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Senior Issues (B) Task Force
Virtual Meeting
July 18, 2024

The Senior Issues (B) Task Force met July 18, 2024. The following Task Force members participated: Scott Kipper represented by Jack Childress, Chair (NV); Peni Itula Sapini Teo, Vice Chair (AS); Lori K. Wing-Heier represented by Sarah Bailey (AK); Mark Fowler (AL); Ricardo Lara represented by Emily Smith (CA); Karima M. Woods represented by Stephen Flick (DC); Trinidad Navarro (DE); Michael Yaworsky represented by Anoush Brangaccio (FL); Doug Ommen represented by Andria Seip (IA); Dean L. Cameron represented by Shannon Hohl (ID); Vicki Schmidt represented by Craig VanAalst (KS); Sharon P. Clark (KY); Timothy J. Temple represented by Vicki Dufrene (LA); Kevin P. Beagan (MA); Joy Y. Hatchette represented by Jamie Sexton (MD); Timothy N. Schott (ME); Anita G. Fox represented by Renee Campbell (MI); Grace Arnold represented by Cam Jenkins (MN); Chlora Lindley-Myers represented by Amy Hoyt (MO); Mike Chaney represented by Bob Williams (MS); Mike Causey represented by Robert Croom (NC); Jon Godfread represented by Chrystal Bartuska (ND); Eric Dunning represented by Martin Swanson (NE); D.J. Bettencourt represented by Maureen Belanger (NH); Alice T. Kane represented by Viara Ianakieva (NM); Judith L. French represented by Tynesia Dorsey (OH); Glen Mulready represented by Mike Rhoads (OK); Michael Humphreys represented by Shannen Logue (PA); Cassie Brown represented by Rachel Bowden (TX); Jon Pike represented by Tomasz Serbinowski (UT); Scott A. White represented by Julie Blauvelt (VA); Kevin Gaffney represented by Mary Block (VT); Mike Kreidler (WA); Nathan Houdek represented by Jennifer Stegall (WI); and Allan L. McVey represented by Joylynn Fix (WV).

1. Discussed the Medigap GI and Provider Withdrawals from Medicare Advantage Plans

Commissioner Teo, at the request of Commissioner Kipper, chaired this meeting. Swanson said a major hospital in Nebraska decided not to retain Medicare Advantage plans and got rid of their contracts. He said the hospital thought the Nebraska Department of Insurance (DOI) would have a say in getting people back onto original Medicare plans. He said the DOI did not think it could do that, but after speaking with the federal Centers for Medicare & Medicaid Services (CMS), it was verified they could do that. He said it was up to CMS to decide whether a special enrollment period (SEP) would be triggered under the scenario of a contract being severed.

Swanson said there is no resolution yet but that the heart of the issue is how CMS determines that an SEP is triggered under the new guidance recently issued and the enrollee can return to original Medicare. He said he believes that would also include Medigap but asked what the process that CMS engages in is and what happens in the meantime.

Swanson asked if other states' hospitals have decided they are no longer going forward with Medicare Advantage plans and, if so, what their experiences have been. He said he believes it comes down to a time and distance standard and how many Medicare Advantage plans are available within that.

Bartuska said she has heard of certain hospitals in her state also not taking a particular carrier's Medicare Advantage plans, which is related to an issue North Dakota has seen where a carrier withdrew their Medicare cost plan. Then, consumers were not allowed to go into other plans as a result of qualifying for a guaranteed issue (GI) open enrollment scenario when a carrier pulls out of a certain county. She said the issue of when an insurer has to discontinue a certain product because it is too populated in a certain area under federal guidelines should fall on the federal government to determine if these scenarios qualify for not only an open enrollment situation but, more importantly, a GI situation.

 

Rhoads asked Swanson if he could go over CMS' explanation again. Swanson said the process is that the hospital notified CMS, as did the carrier. He said CMS gave the proper email box for the information from the hospital to go to; however, the hospital has not heard back yet on a resolution. He said the CMS representative for the area and the company is aware of it and is working with the folks back in DC about whether an SEP under the new guidance is warranted to get these enrollees back into original Medicare.

Bartuska said they reached out to their CMS contact, and he told them to email them every time this situation or scenario arises because then they will have to look into the whole network adequacy, and if these hospitals are not taking this insurance, then there is a whole network issue. She said North Dakota's State Health Insurance Assistance Program (SHIP) department is in its DOI, and some people have to be veered away from some carriers because that consumer will not be in the network. She said it is important to clarify to SHIP clients that they should carefully look at the network before purchasing a plan. She said the intent is not necessarily to veer people into insurance but that people do need doctors. Swanson said Nebraska's SHIP department is not in the state DOI, so he cannot give any advice on this issue.

Rhoads said the only advice is that within that 12-month trial period, they can go back to their original Medicare plan. He said they have these exits in Oklahoma with some health systems, and there is typically a lead-up of around six months. He said an announcement is made, and then on a future effective date, they will no longer accept any of those Medicare Advantage plan enrollees. He asked if that is also the case in Nebraska and North Dakota.

Swanson said there is notification, and CMS is pleased that there are plenty of months ahead of open enrollment, but he does not know the answer to the second part of the question. Rhoads asked David Torian (NAIC) if the Task Force could get something going with CMS. Torian replied that it could.

Dufrene said Louisiana was notified by one of its rural hospitals that it has also been told by a carrier that it is severing its contract and that hospital has talked to another rural hospital that has received the same letter. She said the initial hospital in question has been able to get the carrier to push the termination date closer to the end of the year so that the SHIP has time to work with the beneficiaries and advise them of their options.

Hohl said Idaho has worked with its CMS regional office. If CMS has determined that the network would no longer be adequate, the plan is sometimes discontinued mid-year, which itself would trigger the SEP for another Medicare Advantage plan or potentially go back to original Medicare. She said Idaho has not had any issues working with CMS on this as long as it was demonstrated that it had a significant enough impact on the network that people needed to have the option to move or that the plan was sometimes discontinued. She said this is certainly an issue the Task Force should all be aware of and was glad the Task Force is talking about it, particularly if it runs into it more and more in rural areas, but she said Idaho has so far been able to work through it with CMS to give people options.

Commissioner Teo asked Torian if this was something to be discussed further at the Summer National Meeting. Torian replied that it could be part of the agenda, as this is a serious issue. Torian asked whether enrollees can go to Medigap as well as their original Medicare plans if an SEP is triggered by Medicare Advantage plans being dropped. He said there seems to be more clarification needed.

2. Discussed Section 1557 of the ACA and the Application of Non-Discrimination Rules to Medigap

Brian Webb (NAIC) said this is an issue that goes back to the NAIC's comments on the draft Section 1557 rule back in October 2022. He said the NAIC, at that time, raised concerns about the proposed rule, which would apply non-discrimination rules not just to those plans that receive federal funds but to any plans of a company that receives

 

federal funds. He said it would apply to all accepted benefit plans (such as Medigap plans) if any part of a company received federal funds.

Webb said the NAIC took issue with the underlying idea that all funds are just fungible. He said if you are receiving federal funds for an Affordable Care Act (ACA) plan or a Medicare Advantage plan, you can just move that money around to your accepted benefit plans. He said that is not how it works, and the NAIC noted that it is actually done by markets, by plans. He said when the final rule came out earlier this year, the U.S. Department of Health and Human Services (HHS) Office of Civil Rights (OCR) still kept the application to all plans so if any part of a company receives federal funds and this is raising some alarm, especially for Medigap. He said that if you cannot discriminate or rate based on things like age, this could create a market where some Medigap carriers can age-rate while others cannot, creating an unfair playing field.

Webb said it also brings into question why they would not be able to do that for Medigap when they always have been able to, as age is often something they can rate on even in the ACA. He said that is what the question and final rule really did not address, and the NAIC continues to reach out to the OCR to see if we can have some conversations on this as well as some other issues, but for today's purposes, the concerns are about the impact this could have on Medigap plans.

Swanson asked about ongoing litigation on this issue. Webb said the courts made three different decisions related to this particular rule. He said two of them are specific to the sex discrimination definition—one of those an injunction has been applied nationally and the other one more regionally. He said there is a case regarding the application of the rule on Section 1557, but that seems to only apply to at least Texas and Montana right now. He said it is something that is being discussed, although the specific issue of application of the rule in question has not been the focus of those court cases.

Webb said the NAIC continues to reach out to the OCR on this issue to see if it can get more guidance on this and asked if states are hearing from insurance companies regarding whether this issue has been raised and what potential impact it could have. Rhoads said Oklahoma has not.

Bonnie Burns (Consultant to Consumer Groups) said she is concerned about the marketing that is going to take place for this open annual enrollment period and is also concerned about how Section 1557 elements are going to figure into the marketing once agents understand there is an issue. She said she would like to hear more from the states about what they are hearing about this issue or if it has not yet filtered down to the agent community.

Burns said that if the effective date of Section 1557 has already passed, then those insurers need to comply with those non-discrimination issues for this next SEP. She asked if some companies will not be able to underwrite or age rate Medigap while other companies can. Webb said there was a 60-day period, so it became effective 60 days from when this was published in May. He said that, after that date, carriers are prohibited from discriminating based on all those various categories. He said if they are rating based on those and they receive federal funds for any of their portion, then they could be in violation of Section 1557.

Burns asked how states will deal with this if the insurers have to comply with Section 1557 and how consumer groups will know whether they can or cannot underwrite or age rate. Webb said there is no guidance from the OCR about how to implement and enforce this, and that is one of the NAIC's big questions, and there is no answer. Burns asked what states are going to do. Webb said that currently, if there is a complaint, they can review it to determine whether that company is in violation, but there is no clarity as to what states' role in this is overall. He said this is a federal regulation, so the NAIC is not quite sure of the states' role right now. Burns asked if that means consumers and consumer groups advising consumers are on their own.

 

Swanson said states are on their own at the moment. He said they do not have guidance from the OCR, and there is litigation that will throw a little bit of wrinkle into this. He said he would imagine the plans will publish their plan documents depending on how this goes, and then the SHIPs will take that information as best they can. He said if companies are asked if they are getting federal funds and think they are subject to it, states will have to make some filings at some point to reflect that, which will take quite some time. He said it will not be an overnight process and, especially with ongoing litigation, there will be a lot of confusion for a while. He said that the season is getting closer, and without any guidance, it could very well be an issue, but Nebraska cannot offer any guidance because it doesn't have its own yet.

Amy Killelea (Individual Consumer Advocate) said she agrees with Burns's concerns but that as a consumer representative focused on health insurance access for all, especially the vulnerable, she is excited about the prospect of Section 1557. She said this is a civil rights framework in the ACA and, as it relates to the court cases raised earlier, Section 1557 is a statutory provision that was not created by administrative rule. She said there is an administrative rule that gives contours to it, but that is strongly tethered to statutory language.

Killelea said that in terms of application to Medigap, she is glad the NAIC is having this conversation because consumer representatives are interested in the application of the Section 1557 non-discrimination provisions, not just to Medigap but also to the short-term plan rules and accepted benefits. She said she applauds the OCR for its intentional and exhaustive discussion of the application of the civil rights framework to these types of benefits.

Killelea said it is explicit in the preamble that there is not an intention to overturn the entire market but that the intention is to apply non-discrimination principles across the board to major medical and other health products and that is an overall win for consumers. She said in terms of litigation, there has been litigation for every piece of the ACA over the past decade or longer, and there will continue to be litigation, but Section 1557, as a statute, was not at issue, and there is no injunction on Section 1557. She said it is in full force and is a protection for consumers in every state.

Killelea said in the final rule, there are staggered implementation dates. She said the non-discrimination and health insurance coverage pieces track the usual plan year and ACA effective dates, so by the first day of the first plan year beginning on or after January 2025. She said she would conjecture that this would also apply to the Medicap market. She said that it is important to note and that it would allow for some lead time. She said that as a consumer representative, she looks forward to working with the NAIC, industry, and anyone who wants to sit and think about practical approaches everyone can support to ensure the provisions are implemented appropriately.

Burns said she would like to comment on the earlier topic of the SEP, especially as it relates to marketing because there is a new article from KFF that discusses past marketing efforts.

Burns said her concern is that many people will be inadvertently enrolled in Medicare Advantage plans and then be locked into those plans as the plans and providers go to war with each other because there are health care systems and medical groups consistently withdrawing from Medicare Advantage plans. She said there are Medicare Advantage plans terminating certain providers, particularly in rural areas. She said she has a real concern about the marketing that will happen, especially because of the legal freeze on HHS's efforts to control agent commissions. She said there needs to be much more discussion about this.

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

 