes to parts of Section 5D of Model #120. Silvia Yee (Disability Rights Education and Defense Fund—DREDF) said she supports Ms. Burns' proposal.

Commissioner Pike asked Ms. Burns about her proposed edits to Section 5D. Ms. Burns said she believes the edits could help eliminate this one exception that allows insurers either not to pay benefits at all or to reduce the benefits. She said she would appreciate comments to understand if the proposal she offered would make a difference as she is not an attorney.

Ms. Hohl asked how this would interact with MSP rules and whether that would create a conflict, as that may be where the real issue comes into play. She asked whether it makes sense to revise the language without looking at the MSP rules. Ms. Burns said the MSP rules only apply when a person is actively working, and they apply to the employer group health plan while working; but once a person is not working, under Internal Revenue Service (IRS) rules, the MSP rules do not apply and do not apply to COBRA because COBRA is something one gets when not working.

Jacqueline Cipa (Centers for Medicare & Medicaid Services—CMS), Deputy Director of Medicare Secondary Payer Operations of the CMS, said she was not really aware of these concerns and all the nuances raised, but she invited Ms. Burns to reach out and speak with her office in more detail. Ms. Burns said she is happy to have this discussion. She also asked the CMS to examine all of the information on Medicare.gov because there is nothing about when a person leaves employment and what happens to them regarding the impact of being eligible for Medicare.

Amber Rivers (U.S. Department of Labor—DOL), Director of the Office of Health Plan Standards and Compliance Assistance of the Employee Benefits Security Administration of the DOL, said this matter came on the DOL's radar back in 2020 from a congressional letter received, and what the DOL tried to do was better highlight the interaction with Medicare in the context of consumers not only receiving the general notice about COBRA but also the election notice to help inform consumers. She said there are specific statutory requirements under COBRA that deal with the continuation of coverage provisions, and they have tried to make model notice more robust, but they are not required, and she said the DOL is open to further discussion on how to make it better for consumers. Ms. Burns said she appreciates that the notices are more robust, but consumers are still not getting these notices, and nearly all the information a consumer receives is verbal from their human resources (HR) department.

Ms. Blauvelt said the change Ms. Burns proposes may help with a similar issue involving federal Affordable Care Act (ACA) small group plans, not COBRA, but there are parallel similarities as it pertains to Model #120. She said she had inquired about whether other states have guidance or information regarding the

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coordination of benefits with marketplace consumers of Medicare age who are not enrolled in Medicare for either residency ineligibility (e.g., recently immigrated to the U.S.); insured to pay Part A premium; and/or eligible but not yet enrolled. She said perhaps including a reference to Part A in Ms. Burns' suggested edits could help.
Ms. Burns said the issue is different, but the suggested edits to Model #120 could help with Ms. Blauvelt's issue as well. She said Model #120 Sections 5D(1), (2), and (3) tell an insurer they cannot do the things listed in Sections 5D(1), (2), and (3), and the creation of subsection (4) was suggested for clarity, but not including subsection (4) may actually help both issues. She said she would like some clarity from state insurance regulators regarding whether they think her proposals would do what she intends.

William G. Schiffbauer (Schiffbauer Law Office) said he and Guenther Ruch (GHR Consulting LLC) looked at this issue a few years back for Ms. Burns and came up with the suggestion of adding a subsection (4) to be more explicit. Ms. Burns said perhaps to be more explicit, the proposed subsection (4) could either not include the words "Part B" or include the words "Part A and Part B."

Commissioner Pike asked Ms. Burns if she would like to sit down first with the DOL and/or the CMS and then sit down with state insurance regulators so everyone is on the same page. Ms. Burns said she does not see a reason to sit with the DOL first, as the issue of editing the model is separate from the DOL and the CMS, just as the things the DOL should do is separate from the NAIC. Mr. Schiffbauer felt it would be helpful to meet with the DOL and the CMS and see if the proposed additional language works and everyone can be on the same page.

Commissioner Pike said he would appreciate any direction on how to proceed with Model #120, and he will discuss this further with Commissioner Caride and NAIC staff.

Having no further business, the Senior Issues (B) Task Force adjourned.

SITF Minutes 10-17-22

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Adopted by the Executive (EX) Committee and Plenary, Dec. xx, 2022
Adopted by the Health Insurance and Managed Care (B) Committee, Dec. xx, 2022
Adopted by the Senior Issues (B) Task Force, Oct 17, 2022

2023 Proposed Charges

SENIOR ISSUES (B) TASK FORCE

The mission of the Senior Issues (B) Task Force is to: 1) consider policy issues; 2) develop appropriate regulatory standards; and 3) revise, as necessary, the NAIC models, consumer guides, and training material on Medicare supplement insurance, long-term care insurance (LTCI), senior counseling programs, and other insurance issues that affect older Americans.

Ongoing Support of NAIC Programs, Products, or Services

1. The Senior Issues (B) Task Force will:
   A. Develop appropriate regulatory standards and revisions, as necessary, to the NAIC models, consumer guides, and training material on Medicare supplement insurance, senior counseling programs, and other insurance issues that affect older Americans. Work with federal agencies to advance appropriate regulatory standards for Medicare supplement and other forms of health insurance applicable to older Americans. Review the *Medicare Supplement Insurance Minimum Standards Model Act* (#650) and the *Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act* (#651) to determine if amendments are required based on changes to federal law. Work with the federal Centers for Medicare & Medicaid Services (CMS) to revise the annual joint publication, *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare*.
   B. Monitor the Medicare Advantage and Medicare Part D marketplace. Assist the states, as necessary, with regulatory issues. Maintain a dialogue and coordinate with the CMS on regulatory issues, including solvency oversight of waived plans and agent misconduct. Assist the states and serve as a clearinghouse for information on Medicare Advantage plan activity.
   C. Provide the perspective of state insurance regulators to the U.S. Congress (Congress), as appropriate, and the CMS on insurance issues, including those concerning the effect and result of federal activity on the senior citizen health insurance marketplace and regulatory scheme. Review and monitor state and federal relations with respect to senior health care initiatives and other impacts on the states.
   D. Monitor developments concerning State Health Insurance Assistance Programs (SHIPs), including information on legislation affecting the funding of SHIPs. Assist the states with issues relating to SHIPs and support a strong partnership between SHIPs and the CMS. Provide the perspective of state insurance regulators to federal officials, as appropriate, on issues concerning SHIPs.
   E. Monitor, maintain, and review, in accordance with changes to Model #651, a record of state approvals of all Medicare supplement insurance new or innovative benefits for use by state insurance regulators and others. Review state-approved new or innovative benefits and consider whether to recommend that they be made part of standard benefit plan designs in Model #651.
   F. Develop appropriate regulatory standards and revisions, as necessary, to the NAIC models, consumer guides, and training material on LTCI, including the study and evaluation of evolving LTCI product design, rating, suitability, and other related factors. Work with federal agencies, as appropriate.
   G. Examine examples of health-related financial exploitation of seniors and work with other NAIC committees, task forces, and working groups on possible solutions.
   H. Examine the effects of structural racism and the COVID-19 pandemic on access, affordability, and outcomes for older insurance consumers.

NAIC Support Staff: David Torian

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Senior Issues (B) Task Force
Portland, Oregon
August 10, 2022

The Senior Issues (B) Task Force met in Portland, OR, Aug. 10, 2022. The following Task Force members participated: Marlene Caride, Chair (NJ); Jon Pike, Vice Chair, and Tomasz Serbinowski (UT); Lori K. Wing-Heier represented by Sarah Bailey (AK); Mark Fowler represented by Jennifer Li (AL); Ricardo Lara represented by Ahmad Kamil (CA); Andrew N. Mais represented by Paul Lombardo (CT); Karima M. Woods represented by Howard Liebers (DC); Trinidad Navarro represented by Frank Pyle (DE); David Altmaier represented by John Reilly (FL); Colin M. Hayashida represented by Kathleen Nakasone (HI); Doug Ommen represented by Andria Seip (IA); Dean L. Cameron represented by Randy Pipal (ID); Amy L. Beard represented by Scott Shover (IN); Vicki Schmidt represented by Craig VanAalst (KS); Sharon P. Clark represented by Rob Roberts (KY); James J. Donelon represented by Ron Henderson (LA); Kathleen A. Birrane represented by James Williams (MD); Timothy N. Schott represented by Marti Hooper (ME); Anita G. Fox represented by Renee Campbell (MI); Grace Arnold represented by Julia Drier (MN); Chlora Lindley-Myers represented by Carrie Couch (MO); Mike Causey represented by Robert Croom (NC); Jon Godfread represented by Chrystal Bartuska (ND); Eric Dunning represented by Laura Arp (NE); Barbara D. Richardson represented by Jack Childress (NV); Judith L. French represented by Daniel Bradford (OH); Andrew R. Stolfi represented by Tricia Goldsmith (OR); Michael Humphreys (PA); Larry D. Deiter represented by Jill Kruger (SD); Carter Lawrence represented by Brian Hoffmeister (TN); Cassie Brown represented by Chris Herrick (TX); Scott A. White represented by Julie Blauvelt (VA); Kevin Gaffney represented by Pat Murray (VT); Mike Kreidler represented by Todd Dixon (WA); Nathan Houdek represented by Jennifer Stegall (WI); and Allan L. McVey represented by Erin K. Hunter (WV).

3. Adopted its June 7, May 11, and Spring National Meeting Minutes

The Task Force conducted an e-vote that concluded June 7 to adopt a letter to the federal Centers for Medicare & Medicaid Services (CMS) asking for assurances that there will be coordination between the CMS and the U.S. Social Security Administration (SSA) should the proposed rule to simplify Medicare enrollment and expand access be made final and implemented, and work with state insurance regulators to minimize any possible gaps in coverage for beneficiaries.

The Task Force met May 11 and examined the proposed rule promulgated by the CMS to simplify Medicare enrollment rules and agreed to send a letter asking for assurances that there will be coordination between the CMS and the SSA should the proposed rule to simplify Medicare enrollment and expand access be made final and implemented, and work with state insurance regulators to minimize any possible gaps in coverage for beneficiaries.

Mr. Lombardo made a motion, seconded by Mr. Croom, to adopt the Task Force's June 7 (Attachment One); May 11 (Attachment Two); and March 17 (*see NAIC Proceedings – Spring 2022, Senior Issues (B) Task Force*) minutes. The motion passed unanimously.

4. Heard a Presentation Regarding Medicare Part D and Auto-Enrollment

Harry Ting (Health Consumer Advocate) presented an issue that poses difficulties for State Health Insurance Assistance Program (SHIP) counselors and the harm inflicted on Medicare Part D enrollees. He said he is asking the Task Force to endorse some actions and contact the CMS regarding this problem.

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Dr. Ting said the situation arises when an insurer discontinues one of its Medicare prescription drug plans (PDPs) for the next calendar year and the beneficiary is then crosswalked to another of the insurer's PDPs. He said enrollees are notified via the Annual Notice of Change (ANOC) mailing in September, and in 2021, 3.2 million PDP enrollees were crosswalked into a different PDP for 2022.

Dr. Ting said many of these ANOCs are confused with junk mail and thrown out by the beneficiary. He said the same ANOC formats are sent out every year to all Medicare Part D enrollees, but the choice they are presented with is confusing, and the beneficiaries are not given proper guidance. He provided an example of a client being crosswalked from the Mutual of Omaha Rx Value Plan and thus being switched from one of the lowest cost plans in the beneficiary's area to one of the highest. He said the change in premium for this client went from $22.20 a month to $77.90 a month. He said it is not the fault of the insurance plan but rather a problem with the CMS' rules and regulations.

Dr. Ting said the ANOC tells beneficiaries to check the changes to the benefits and costs to see if they affect the beneficiary. He said this is difficult for many beneficiaries to do. For example, he said one client of his takes 43 different medications and drugs, and the ANOC tells the beneficiary to go to the online drug list if there are changes. He said the online drug list is a 45-page formulary for seniors to go through. He said the ANOC asks whether one's drugs are in a different tier with different cost sharing and points out that there are five tiers with 10 cost-sharing categories. He said the ANOC asks whether one's drugs have new restrictions, and it instructs seniors to call their insurer; if the senior can use the same pharmacy, the senior is instructed to go to a website or call to obtain a directory. He said there is no mention of Medicare or SHIP resources, and the section entitled "additional resources" tells seniors to call their insurer, which is not helpful when seeking unbiased and objective answers.

Dr. Ting said there are three changes the CMS can do to address this issue, and he asks that the NAIC act in contacting the CMS to implement these changes. He said the first change is for the CMS to notify crosswalked Medicare Part D enrollees directly so the ANOC letters are not confused as junk mail and the beneficiary has notice from the CMS about upcoming changes. He suggested a sample letter that the CMS could implement. He said the second change is to modify the ANOC template currently being used. He said additional language should be made available beyond the current standard language that this document is available in (e.g., Spanish, Braille, and large print). He suggested that the section start with advising beneficiaries to call their SHIP or the 800 Medicare number, as well as provide the Medicare.gov web page.

Dr. Ting said the first two suggestions can be done by the CMS through its current rules. He said the third suggestion is for the CMS to allow crosswalked Part D plan enrollees to switch Part D plans during the January through March period, the same as Medicare Advantage (MA) enrollees. He said he believes this can be implemented through the CMS' regulations, but if not, he would propose it as an amendment. He said he would like the Task Force and the NAIC to support the three suggestions and ask the CMS to modify its Medicare Part D ANOC template to include objective resources and tell the CMS to give crosswalked Medicare Part D drug plan enrollees the same protections as those in MA plans.

Mr. Lombardo asked Dr. Ting if he has reached out to the CMS and, if so, what response has he received, if any. Dr. Ting said he has reached out several times and has to date received no response. Ms. Seip asked if Dr. Ting has reached out to the SHIP offices and programs about this matter. Dr. Ting said he has spoken to many SHIPs as they are in some states better equipped to address the problems than departments of insurance (DOIs) and they are aware, but the work is on a case-by-case basis.

Commissioner Caride asked if a letter from the Task Force to the CMS to help get a response to Dr. Ting might be in order and asked if there was any objection. Mr. Henderson and Mr. Lombardo both agreed a

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letter is a good idea, at least to let the CMS know that state insurance regulators are aware of this matter. Mr. Dixon said a letter is a good idea and pointed out that many SHIP counselors are volunteers and, in most cases, cannot lobby or advocate to the CMS. Commissioner Caride asked David Torian (NAIC) to work with Dr. Ting to draft language.

5. Heard a Discussion About Medicare and COBRA

Bonnie Burns (California Health Advocates—CHA) said the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal law giving one the legal right to keep their employer's health benefits that might otherwise end due to job loss, divorce, or death. She said employers of a certain size are required to offer COBRA when one retires or leaves an employer, and this is the same health plan coverage one had while working. Yet federal health benefit payment rules that apply while one is working and eligible for Medicare are not the same after one stops working and is eligible for COBRA and Medicare at the same time.

Ms. Burns said CMS' recent rule establishing a new special enrollment period (SEP) for health plan or employer error provides relief in instances where individuals can demonstrate that their employer or health plan, or agent materially misrepresented information related to enrolling in Medicare timely. She said the benefits of this narrow SEP are: 1) it avoids waiting to enroll during the general enrollment period (GEP); 2) it avoids late enrollment penalty avoids gap in coverage; and 3) it provides Medigap guaranteed issue.

Ms. Burns said individuals would be required to provide the SSA or CMS evidence that shows what misinformation was initially provided by the employer, group health plan (GHP), or representative. She said those tasked with providing information and guidance—employers and their agents, including human resources (HR) firms and agents/brokers—often do not understand the complex rules involving Medicare and COBRA coverage and material misrepresentation is difficult to document and prove. She said most information about COBRA occurs in verbal conversations with HR or other representatives, and employers are unlikely to state misrepresentation in writing.

Ms. Burns provided as an example a 76-year-old client who left employment and signed up for Medicare Part A at age 65 but did not sign up for Part B as he was still working. She said the employer is large group health benefits consultant, the employer provided eight months free COBRA as part of his separation agreement, and he was provided a lot of verbal instruction. She said the COBRA carrier is large group health benefits company and paid the COBRA primary benefits, but at six months, the carrier discovered eligibility for Medicare but not enrolled for benefits. She said the client had large medical expenses, and the carrier sought recovery for $80,000 of primary COBRA paid benefits.

Ms. Burns said COBRA is the same as primary health benefits as employed. She said the former employee pays 100% of premium plus an administrative fee. She said with or without Medicare benefits, Medicare Secondary Payer rules do not apply. She said COBRA is automatically secondary and added there is a disconnect between Social Security and Medicare.

Ms. Burns said the NAIC *Coordination of Benefits Model Regulation* (Model #120) exception pertaining to people who are eligible or who could be eligible for Medicare benefits is unfairly discriminatory. She said the NAIC should delete the exception for Medicare Part B in Model #120 as there is no rationale for this exception in the NAIC historical record, and it unfairly penalizes and discriminates against Medicare beneficiaries. She said the action specified in the exception, "is or could have been covered," produces a result that is expressly prohibited in the same subsection for any other form of health benefits. Ms. Burns recommended changes to parts of Section 5 of Model #120.

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Commissioner Caride suggested that the Task Force hold an open meeting solely on this issue to discuss the matter further, and invite relevant stakeholders to help state insurance regulators decide if Model #120 should be opened and edited. Commissioner Pike asked if Ms. Burns knew how many states follow the model law and how widespread the problem is. Ms. Burns said she does not know how many states follow the model but that most states have their own regulation or laws on coordination of benefits. Ms. Blauvelt raised a similar issue involving the Affordable Care Act (ACA) small group plans, not COBRA, but that there are parallel similarities as it pertains to Model #120. She said she had inquired if other states have guidance or information regarding coordination of benefits with marketplace consumers of Medicare age who not enrolled in Medicare for either residency ineligibility (recently immigrated to the U.S.); insured to pay Part A premium; and/or eligible but not yet enrolled.

6. Disbanded the Long-Term Care Insurance Model Update (B) Subgroup

Commissioner Caride asked Mr. Torian to explain the situation. Mr. Torian said since the previous chair of the Subgroup had left in December 2021, a new chair has not been found. He said in that time, there has been only one inquiry into the status of the Subgroup. He said the anticipated work from the Long-Term Care Insurance Reduced Benefits Options (EX) Subgroup never materialized, and that Subgroup is not disbanded. He pointed out that the charge of the Long-Term Care Insurance Model Update (B) Subgroup is to determine whether the *Long-Term Care Insurance Model Act* (#640) and the *Long-Term Care Insurance Model Regulation* (#641) retain their flexibility to remain compatible with the evolving delivery of long-term care (LTC) services and the evolving long-term care insurance (LTCI) marketplace. He said it appears by the lack of interest in the status of the Subgroup that there may be a feeling that the models do retain their flexibility to be compatible with the evolving delivery of LTC services and the evolving LTCI marketplace, and the purpose of this agenda item is for the Task Force to discuss the future of the Subgroup and whether it should be repurposed or disbanded.

Mr. Lombardo said he thinks that the lack of inquiry into the status of the Subgroup leads towards disbanding the Subgroup and that he would support that move. Ms. Arp said that the models do work and that the work of the Subgroup did not make much of an impact. Mr. Serbinowski said the Subgroup did a lot of work, and it should not end in this manner without some wrap-up or summary of the work done. He said the Subgroup did go section by section through Model #640 and part of Model #641 and offered some good suggestions to address products and changes in the marketplace that are not reflected in the model, such as hybrid products and revision issues. Ms. Burns agreed with Mr. Serbinowski.

Commissioner Caride agreed the work of the Subgroup should not be dismissed so easily but asked the Task Force what should be done. Mr. Lombardo made a motion, seconded by Mr. Hoffmeister, to disband the Long-Term Care Insurance Model Update (B) Subgroup. The motion passed.

7. Discussed Any Other Matters

Commissioner Caride informed the Task Force that the previous night, she received a response from the CMS to the March 17 letter sent by the Task Force seeking guidance from the CMS on the issue of the treatment of nonparticipating durable medical equipment (DME) suppliers under Medicare's “Limitation on Beneficiary Liability.” She said the CMS response was sent out to Task Force members, interested state insurance regulators, and interested parties, and it has been posted on the Task Force’s web page.

Having no further business, the Senior Issues (B) Task Force adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/B CMTE/SITF

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AGENDA ITEM #2

XXXX XX, 2023

These congressional letters will go to House and Senate leadership as well as the chairs and rankings of the relevant committees.

Dear :

On behalf of The National Association of Insurance Commissioners (NAIC), the standard setting organization representing the chief insurance regulators in the 50 states, the District of Columbia, and the United States territories, we write to you regarding the confusion and costly expenses some workers and retirees are facing with the transition to coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) accompanied by eligibility for Medicare.

As you are aware, COBRA grants temporary continuation of coverage to individuals enrolled in group health plans when coverage would otherwise end upon the occurrence of a qualifying event. For individuals who are eligible or enrolled in Medicare when COBRA coverage begins, Medicare is the primary payer and COBRA plans become secondary.

However, for individuals that qualify for COBRA and are eligible for Medicare but have not yet enrolled in either Medicare Part A or Medicare Part B, group health plans may recoup any paid claims and many workers and retirees are not aware of their Medicare eligibility or the need to enroll in the program, even if one is still employed. As a result, many workers and retirees find themselves facing out-of-pocket costs for claims paid under COBRA benefits due to their Medicare eligibility, as well as penalties for late enrollment in Medicare.

An example brought to our attention is of a gentleman who signed up for Medicare Part A at age 65 but did not sign up for Part B as he was still working. At age 76, he left employment and his employer provided eight months of COBRA as part of his separation agreement, The COBRA carrier paid benefits as the primary plan, but after six months the carrier discovered the gentleman was *eligible* for Medicare but was not *enrolled* for benefits. The gentleman had large medical expenses during this time and the carrier sought recovery for $80,000 of benefits paid by COBRA.

Medicare enrollment and penalties, secondary payment rules, and COBRA are confusing, and we have heard some suggestions to help consumers better navigate these rules. One is better coordination between the Departments of Labor (DOL) and Health and Human Services (HHS). As you are aware, COBRA notices issued by DOL are not required under COBRA nor mentioned under Medicare. Another suggestion is for additional clarification in the law as to which coverage, Medicare or COBRA, is primary and which is secondary in these situations.

The NAIC requests you to examine this issue and we, as the state insurance regulators, are prepared to work with you to find solutions to aid and help our workers and retirees navigate this confusing interaction between COBRA and Medicare.

Sincerely,

Dean L. Cameron
NAIC President
Director
Idaho Department of Insurance

Chlora Lindley-Myers
NAIC President-Elect
Director
Missouri Department of Commerce and Insurance

Andrew N. Mais
NAIC Vice President
Commissioner
Connecticut Insurance Department

Jon Godfread
NAIC Secretary-Treasurer
Commissioner
North Dakota Insurance Department

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XXXX XX, 2023

The Honorable Martin J. Walsh
Secretary
U.S. Department of Labor
200 Constitution Avenue NW
Washington D.C. 20210

Dear Secretary Walsh:

On behalf of The National Association of Insurance Commissioners (NAIC), the standard setting organization representing the chief insurance regulators in the 50 states, the District of Columbia, and the United States territories, we write to you regarding the confusion and costly expenses some workers and retirees are facing with the transition to coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) accompanied by eligibility for Medicare.

We thank you for the members of your department's Employee Benefits Security Administration who joined the October 17 open meeting of the NAIC's Senior Issues Task Force to discuss this topic. Their participation was helpful.

As you are aware, COBRA grants temporary continuation of coverage to individuals enrolled in group health plans when coverage would otherwise end upon the occurrence of a qualifying event. For individuals who are eligible for or enrolled in Medicare when COBRA coverage begins, Medicare is the primary payer and COBRA plans become secondary.

However, for individuals that qualify for COBRA and are eligible for Medicare but have not yet enrolled in either Medicare Part A or Medicare Part B, group health plans may recoup any paid claims and many workers and retirees are not aware of their Medicare eligibility or the need to enroll in the program, even if one is still employed. As a result, many workers and retirees find themselves facing out-of-pocket costs for claims paid under COBRA benefits due to their Medicare eligibility, as well as penalties for late enrollment in Medicare.

One of the suggestions offered during the October 17 meeting is for more robust notification and communication about COBRA and Medicare to workers and retirees. We appreciate that Medicare enrollment and penalties, secondary payment rules, and COBRA are complicated issues. The NAIC requests you to examine this issue and we, as the state insurance regulators, are prepared to work with you to find solutions to aid and help our workers and retirees in this confusing interaction between COBRA and Medicare.

Sincerely,

Dean L. Cameron
NAIC President
Director
Idaho Department of Insurance

Chlora Lindley-Myers
NAIC President-Elect
Director
Missouri Department of Commerce and Insurance

Andrew N. Mais
NAIC Vice President
Commissioner
Connecticut Insurance Department

Jon Godfread
NAIC Secretary-Treasurer
Commissioner
North Dakota Insurance Department

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CALIFORNIA HEALTH ADVOCATES
Medicare: Policy, Advocacy and Education

December 8, 2022

Commissioner Marlene Caride, Chair
NAIC Senior Issues Task Force
Attn: David Torian, SITF Counsel and Health Policy Analyst

Re: NAIC Draft letters to Congress and DOL

Dear Commissioner Caride:

California Health Advocates has deep experience with consumers caught between COBRA benefits and Medicare. We have presented on this issue in several different venues of the NAIC over the last five years. We reported on the problems of older former employees who were caught in the complex conflict between being eligible for Medicare when receiving benefits under COBRA. We are deeply disappointed that the Task Force has decided against any revision of the offending language in the NAIC Coordination of Benefits Model Act that allows insurers to refuse to pay benefits for secondary coverage based on Medicare eligibility.

While there is no doubt that Medicare is primary when an eligible beneficiary is enrolled in a COBRA plan and eligible for Medicare at the same time, the Model Act provides insurers an iron clad justification to deny payment of secondary benefits based on eligibility for Medicare Part B alone. There are no other medical coverage situations described in that section of the Model Act that allow an insurer to refuse payment of medical benefits.

As long as this language remains in the Model the NAIC is actively allowing insurers to continue discriminating against a person solely on the basis of their eligibility for Medicare. We hope that DOL and CMS each make revisions to their processes that will resolve some of the conflicts between these two federal medical benefit programs, but the law will still allow insurers to continue denying benefit payment to Medicare eligible individuals based on that one provision in the NAIC Model or a similar provision of state law.

We ask that the Task Force reconsider its decision and make a simple change to the Model Act that will begin to correct the harm that occurs to older individuals when they leave their current employment.

Sincerely,

Bonnie Burns

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December 8, 2022

Commissioner Marlene Caride, Chair
NAIC Senior Issues Task Force

Re: Models 640 and 641

Dear Commissioner Caride:

California Health Advocates has commented extensively on NAIC Models 640 and 641 over many years. We have long standing experience with the marketing, sales, benefits, and premiums of long-term care insurance and have commented for decades on these issues and on the experience of consumers with these products. We have witnessed the evolving structure of these products from the early 1980's to the present. We are deeply concerned that the current models do not adequately reflect the current marketplace. In addition we believe there are huge holes in regulatory requirements that disadvantage consumers. We do not believe that these models adequately reflect the marketplace or the benefits being added to or combined with life and annuity products of multiple design platforms and benefits.

Consumers are being asked to invest in products with two, sometimes three complicated types of coverage rolled into one. For instance consumers buying life insurance with an accelerated death benefit for long-term care expenses are unaware that the death benefit upon which their long-term care benefits are based seldom increases over their lifetime even as their cash value may grow. Twenty years from now their static long-term care benefit will be inadequate to pay for their care. Consumers buying indexed variable life products --combining life, investments, and long-term care benefits-- have even less understanding of how the various components of this product will be available to pay for care decades later. Indeed, many agents do not understand the products they sell well enough to explain the various components of these products and the amount of long-term care expenses that will be covered decades later.

A cursory review of the comments that were recorded during the many calls of the now defunct Model Review Subgroup reveals the many ways the current models do not adequately address the evolving marketplace. At a bare minimum, current disclosures are completely inadequate for the purpose of helping applicants to understand how their long-term care costs will be protected by the benefits of combination life and annuity products they buy for that purpose.

A subgroup on benefit options evaporated, leaving that topic to the discretion of insurers. Policyholders are receiving premium increase notices and various options to reduce the impact of that new cost in return for giving up benefits they previously purchased. They have few if any ideas about how to exercise those options to their best advantage. Again, the models do not address these issues.

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We hope the task force will consider bringing these models up to date.

Sincerely,

Bonnie Burns

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AGENDA ITEM #3

The Summary of the work completed by the now-disbanded Long-Term Care Insurance Model Update (B) Subgroup can be found at the following link:

https://content.naic.org/sites/default/files/inline-files/LTCIMUSG%20Summary.pdf

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