

2021 Proposed Agenda for the Senior Issues (B) Task Force

POTENTIAL TOPICS/ISSUES FOR 2021

- LTCI Model Update (B) Subgroup

The Subgroup is charged to review whether the *Long-Term Care Insurance Model Act* (#640) and *Long-Term Care Insurance Model Regulation* (#641) should be updated. The Subgroup would then report its findings to the Task Force and, if updates are necessary, the Subgroup would then be charged with making those updates.

In addition, should the Long-Term Care Insurance (EX) Task Force adopt any provisions or suggestions that require a change to the *Long-Term Care Insurance Model Act* (#640) and *Long-Term Care Insurance Model Regulation* (#641), the Subgroup would be operational and prepared to make such changes.

The Subgroup was established early last year but COVID issues took over of importance, so the Subgroup had not begun any work. The Subgroup consists of 8 Members: Alaska, California, Nebraska, New Hampshire, New Jersey, South Dakota, Utah, Virginia and Washington. New Jersey is Chair and Nebraska is Vice Chair of the Subgroup.

- Update of Medigap Innovative Benefits

The NAIC Medicare Supplement Model Regulation (#651) and the NAIC Medicare Supplement Compliance Manual call upon the Senior Issues (B) Task Force to maintain a record of state-approved Medicare Supplement “new or innovative benefits” for use by regulators and others. It is intended that states regularly report this information to the Task Force, and that this record be updated periodically and posted on the Task Force’s web page to be available to regulators and interested parties. Due to the infrequency of new benefits, the survey is conducted every two years. The last survey was in 2019. The 2021 survey will be conducted sometime in May or June of 2021.

- LTCI Policy Recommendations

SITF will continue to be prepared to work with interested Capitol Hill staff when the 10 LTCI policy recommendations developed by SITF in 2017 are used to develop congressional legislative proposals.

- Medicare Advantage

Some in the new Congress have expressed some interest in revisiting the 2003 Medicare Modernization Act (MMA) and whether State oversight of Medicare Advantage should be reinstated fully.

As you are aware, prior to the MMA States had full authority to review marketing practices, pursue market conduct reviews, and penalize poor actors. After the MMA,

States lost their authority over the plans except to ensure they are licensed and remain solvent. SITF may wish to discuss this issue, perhaps at the Spring National Meeting.

- Medicare at Age 60

Biden Admin is considering asking Congress to move the Medicare age down to 60 as an option for early retirees. If so, states would need to decide whether Medigap will also be available for the under-65 group.

- Addressing Fraud Targeting Seniors, including financial security and cyber security *(developing a consumer alert on variety of insurance scams and frauds affecting seniors, akin to the U.S. Senate Aging Committee Fighting Fraud document:*

<https://www.aging.senate.gov/imo/media/doc/Fraud%20Book%20%202020.pdf>

The idea is for the Task Force to develop a document like the Senate document focusing on relevant insurance issues affecting seniors. If there is an interest in developing such a document, perhaps an ad hoc group can be formed to work on these matters and report to the SITF?

FYI – Sens. Klobuchar (MN) and Moran (KS) have introduced legislation that directs the Federal Trade Commission (FTC) to report scams targeting seniors during the pandemic to Congress and make recommendations on how to prevent future scams during emergencies: <https://www.klobuchar.senate.gov/public/index.cfm/2021/1/klobuchar-moran-kelly-balderson-lead-bipartisan-bicameral-legislation-to-protect-seniors-from-scams-during-the-coronavirus-pandemic>

- Issue from Nebraska

Nebraska has DME providers (or at least a provider) who has not taken assignment on certain DME products. The DME provider discovers that the person is on Medicare and has a Plan F. The DME provider then charges “what he wants” or, at minimum, full retail for the equipment because he knows that Plan F pays for 100% of the excess charges.

The federal government normally caps the excess amount on Part B at 15%. This is not the case for DME. Plans F and G are then exposed to 100% of the cost of the DME product in this circumstance. In reaction, some carriers have said, in their policy, that the cost of the product must be medically necessary, and the charge must be reasonable. Others may have utilized a UCR standard and limited the payment to that. The consumer, who bought the Plan F then may be subject to “balance billing” based upon what the carrier did not pay to the DME provider.

The question becomes can a Medicare Supplement carrier limit the amount paid for the product even though there is no assignment, no cap imposed by the federal government like in other excess charges and what, if anything, would allow a carrier to not pay the full retail (or more) price imposed by a DME provider within the scope of the Medicare Supplement regulation model. Nebraska knows of some states that have imposed some restrictions on excess charges. Nebraska also doesn’t know, off hand, how many states have seen this issue arise.

Nebraska is currently asking their carriers about this issue and will come back to the Task Force after they have crafted a narrowly tailored question for distribution to the states.