SENIOR ISSUES (B) TASK FORCE

Senior Issues (B) Task Force Feb. 25, 2022, Minutes
Senior Issues (B) Task Force Feb. 8, 2022, Minutes
Senior Issues (B) Task Force Nov. 30 Interim Meeting in lieu of Fall 2021 National Meeting Minutes

Draft: 3/1/22

Senior Issues (B) Task Force
E-Vote
February 25, 2022

The Senior Issues (B) Task Force conducted an e-vote that concluded Feb. 25, 2022. The following Committee members participated: Marlene Caride, Chair (NJ); Jon Pike, Vice Chair (UT); Lori K. Wing-Heier (AK); Jim L. Ridling (AL); Alan McClain (AR); Ricardo Lara (CA); Andrew N. Mais (CT); Trinidad Navarro (DE); John F. King (GA); Colin M. Hayashida (HI); Dean L. Cameron (ID); Amy L. Beard (IN); Vicki Schmidt (KS); Sharon P. Clark (KY); James L. Donelon (LA); Gary D. Anderson (MA); Kathleen A. Birrane (MD); Eric A. Cioppa (ME); Anita G. Fox (MI); Chlora Lindley-Myers (MO); Troy Downing (MT); Mike Causey (NC); Jon Godfread (ND); Eric Dunning (NE); Barbara D. Richardson (NV); Judith L. French (OH); Jessica K. Altman (PA); Larry D. Deiter (SD); Carter Lawrence (TN); Cassie Brown (TX); Michael S. Pieciak (VT); Mike Kreidler (WA); Nathan Houdek (WI); and Allan L. McVey (WV).

1. Adopted a Letter in Support of the CMS' Proposed Rule on Stricter Marketing Guidelines for Medicare Advantage and Medicare Part D Plans

The Task Force conducted an e-vote to consider adoption of a comment letter in support of the Centers for Medicare & Medicaid Services' (CMS') proposed rule on stricter marketing guidelines for Medicare Advantage (MA) and Medicare Part D plans.

Without objection, the Task Force adopted the comment letter. (Attachment One)

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

Attachment One

March 4, 2022

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4192-P
P.O. Box 8013
Baltimore, MD 21244-8013

Via Regulations.gov

To Whom It May Concern:

The following comments on **CY 2023 Medicare Advantage and Part D Proposed Rule (CMS-4192-P),** as published in the Federal Register on January 12, 2022, are submitted on behalf of the members of the National Association of Insurance Commissioners (NAIC), which represents the chief insurance regulators in the 50 states, the District of Columbia, and the United States territories. The comments specifically address the portion of the proposed rule focused on the practices of third-party marketing organizations (TPMO) of Medicare Advantage (MA) Plans.

CMS notes in its own explanation of its proposed rule that the Federal government is seeing an increase in beneficiary complaints associated with TPMO advertisements and has received feedback from beneficiary advocates and stakeholders concerned about marketing practices. State insurance regulators have also heard many complaints regarding these TPMOs and the advertisements of MA plans.

The NAIC's Senior Issues (B) Task Force and the Improper Marketing of Health Insurance (D) Working Group have heard from many state regulators regarding consumers being switched from their original plans after either inquiring in response to ads or receiving cold calls from these marketers. One insurance commissioner described some of these ads as somewhat misleading at the very best and close to fraudulent at the very worst.

State insurance regulators and consumer advocates have noted an increase in the improper marketing of MA plans geared toward seniors that have included not only the running of television commercials that provided incorrect information, but a significant increase in social media ads, unsolicited phone calls to seniors and mass mailings from unidentified entities attempting to solicit business. During the past several years, advertising for these plans has increased and has emphasized extra or chronic care benefits often only available in particular sets of circumstances and not to the average MA plan enrollee.

The NAIC and state regulators have heard many stories in which beneficiaries have enrolled in or been enrolled in plans with narrow networks that didn't include their current providers, had pharmacy benefits with higher costs, imposed higher copayments than expected, didn't have the benefits they had seen advertised, or that were completely inappropriate for their particular needs and not what they thought they were buying. These sales often involve agents/brokerages or TPMOs that represent only some of the options available to Medicare beneficiaries.

Many of these TPMOs have names with "Medicare" or "Seniors" (i.e. American Medicare Advisors, Medicare Insurance Advisors, Medicare Plan Store, Senior Health Plans, etc.) and/or contain endorsements by known celebrities adding further confusion and misrepresentation. Many complaints involve agents or third-party marketers cold-calling or going door-to-door, often in senior-living housing/communities.

The NAIC notes there are gaps in MA regulation. The states are only allowed, by federal law, to initially license the plan, ensure the financial solvency of the carrier, and hold the license of both the carrier and insurance producer who

sells the plan. The federal government oversees the MA plans themselves and sets out rules for the marketing of them.

Many state insurance regulators work with State Health Insurance Assistance Programs (SHIP) coordinators and state Senior Medicare Patrol (SMP) coordinators on multiple complaints from beneficiaries but are confronted with limited or no positive results. State regulatory authority for these plans is limited to the agents and any misrepresentation; however, most complaints fall into an area that limits any actions states can take against these agents/brokers or TPMOs.

Some states, using state laws, have successfully prosecuted producers when they have violated CMS rules in the sale of the product. We ask CMS to provide the states all of the evidentiary information CMS collects for prosecution.

While the proposed rule may not go far enough for some, we feel this is a good start. We have received suggestions and recommendations that CMS should consider additional language; stronger marketing disclosure language; labeling the marketing disclosures in a separate color or in a text box with defined borders in at least a larger font that garner attention from the consumer; and requiring all producers to identify existing coverage and inquire about an applicant's intent to replace existing coverage before taking an application from someone already covered.

Other suggestions and recommendations CMS should consider include requiring TPMOs to inform beneficiaries of the option to use 1-800-MEDICARE or www.medicare.gov to compare the total cost of drugs that the beneficiary will incur if they select any MA or Part D plan and requiring TPMOs to report the number of complaints they receive each month from consumers.

Finally, consumers must have a source of unbiased information in the very complex Medicare world. CMS should consider adding contact information for states' SHIP programs, SMP programs, and other Medicare consumer advocate divisions and programs to marketing disclosure requirements and to written, oral and online information about Medicare enrollment.

The NAIC will continue to review proposed rules and provide comments on the potential impact on market competition and consumer protections. We are available to discuss these or other issues as this proposed rule is finalized.

Sincerely,

Draft: 2/9/22

Senior Issues (B) Task Force
Virtual Meeting
February 8, 2022

The Senior Issues (B) Task Force met Feb. 8, 2022. The following Task Force members participated: Marlene Caride, Chair (NJ); Jon Pike, Vice Chair (UT); Lori K. Wing-Heier represented by Sarah Bailey (AK); Jim L. Ridling represented by Willard Smith (AL); Alan McClain represented by Carroll Astin (AR); Evan G. Daniels represented by Erin Klug (AZ); Ricardo Lara represented by Tyler McKinney (CA); Michael Conway represented by Peg Brown (CO); Andrew N. Mais represented by Paul Lombardo (CT); Karima M. Woods represented by Howard Liebers (DC); Trinidad Navarro represented by Susan Jennette (DE); David Altmaier represented by Chris Struk (FL); John F. King represented by Matthew Padova (GA); Colin M. Hayashida represented by Kathleen Nakasone (HI); Doug Ommen (IA); Dean L. Cameron represented by Kathy McGill (ID); Amy L. Beard represented by Rebecca Vaughan (IN); Vicki Schmidt represented by Julie Holmes (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 Joy Hatchette (MD); Eric A. Cioppa represented by Sherry Ingalls (ME); Anita G. Fox represented by Renee Campbell (MI); Grace Arnold represented by Theodore Patton (MN); Chlora Lindley-Myers (MO); Mike Causey represented by Ted Hamby (NC); Jon Godfread represented by Yuri Venjohn (ND); Eric Dunning and Martin Swanson (NE); Barbara D. Richardson represented by Jack Childress (NV); Judith L. French represented by Tynesia Dorsey (OH); Jessica K. Altman represented by Michael Gurgiolo (PA); Elizabeth Kelleher Dwyer represented by Patrick Smock (RI); Larry D. Deiter represented by Jill Kruger (SD); Carter Lawrence represented by Brian Hoffmeister (TN); Cassie Brown represented by Dannette Smith (TX); Scott A. White represented by Bob Grissom (VA); Michael S. Pieciak represented by Mary Block (VT); Mike Kreidler represented by Molly Nollette (WA); Nathan Houdek represented by Jennifer Stegall (WI); and Allan L. McVey (WV). Also participating were: Eric Anderson (IL); Kay Warrington (MS); Ingrid Marsh (NH); Bogdanka Kurahovic (NM); Martin Wojcik (NY); Glen Mulready (OK); Andrew Dvorine (SC); and Mavis Earnshaw (WY).

1. Discussed the CMS's Proposed Rule on Stricter Marketing Guidelines for MA Plans

Commissioner Caride said the purpose of this Task Force meeting is to examine the proposed rule promulgated by the Centers for Medicare & Medicaid Services (CMS) to impose stricter marketing guidelines for Medicare Advantage (MA) plans. She said this meeting is not to target MA plans but to focus on the deceptive marketing advertisements to sell MA plans. She said the Task Force has heard from state insurance regulators, most notably from Louisiana and Nebraska, regarding consumers being switched from their original plans after either inquiring in response to ads or receiving cold calls from these marketers.

Mr. Swanson gave some background on what he has heard from Nebraska and other states regarding these solicitations. He said Nebraska has a very good working relationship with its regional CMS representatives and shares information with other states. He said these issues have been raised and are being examined by the Improper Marketing of Health Insurance (D) Working Group; and because many of these Working Group calls are regulator-only, frank discussions are had with the CMS and the federal *Center for Consumer Information and Insurance Oversight* (*CCIIO*). He said some of these calls have died down after open enrollment closed, but MA plan open enrollment does not end for another month.

Commissioner McVey said he has seen these advertisements; they are somewhat misleading at the very best, and they are close to fraudulent at the very worst. He said he would like to address this situation; even though he has seen one of the ads revamped, it is still not a good situation, and more complaints will come.

Mr. Henderson said one of the biggest issues is that those third-party callers who are not necessarily agents can call seniors asking if they would like to change their plan, and the next thing the senior discovers is that they have been switched into another plan, and that new plan does not even take the senior's doctor. He related a story he told before about being present when a call came in to a senior; when he took the phone to ask for the caller's license,

the caller hung up. He said Commissioner Schmidt, the Director of the Louisiana State Health Insurance Assistance Program (SHIP), is constantly making changes on behalf of seniors who have been moved out of their plans. He said many seniors are being incentivized to make changes because the marketing caller tells them they are not getting all they deserve when in fact they are getting what they need. He said it must be emphasized to the CMS that these third-party marketing callers are using unlicensed persons to make the calls and then hand the call over to a licensed person.

Commissioner Caride asked the Task Force if it would agree to comment on the CMS's proposed rule and any objections to commenting. Mr. Swanson said the regional CMS personnel he has engaged with would appreciate input from the NAIC to get the attention of the officials in the District of Columbia. Commissioner Caride noted that both Idaho and Missouri concur with Mr. Swanson's comments. She asked if there are any interested parties that wish to comment.

Bonnie Burns (California Health Advocates—CHA) said the CHA submitted a letter to the Task Force laying out its position and what it has commented to the CMS. She said there has been a massive increase in the number of people being switched to plans they either did not want or were not appropriate for them. She said she has seen those dually eligible being moved from their non-premium plans to plans with premiums and plans that have co-payments when they should not have any co-payments. She said the CMS's own statistics show there has been a jump in complaints. She said in 2020, the CMS received a total of 15,497 complaints related to marketing; and in 2021, excluding December, the CMS received 39,617 complaints. She said this is an indication of companies fighting for market share and agents and brokers fighting for sale commissions.

Ms. Burns said one area of great concern is that there is no indication to how any enforcement is taking place. She said some states have memorandums of understanding (MoUs) with the CMS so there would be a transfer of information, but when an agent or a broker where these actions are taking place is identified, there does not appear to be any formal process in the CMS proposed rule for these agents and brokers who are licensed to be disciplined through the states' licensing and enforcement system. She said the CMS is proposing a disclaimer to be added to websites and advertisements stating that the consumer is not being given all the information about plans available to them. She said such a disclaimer is ineffective, and she said she proposed in the letter to the Task Force what would be an adequate disclosure to consumers. She said SHIPs are not even referenced in the proposed rules, and she strongly believes SHIPs must be included. She also said the proposed rule should require agents and brokers to sign an attestation to show that what is being offered and sold is an improvement to the consumer from what they are already enrolled in. She said this already exists for Medicare Supplement plans, so it should apply to MA plans.

Mr. Henderson pointed out that most of the SHIPs are in states' Aging and Elderly offices, so if there is no connection to the state insurance departments, many of these issues are going unheard and are not being reported to insurance departments.

Harry Ting (Health Consumer Advocate) said he is an NAIC consumer representative and SHIP counselor. He said he had a client who was cold called, told the caller she did not want to change but was changed to a new plan that did not fit her needs. He said when he asked the new plan who the producer was who called the client and switched her to the new plan, they said they did not know. He said these marketing organizations have very little incentive to discipline their people, and when he asked the clint if she would like to file a complaint, she was reluctant to do so. Dr. Ting said he agrees with Ms. Burns that the CMS proposed rule is not impactful enough. He proposed that the CMS use its complaint tracking module that counted over 39,000 complaints in 2021 to enter a star system calculation and assign a certain number of stars to those plans. He said it would make the marketing organization more sensitive and willing to take action to reduce complaints.

Commissioner Mulready said the Oklahoma Insurance Department has received dozens and dozens of calls and complaints, and it is supportive of letting the CMS know what states are experiencing. Ms. Burns said holding plans or marketing organizations accountable is laudable, but it does no good if the complaints and information are not

getting to the states' departments of insurance (DOI), and in turn, there is no action on a state level holding these actual sellers accountable.

Commissioner McVey made a motion, seconded by Commissioner Pike, that the Task Force submit comments in response to the CMS's proposed rule on stricter marketing guidelines for MA plans. The motion passed unanimously.

Commissioner McVey asked about the process of submitting comments. Commissioner Caride asked David Torian (NAIC) to explain. Mr. Torian said he would like comments to be submitted by week's end, or Monday, Feb. 14 at the latest. He said he would collate the comments into a single letter for the Task Force to adopt via an e-vote. He reminded the Task Force that time is of the essence, as the deadline for comments to the CMS is March 7, and any comments adopted by the Task Force will need approval from the Government Relations (EX) Leadership Council. Commissioner Caride asked if there are any issues or problems with that process, and none were heard.

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

Draft: 12/6/21

Senior Issues (B) Task Force
Virtual Meeting (*in lieu of meeting at the 2021 Fall National Meeting*)
November 30, 2021

The Senior Issues (B) Task Force met Nov. 30, 2021. The following Task Force members participated: Marlene Caride, Chair (NJ); Lori K. Wing-Heier, Vice Chair (AK); Jim L. Ridling represented by Steve Dozier (AL); Evan G. Daniels represented by Erin Klug (AZ); Ricardo Lara represented by Tyler McKinney (CA); Michael Conway represented by Peg Brown (CO); Andrew N. Mais represented by Paul Lombardo (CT); Karima M. Woods (DC); Trinidad Navarro represented by Susan Jennette (DE); David Altmaier represented by Chris Struk (FL); John F. King represented by Matthew Padova (GA); Colin M. Hayashida represented by Kathleen Nakasone (HI); Doug Ommen represented by Andria Seip (IA); Dean L. Cameron represented by Weston Trexler (ID); Amy L. Beard represented by Rebecca Vaughan (IN); 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 Joy Hatchette (MD); Eric A. Cioppa represented by Sherry Ingalls (ME); Anita G. Fox represented by Renee Campbell (MI); Grace Arnold represented by Fred Andersen (MN); Chlora Lindley-Myers (MO); Troy Downing (MT); Mike Causey represented by Garlinda Taylor (NC); Jon Godfread represented by Chrystal Bartuska (ND); Eric Dunning and Laura Arp (NE); Chris Nicolopoulos represented by Roni Karnis (NH); Barbara D. Richardson (NV); Judith L. French represented by Tynesia Dorsey (OH); Glen Mulready represented by Mike Rhoads (OK); Andrew R. Stolfi represented by Gayle Woods (OR); Jessica K. Altman (PA); Larry D. Deiter represented by Jill Kruger (SD); Carter Lawrence represented by Brian Hoffmeister (TN); Cassie Brown represented by Chris Herrick (TX); Jonathan T. Pike (UT); Scott A. White represented by Bob Grissom (VA); Mike Kreidler represented by Molly Nollette (WA); Mark Afable represented by Jennifer Stegall (WI); and Allan L. McVey represented by Ellen Potter (WV). Also participating were: Sara Stanberry (IL); Kay Warrington (MS); Bogdanka Kurahovic (NM); Martin Wojcik (NY); Patrick Smock (RI); Andrew Dvorine (SC); Isabelle Keiser (VT); and Mavis Earnshaw (WY).

1. Adopted its Oct. 6 Minutes

   The Task Force met Oct. 6 and took the following action: 1) adopted its 2022 proposed charges; and 2) heard a presentation on the WA Cares Fund.

   Ms. Karnis made a motion, seconded by Director Wing-Heier, to adopt the Task Force's Oct. 6 minutes. The motion passed unanimously.

2. Adopted the Report of the Long-Term Care Insurance Model Update (B) Subgroup

   The Long-Term Care Insurance Model Update (B) Subgroup met Nov. 3 and Oct. 13. During its Nov. 3 meeting, the Subgroup continued its cursory review of Section 7 through Section 12 of the *Long-Term Care Insurance Model Regulation* (#641). During its Oct. 13 meeting, the Subgroup began its cursory review Model #641, beginning with Section 1 through Section 6. The Subgroup plans to meet Dec. 1 to continue its cursory review of Section 13 through Section 19.

   Director Wing-Heier made a motion, seconded by Ms. Kruger, to adopt the report of the Long-Term Care Insurance Model Update (B) Subgroup (Attachment). The motion passed unanimously.

3. Discussed DME, Medicare Supplement, and Excess Charges

   Ms. Arp began the discussion by noting there appears to be a loophole being exploited by durable medical equipment (DME) suppliers. She said it may not be fraud, but it is certainly waste. She referred to the slide deck,

pointing out that the slide refers to the same patient and the same DME provider for a nasal prothesis. She pointed out that the charges jumped from $4,850 to $91,274 in a span of five years.

Ms. Arp cited another example involving scooters and power wheelchairs. She said, for example, in 2019, Medicare was billed $43,485.10 for a power wheelchair and Medicare approved $4,702, leaving the insurer to pay the balance of $38,783.10. She cited another example where Medicare was billed $44,422.83 for a power wheelchair and Medicare approved $4,706.58, leaving the insurer to pay the balance of $39,716.25. She said in another example from 2021, Medicare was billed $10,841.04 for a hospital bed and Medicare approved a monthly rental charge only, which left the insurer to pay the balance after the approved charge of $10,767.18. She said a call was made on this claim, and the insurer was told that the scooter store billed for the cost of the bed, and they billed it again as not assigned, and they will bill Medicare the monthly rental of the bed. She said that the most costly scooters are at around $13,000, according to these suppliers' websites, but the charged amounts went as high at $31,500. She said these are the amounts they are charging when it is found out a beneficiary has Medigap Plan F or Plan G. She said they know the insurer is on the hook for the excess charges.

Ms. Arp said the *Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act* (#651) states in the excess charges section, have coverage for either 80% or 100%, depending on the plan of excess charges, and it is not to exceed any charge limitation established by the Medicare program or state law. She said Plan F and Plan F High Deductible shall include 100% of the excess charges, and Plan G shall include 80% of the excess charges. She said the next step is to look at what limitations exist. She said in the relevant sections of the federal Social Security Act (SSA), a person is not liable for payment of amounts billed for the service in excess of the limiting charge. She said that is a kind of balance billing protection built into this framework. She said the limiting charge is defined in the same relevant section as "115% of the recognized payment amount for non-participating physicians, or non -participating suppliers, or other persons."

Ms. Arp said if one looks back at the limitation on beneficiary liability in the SSA, it states, "In the case of a nonparticipating physician or nonparticipating supplier or other person (as defined in section 1395u(i)(2) of this title) who does not accept payment on an assignment-related basis for a physician's service furnished with respect to an individual enrolled under this part, the following rules apply … ." She said the rules are the limiting charge, and the insured is not liable for any difference, so it begs the question: If this 115% limitation is applicable to physician billing, why does it say "… nonparticipating physicians, or nonparticipating suppliers, or other persons"? Ms. Arp said providers are operating on the assumption that 115% only applies to physicians and that they are free to charge whatever they want.

Ms. Arp said there are options to address this. She said state laws could be changed. She said eight states have done this already. She said Medigap regulations could be changed. She said the other option is to provide some kind of interpretation or bulletin that explains that the term physician service can be read to include the physician service of writing the prescription for the DME for which the supplier fills, and that would make more sense with the limiting charge language that includes both nonparticipating physician and nonparticipating suppliers or other persons.

Commissioner Caride asked if there are any comments from Task Force members. Director Wing-Heier said she appreciates this being discussed and dislikes price gouging. She said when people take advantage of a loophole, it destroys the system. She said issues like this are the reasons consumers pay what they are paying. Commissioner Caride agreed.

Meghan Stringer (America's Health Insurance Plans—AHIP) presented her slides and said some of the AHIP's Medigap members brought this to her team's attention. She said there are other DME items, other than scooters, are subject to these excess charges, such as dental devices for sleep apnea and knee therapy devices. She said there is an issue with advertisements where the ads state if you have a Medigap plan these items are no cost to you and some of the carriers feel there is misleading information in these advertisements. She said on the scooters in particular the supplier website will indicate that standard parts are included but

items that one would think are standard, like wheels or batteries, are billed separately. She said their members are seeing reports across the country in nearly every state. She said in some instances if the Medigap plan tries to push back, the supplier then says it will balance bill the beneficiary which cannot happen so the plan eats the costs.

Silvia Yee (Disability Rights Education and Defense Fund—DREDF) said when looking at finding solutions to price gouging and fraud that the consumer should not be forgotten in the process. She said those with rehabilitative needs, such as post-polio or achondroplasia people, who really need the various parts to a wheelchair or scooter because they cannot live their lives need to be considered when thinking about a narrow or tailored response to price gouging or fraud.

Bill Schiffbauer (Schiffbauer Law Office) said Medicare requires a doctor to prescribe the DME and the Medicare handbook says that it only covers the DME if it is from a Medicare enrolled supplier so that means the supplier has to be approved by Medicare and have a Medicare supplier number. He said a lot of the DME is also required to be part of a competitive bidding process. He said those non-participating suppliers technically would not be paid by Medicare and if they are not being paid by Medicare, Medigap plans are generally limited to Medicare approved cost sharing.

Mr. Schiffbauer said there is a law in the Social Security Act that limits liability for non-participating providers, like physicians and suppliers. He said the regulations promulgated by the U.S. Department of Health and Human Services (HHS) to implement this statute defines suppliers rather broadly and specifically limits the actual charges of non-participating suppliers. He said that would limit, in theory, the base payment to whatever Medicare would approve for their competitive bidding suppliers and limit Medigap's charge to whatever to the total would be of the Medicare approved charge. He said the excess charges provisions in the Model #651 probably would need a little fine tuning.

Bonnie Burns (California Health Advocates—CHA) said agreed with Ms. Yee's comments and pointed out that so many of these companies try to find loopholes and what happens when trying to control fraud and abuse with DMEs is that the people who really need these DMEs are not able to get what they need. She said the scooters and the parts for the scooters are very critical to those people who really need them. She said these scooters and wheelchairs are expensive and these suppliers seem to find ways to get around the law so in the effort to prevent going around the law it is important not to forget the consumer and beneficiary who really need these DMEs.

Commissioner Caride said while there are several states that have changed their laws not every state can go to their state legislatures and while legislatures want to help their constituents, nothing happens quickly. She asked what can be done to help our consumers and beneficiaries to prevent them from being taken advantage of without going to our state legislatures and having 50 different state laws?

Mr. Schiffbauer said if we had federal law that said non-participating DME suppliers are limited in what they can charge to the Medicare approved amount and if they go through Medicare plus the 15% the way non-participating physicians are treated then there would be some protection. He said that would have to be made explicit by the contacts and Centers for Medicare and Medicaid Services (CMS) to make insurers and the NAIC feel comfortable enough to either clarify it in the model or issue a bulletin to that effect.

Derrick Claggett (Centers for Medicare and Medicaid Services—CMS) said this is a statutory provision and is a congressional issue. He said this is not a new issue for CMS and this has come up before. He said Congress did not include a provision for DME providers specifically for this limiting charge. He said it has been imposed on other providers and other physicians but there is not anything specific to DME providers. He said he made inquiries about this matter and asked if within the confines of the statute or other regulations, does CMS have the discretion to limit excess charges and was informed explicitly that CMS does not have that discretion and would require an amendment to the statute.

Mr. Schiffbauer said CMS should go back and review the definition of supplier which seems to be broadly defined and would seem to offer a lot of wiggle room. Ms. Arp said supplier would not have been put in that statutory provision if not intended to mean supplier. She said the statue says "115% of the recognized payment amount for non-participating physicians, or non -participating suppliers, or other persons." Mr. Schiffbauer said the regulation defines supplier to mean a physician or other practitioner or an entity other than a provider that furnishes health care under Medicare. He said Medicare beneficiaries need to be made more explicitly aware that they should be purchasing these DMEs from participating suppliers and it should be more prominently noted in the Medicare DME Handbook.

Director Wing-Heier said this is extremely troubling. She said that the commentary that has been made is that the advertisements state a consumer can get an electric scooter at no cost to them and the cost is x-amount and posted on their website but then we find out that it does not cover all parts and pieces that one would expect to be on that equipment. She asked if this could be addressed from a false advertising point of view because consumers are being told one thing but then find various prices or parts that anyone would normally expect to be part of the equipment are not included and could we, as state regulators, rattle some cages invoking or utilizing a false advertising front?

Mr. Schiffbauer said there is the Market Regulation and Consumer Affairs (D) Committee but the beneficiary liability protection provisions in the statute seem to be written broadly enough that it could help as the basis to mitigate and say only so much can be paid, the 15% above the Medicare approved charge. He said to get that broad term supplier clarified would help immensely and then there would be something to help back up regulators on the marketing front. He said although the Medicare DME Handbook does warn that if a DME is not purchased from a Medicare participating supplier you may have to pay the full amount, it does not seem many seniors, the Medigap industry and regulators are fully appreciative of how this might work.

Commissioner Caride said it would be helpful for CMS to go back take a second look at the language in the stature and regulations. She said in New Jersey they have gone after producers for falsely advertising in New Jersey and perhaps this is a tool to utilize and, to use Director Wing-Heier's phrase, to rattle some cages in the producer and supplier market and make them think twice.

Ms. Yee said there are other ways advertisers are misleading consumers directly. She said there are producers and suppliers that use a bait and switch type of technique where a consumer is told that the battery is covered but it requires to be charged every 30 minutes, which is extremely limiting to the consumer, but if you want a battery that needs to be charged every 4 hours that will cost more.

Ms. Brown asked Mr. Schiffbauer about going to the Federal Trade Commission (FTC) on this matter. Mr. Schiffbauer said that is a possibility, but they would probably respond by asking how misleading this is if we do not know what these rules are under Medicare or how this Medicare beneficiary liability protection applies. He said if cages are to be rattled perhaps the NAIC issues its own bulleting which may get the attention of CMS.

Ms. Brown said it would be helpful to do some investigating and then write a letter to CMS to get clarification and a legal interpretation so that we can go to the FTC. She said working with Senior Medicare Patrol (SMP) would be a great idea.

Director Wing-Heier said that as congressional midterms are close at hand and Members of Congress look for ways to be helpful to problems in their respective states that this is a great opportunity to go to our respective congressional delegations. She said if CMS is statutory then we need to go to Congress.

Ms. Burns asked if a subgroup could be constructed from Senior Issues (B) Task Force. Commissioner Caride said it something to possibly consider and asked David Torian (NAIC) for input. Mr. Torian said that it would be prudent to first ascertain whether it is a congressional issue because it is statutory or get clarification from CMS by letter as Ms. Brown suggested before just creating a sub- or working group.

Mr. Claggett said it would be very helpful to summarize these issues, particularly the statutory references Mr. Schiffbauer raised, and he would like to work with the Task Force in getting this information to the appropriate people in CMS, including CMS leadership. He said one of the key points of this discussion is the interpretation of the word supplier as raised by Mr. Schiffbauer and to the extent that can be summarized and referenced as to actually include DME suppliers and why or what precedent they are not being covered under that statute.

Commissioner Caride said a letter is a good idea and asked Mr. Schiffbauer to provide Mr. Torian with some suggestions. She said the suggestion offered by the Task Force's Vice Chair, Director Wing-Heier, to go to our respective congressional delegations and raise this issue and make them aware that a solution may have to come from them is excellent, especially as the midterm elections are around the corner. She said the last thing anyone wants is to see and to have their constituents taken advantage of, especially seniors and those most vulnerable.

4. Heard a Federal Update

David Torian (NAIC) provided the Task Force with a federal update. He said funding for the State Health Insurance Assistance Program (SHIP) is operating under fiscal year (FY) 2021 levels, and SHIP funding is at $55 million. He said the U.S. House of Representatives (House) did pass its FY 2022 Labor, Health and Human Services, Education and Related Agencies funding bill on July 29, and it included an increase to SHIP to a level of $57,115,000. He said the U.S. Senate (Senate) has not acted on its appropriation bills. He said the U.S. Congress is looking at doing a short continuing resolution (CR) to keep the government funded through December.

Mr. Torian said the House passed the reconciliation bill on Nov. 19, which included language to provide for coverage of hearing aids under Medicare Part B for individuals with severe or profound hearing loss in one or both ears, once every five years and if furnished through a written order by a physician, qualified audiologist, hearing aid professional, physician assistant, nurse practitioner, or clinical nurse specialist qualified to write such order by the state. He said it is unclear when the Senate will consider this measure and if any of the hearing provisions may be changed.

Mr. Torian discussed an issue brought to the attention of the NAIC regarding delays with Medicare cards. He said the Social Security Administration (SSA) mails out (usually initiated by a phone call) the application and receives and processes the application. It then sends it to the federal Centers for Medicare & Medicaid Services (CMS) to send the Medicare card to the enrollee. He said since many SSA field offices have been closed due to the pandemic, almost all applications are being mailed to seniors, and then they must mail the application and supporting materials back to the SSA. He said the CMS and the SSA have found that serious mail delays (three to four weeks for each mailing) have resulted in significant delays in the final application being received by the SSA. He said the mail delivery and the slow down at the U.S. Postal Service (USPS) seems to be the main issue. The CMS and the SSA are looking at ways to address this, but this may take some time to resolve. He said the NAIC continues to monitor the matter and is in communication with the SSA and the CMS.

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