

Draft: 3/6/24

Senior Issues (B) Task Force
Virtual Meeting
February 29, 2024

The Senior Issues (B) Task Force met Feb. 29, 2024. The following Task Force members participated: Scott Kipper, Chair (NV); Peni 'Ben' Itula Sapini Teo, Vice Chair (AS); Lori K. Wing-Heier represented by Sarah Bailey (AK); Ricardo Lara represented by Tyler McKinney (CA); Karima M. Woods represented by Howard Liebers (DC); Trinidad Navarro represented by Susan Jennette (DE); Michael Yaworsky represented by Anoush Brangaccio (FL); Doug Ommen represented by Andria Seip (IA); Dean L. Cameron represented by Weston Trexler (ID); Amy Beard represented by Alex Peck (IN); Vicki Schmidt represented by Craig VanAalst (KS); Sharon P. Clark represented by Stephanie McGaughey-Bowker (KY); Timothy J. Temple represented by Ron Henderson (LA); Gary D. Anderson represented by Kevin Beagan (MA); Kathleen A. Birrane represented by Joy Hatchette (MD); Timothy N. Schott (ME); Anita G. Fox represented by Renee Campbell (MI); Grace Arnold represented by Julia Dreier (MN); Chlora Lindley-Myers represented by Amy Hoyt (MO); Mike Chaney represented by Bob Williams (MS); Mike Causey represented by Ted Hamby (NC); Jon Godfread represented by Chrystal Bartuska (ND); Eric Dunning represented by Maggie Reinert (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); Michael Humphreys represented by Shannen Logue (PA); Carter Lawrence represented by Emily Marsh (TN); Cassie Brown represented by Valerie Brown (TX); Jon Pike represented by Tanji J. Northrup (UT); Scott A. White represented by Julie Blauvelt (VA); Tregenza A. Roach (VI); Kevin Gaffney (VT); Mike Kreidler represented by Todd Dixon (WA); Nathan Houdek represented by Jennifer Stegall (WI); and Allan L. McVey represented by Joylynn Fix (WV).

1. Adopted its 2023 Fall National Meeting Minutes

VanAalst made a motion, seconded by Dixon, to adopt the Task Force's 2023 Fall National Meeting Minutes (*see NAIC Proceedings – Fall 2023, Senior Issues (B) Task Force*). The motion passed unanimously.

2. Heard a Presentation on Access to Medigap Coverage and Challenges for Those Under and Over Age 65

Kara Nett Hinkley (The ALS Association) said that although those under age 65 have had difficulties accessing Medicare supplemental insurance (Medigap) policies since the 1990s, those over age 65 are now seeing similar challenges. She said many are enrolled in Medicare Advantage plans and stuck in plans where the benefit providers or networks change and the plan no longer meets the patients' needs. She said that while Medicare Advantage members change to return to their original Medicare during the annual enrollment period, that is not the case with Medigap in most states.

Hinkley said the following presentation will look at Medicare beneficiaries under age 65 and their difficulty in gaining access to Medigap, as well as those over age 65, and what the federal government is doing to make it less enticing to leave a Medicare Advantage plan.

Bonnie Burns (California Health Advocates—CHA) said there is no federal right to Medigap until age 65. She said that amounts to discrimination based on age. Burns said there are protections for those over age 65 with chronic medical conditions but not for those under age 65. She said access to Medigap for those under age 65 varies widely among the states. Burns said variations range from the same Medigap rights as those over age 65 to those states with limited access to certain Medigap plans and higher premiums, with some limitations to those states that allow access through a state high-risk pool, to some with voluntary sales with health underwriting, to those states with no access to those under age 65.

Burns said three states require the same Medigap plans as age 65 with no change in premiums. She said five states require the same Medigaps as age 65 with limits on premiums, caps, or other limitations. Burns said the Medigap waiver states limit premiums and have some Medigaps available to younger beneficiaries. She said 13 states and D.C. have no Medigap requirements for under age 65, and seven of those states provide coverage through the state's high-risk pool. She said one state has year-round open enrollment without health underwriting or age-rated premiums.

Burns asked how the three states that require the same Medigap plans as age 65 with no change in premiums can do this. She asked what the Medigap experience is in those states in relation to premium costs, medical and claims experience, and loss-ratio experience. Burns asked how they compare to other states.

Burns suggested the NAIC should collect data to inform states and policymakers. She said such data should include the impact of state rules on access to Medigap, Medigap rates, loss ratios, state high-risk pools, and the Medicare/Medicaid dual-eligible populations, both under and over age 65. She said the NAIC should also collect insurer data, including health underwriting in voluntary markets and pricing data.

Deborah Darcy (American Kidney Fund—AKF) said she would address the Medicare beneficiaries over 65 and how many seniors feel stuck in Medicare Advantage. She said that in 2021, about 58 million people were enrolled in both Medicare Part A and Part B, with about 53% covered under traditional Medicare and 47% enrolled in Medicare Advantage plans. She said that in 2023, the growth of Medicare Advantage plans increased, and 51% or almost 31 million people are now enrolled in a Medicare Advantage plan.

Darcy said that the breakdown of those with traditional Medicare is about 40%, with traditional Medicare and Medigap; a little over 30% with traditional Medicare and employer coverage; 17% with traditional Medicare and Medicaid; with the remaining having traditional Medicare and either another type of coverage or no other coverage.

Darcy said that the consumer protections in Medigap under federal law state that when an individual first gets Medicare coverage, they have six months wherein a medical insurer cannot deny a Medigap policy to any applicant based upon age, gender, health status, preexisting conditions; however, outside of those six months, there are no federal protections and state law decides the consumer protections.

Darcy said that four states require either continuous or annual guaranteed protections for Medigap beneficiaries, and 28 states require Medigap insurers to issue policies to those eligible when their employer coverage has changed, so if they had a retirement plan and that changed, they would have access to those plans. She said that in other states, people may be denied a Medigap plan when they switch from a Medicare Advantage plan to traditional Medicare because they have a preexisting condition.

Darcy highlighted some reasons someone may want to leave a Medicare Advantage plan, such as provider directory inaccuracies, inadequate provider and facility network standards, prior authorizations, or delay or denial of care. She said that approximately 50% of beneficiaries leave their current Medicare Advantage plan within five years, which could be looked at in two different ways. Darcy said that the market is working or that beneficiaries are unhappy with their Medicare Advantage plan.

Darcy said that as the number of beneficiaries enrolling in Medicare Advantage plans increases, there will be more beneficiaries who would like to leave their plans and go back to traditional fee-for-service Medicare, but essentially, they cannot because they do not have secondary insurance. She said that as a representative of the AKF, this is especially important for dialysis patients. Darcy said that people who have kidney failure and only have

a traditional Medicare Advantage plan without a secondary plan (with the secondary plan being a retirement or Medigap plan) will not be considered fully insured and will not be placed on the transplant waiting list. Therefore, being fully insured is very important.

Darcy said that the Administration provided updated network adequacy standards and new guidance in December 2023, but dialysis centers are still not included in these Medicare Advantage network adequacy standards. She said they rely on consumer complaints and tracking those but it would be far more helpful if dialysis centers were included. She said the U.S. Senate Committee on Finance has been active recently on Medicare Advantage deceptive marketing, including sending letters to third-party marketing organizations (TPMOs) seeking information on data collection and enrollment targeting seniors looking at Medicare Advantage plans.

Silvia Yee (Disability Rights Education and Defense Fund—DREDF) said it is important to highlight the many negative impacts on Medicare beneficiaries, both over and under age 65, on the lack of access to Medigap policies and to explain the unfairness of this status. She said states have the capacity to help address this unfairness for Medicare consumers, and some states have done so.

Yee said she wanted to explain how Medicare beneficiaries excluded from purchasing Medigap products can be particularly impacted when states maintain narrow Medigap eligibility policies. She said people under age 65 who are on Medicare and who have a range of disabilities are particularly impacted by the narrow provider networks. Yee said they are more likely to need specialty care and specialty providers and have medical conditions and unique drug interactions that are typically not addressed in Medicare Advantage plans.

Yee said that there are children and young adults with disabilities on Medicare, just as there are people who need to receive reproductive care, and that providers such as pediatric psychologists or obstetricians can be seen as unnecessary. She said it can become a difficult situation if a particular needed provider is in a network and leaves, and the Medicare Advantage plan does not do anything about it or moves slowly to address it. Yee said Medicare beneficiaries with mobility disabilities are likely to encounter providers in network that do not have accessible equipment or problematically refuse to provide immediate accommodations, such as sign language for communication.

Yee said the percentage of offices with even basic accessible weight scales and height adjustable tables remains in the mid-teens and asked if those providers are not taking new patients, how long a Medicare beneficiary should have to wait for a Medicare Advantage plan to fix the situation. She said people with disabilities could have serious reasons to want to return to fee-for-service Medicare, but once they do, they will find themselves forced to take the full financial impact of Medicare's 20% copay without the option of Medigap. She said younger disabled people on Medicare may or may not be employed, but they are less likely to have employment insurance as a backup to Medicare. She said that the U.S. Bureau of Labor Statistics reports that workers with a disability were more likely to be employed part-time than were those with no disability, and about 29% of those with a disability usually worked part-time compared to about 16% of workers without a disability.

Yee said more than 17 million Americans over age 65 are economically insecure, living at or below 200% of the federal poverty level. She said these older adults struggle with the rising cost of housing and healthcare, inadequate nutrition, lack of transportation, diminished savings, and job loss. She said the burden of having to cover 20% of the costs of a single significant health event or condition can be catastrophic. She said Medicare beneficiaries, both under and over age 65, who are left without the option of a Medigap policy are the very individuals and families who are least able to get by without those policies. Medicare's 20% copay can be very sizeable for this group and lead to healthcare being delayed or entirely avoided.

Yee said it is incorrect to assume that allowing people over age 65 and Medicare recipients under 65 to obtain a Medigap product would make premiums unaffordable. She said some states have made Medigap policies much more affordable, and the sky has not fallen. Yee said giving people the healthcare they need and ensuring that they are not skipping medication doses and checkups will lead to better health outcomes and delay or prevent the onset of costlier health expenses later on. She said there is no reason for state insurance regulators and policymakers to just take the word of insurers that Medigap will be priced out of existence and the policies were more broadly subject to guaranteed issues. Yee said the current unfair status quo will always prevail because consumers and advocates do not have access to the financial and actuarial information for themselves.

Dixon asked if there are federal protections for guaranteed issue under Medigap in the currently ongoing Medicare Advantage enrollment period. Burns said there is no federal rule that allows a person to go back to traditional Medicare and get Medigap. She said legislation will be introduced in California to correct that, and some states already have that rule. She said California has a rule that when a person's Medicare Advantage plan increases costs or terminates a provider, there is a guaranteed issue. However, if a provider leaves a plan or network, there is no right because it is the provider's decision.

Commissioner Gaffney asked if there is a specific list of states highlighted in the presentation that could be reviewed to see where and how a state is listed, such as Vermont. He also asked if there are demographics on those who choose Medicare Advantage versus Medigap. Commissioner Gaffney suggested that the reason for choosing Medicare Advantage over Medigap could be financial. Darcy said she tried not to call out any states but could get that information. There are only four states with a guaranteed issue: Connecticut, Maine, Massachusetts, and New York. She said 28 states require Medigap insurers to issue policies when they have had their employer retirement plan be secondary to Medicare, and she would provide that list. Darcy said that as for the demographics, her source was the KFF, and she would also provide that.

Commissioner Gaffney said there is a preponderance of individuals now working past age 65. When they are making their Medicare Part A and Part B decisions, they do not have supplemental insurance through employment. He asked if there is a missed opportunity there, as those individuals are still working but not thinking of purchasing Medigap. Burns said the problem is that many of these workers are being offered coverage by the federal Consolidated Omnibus Budget Reconciliation Act of 1995 (COBRA), which is a nightmare situation. She said many do not understand they have the right to Medigap, and some may not even know what Medigap is, so they are defaulting to COBRA because it is all that is presented to them. The Medicare and COBRA combination creates all kinds of problems.

Burns said another point is that a lot of people who cannot get Medigap end up spending down into Medicaid, and once on Medicaid, they will be on it for the rest of their lives. Therefore, the costs are getting absorbed somewhere. Yee said that the advertising and similar factors that draw people into Medicare Advantage plans fail to point out what may already exist in Medicare and Medigap. Burns said this boils down to states being allowed to regulate Medicare Advantage marketing and plans, which they cannot do. She said that it is relegated by the federal Centers for Medicare & Medicaid Services (CMS), and she knows that the Senior Issues (B) Task Force and state insurance regulators are supportive of wanting that oversight authority brought back to them.

Commissioner Kipper said the issue of Medicare Advantage marketing and oversight by states was a highlighted topic at the recent Commissioners' Conference, and the NAIC remains concerned about the marketing of Medicare Advantage plans.

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

[SITF Feb 29 Minutes](#)