Draft Pending Adoption

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Senior Issues (B) Task Force
Chicago, Illinois
August 13, 2024

The Senior Issues (B) Task Force met in Chicago, IL, Aug. 13, 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); Mark Fowler represented by John Buono (AL); Ricardo Lara represented by Emily Smith (CA); Andrew N. Mais represented by Paul Lombardo (CT); Karima M. Woods represented by Colin Johnson (DC); Trinidad Navarro represented by Jessica Luff (DE); Michael Yaworsky represented by Alexis Bakofsky (FL); Doug Ommen represented by Andria Seip (IA); Dean L. Cameron represented by Shannon Hohl (ID); Amy L. Beard represented by Scott Shover (IN); Vicki Schmidt represented by Julie Holmes (KS); Sharon P. Clark represented by Shaun Orme (KY); Timothy J. Temple represented by Ron Henderson (LA); Kevin P. Beagan (MA); Joy Y. Hatchette represented by Jamie Sexton (MD); Robert L. Carey represented by Marti Hooper (ME); Anita G. Fox represented by Renee Campbell (MI); Chlora Lindley-Myers represented by Amy Hoyt (MO); Grace Arnold represented by Sherri Mortensen-Brown (MN); Mike Chaney represented by Bob Williams (MS); Mike Causey represented by John Hoomani (NC); Jon Godfread represented by Chrystal Bartuska (ND); Eric Dunning represented by Martin Swanson (NE); D.J. Bettencourt represented by Michelle Heaton (NH); Alice T. Kane represented by Blanca Ramirez (NM); Judith L. French represented by Laura Miller (OH); Glen Mulready represented by Mike Rhoads (OK); Andrew R. Stolfi represented by Tricia Goldsmith (OR); Michael Humphreys represented by Michael Gurgiolo (PA); Alexander S. Adams Vega represented by Brenda Perez (PR); Larry D. Deiter represented by Jill Kruger (SD); Carter Lawrence represented by Scott McAnally (TN); Cassie Brown represented Debra Diaz-Lara (TX); Jon Pike represented by Tanji Northrup (UT); Scott A. White represented by Julie Blauvelt (VA); Tregenza A. Roach (VI); Kevin Gaffney represented by Emily Brown (VT); Mike Kreidler represented by Todd Dixon (WA); Nathan Houdek represented by Darcy Paskey (WI); and Allan L. McVey represented by Joylynn Fix (WV).

1. Adopted its July 18 and Spring National Meeting Minutes

The Task Force met July 18. During this meeting, the Task Force took the following action: 1) discussed Medicare supplement insurance (Medigap) guarantee issue and provider withdrawals from Medicare Advantage plans; and 2) discussed the impacts of Section 1557 of the Affordable Care Act (ACA) and the application of non-discrimination rules to Medigap.

Swanson made a motion, seconded by Bartuska, to adopt the Task Force's July 18 (Attachment One) and March 16 (*see NAIC Proceedings – Spring 2024, Senior Issues (B) Task Force*) minutes. The motion passed unanimously.

2. Heard a Presentation on SHIPs

Commissioner Kipper said state health insurance assistance programs (SHIPs) are a vital component in helping consumers navigate health care. Vicki Dufrene (Louisiana Department of Insurance [DOI]) said she has seen a lot of changes in these programs throughout the years. She thanked the Task Force and the NAIC for their constant support of SHIPs, not only in Louisiana but the 54 different SHIPs that are available across the country. She said her department is housed within the Louisiana Department of Insurance and falls under the purview of Deputy Commissioner Ron Henderson under the Office of Consumer Advocacy and Diversity, which allows staff to help educate the Medicare population, caregivers, providers, agents, and others.

Dufrene said when it comes to long-term care (LTC), she had a call regarding an LTC policy with an individual trying to understand their benefits and the premiums that they are going to be facing. She said they discussed the matter, and it is fortunate that Louisiana is a partnership state, so its Medicaid program does help provide some

services that help those individuals make the determination between keeping their high-premium policy with a reduction in benefits or dropping the policy so they can afford other life necessities. She said this particular individual retired from a chemical plant so they had the financial backing to keep the policy, but they reduced some of the benefits.

Dufrene said she started her job when she was 34 years old, and after the first week, she went home and told her husband they needed long-term care insurance (LTCI). She said she comes from a family where both sets of grandparents had some form of dementia or Alzheimer's disease. She said that as she looked at the policy and began to understand it, she knew in the years to come, she was not going to be able to afford this policy or the benefits. She believes LTCI is a good policy, but it has priced itself out for the average citizen, which is sad because folks will have to rely on their state Medicaid programs, which do not have the funding or the facilities to house people who truly need LTC. She said nursing homes are not prepared for these people, and they will go into a lockdown unit, and that's where they stay while their family hopes their loved one is receiving some type of care. She said there is nothing set in place for those individuals to get better care for their loved ones or go into specialized nursing homes that focus on dementia patients or those with mental challenges. She said she hopes this is something the Task Force will look into.

Dufrene said in preparation for the 2024/2025 Medicare annual open enrollment period, she hopes regulators and those with SHIPs within their departments of insurance (DOIs) will provide them the support needed because this upcoming enrollment period is going to be a wild ride trying to make sure that consumers understand the Medicare prescription drug payment plan. She said that the MA plans and prescription drug plans available for next year are not going to be as nice as they have been in the past.

Dufrene said she hopes the Task Force will continue to rally for federal SHIP funding. She said the $55 million that is available in funding is spread among the 54 SHIPs and certainly does not go as far as it did years ago. She said her office is 100% federally funded, and the amount of money they receive is a little over $700,000, which leaves little wiggle room for expenses. She said she knows all SHIPs struggle, and some do receive state funding, and she applauds those that do. She thanked the Task Force for all the support it has given to SHIPs and hopes it will continue to fight for the program because it is the best program out there.

Swanson thanked Dufrene for attending the meeting and said he is proud of Nebraska's SHIP program as well. He said the Nebraska DOI is struggling with fraud, and he sees it on a national level as well, where catheter braces are being sent without authorization. He said that elbow, wrist, and knee braces were sent to his mother's home a couple of weeks ago without authorization from her or her doctor. He said it is under investigation right now with the Office of Inspector General (OIG), and he asked Dufrene if she could comment on what a SHIP does in these particular instances.

Dufrene said every state has a Senior Medicare Patrol (SMP), which is a fraud unit. In some states, it may be housed within the SHIP, and in other states, such as Louisiana, Mississippi, Georgia, and possibly, Florida, it is housed within a different entity. She has heard of individuals getting fraudulent durable medical equipment (DME), and those individuals then work with their state fraud sections. She has received information on various fraud issues where companies have nurses administer tests on individuals so the company can count them as services provided, and Medicare reimburses the company. She said this DME fraud issue was a hot topic at the most recent SHIP/SMP conference in New Orleans last month.

Bartuska asked if the other states that have SHIP directors within their insurance departments are as concerned as much as North Dakota is regarding the new payment plan options, Medicare plan finder, and how those systems are going to communicate when it comes to the new Medicare Part D. She asked if there was anyone from the

federal government in the meeting that could provide more information but also said she presumed the Medicare plan finder topic came up during the SHIP/SMP conference in New Orleans.

Dufrene said supposedly the Centers for Medicare & Medicaid Services (CMS) and Medicare plan finder will have calculators at the end of September that should help these offices look at an individual's medications. She said this is called "smoothing," and although it may be a benefit to the individual, SHIP administrators need to access the system and become familiar with it before giving advice and recommendations to individuals. She used her father as an example, as he has some high-priced medications, but he also has five generic medications that are tier-one, so they are no cost. If she completes this smoothing process for her father, those generics will be factored in, and it could be more costly for him than more cost-effective. She hopes the calculators are released early enough so SHIP administrators can become familiar with their functionality before they help a beneficiary.

Seip asked if CMS gave a backup plan. Dufrene said no. The open enrollment period is October through December, while January through March is typically the Medicare Advantage open enrollment period. This time period will become the annual "file-a-complaint" period because this is when beneficiaries will file a complaint regarding receiving misinformation, which then was placed into plans that are no longer cost-effective for them, or they may file a complaint saying the information they received was completely inaccurate with the agent or company.

In July, Dufrene was told by CMS that the plans are reaching out to policyholders who have the higher-cost medications, are in the gap, and have gone into catastrophic to introduce the smoothing process to them. However, the policyholder's plan may not work for them next year, so they may need to change it, so while she applauds CMS for being proactive, she is leery that the policyholders are not going to receive the best information available.

Commissioner Kipper said this discussion has been incredibly informative. He said in his state, the SHIP program is housed in its aging division under its health and human services area, and his DOI could use better coordination with SHIP. It is clear that the Task Force needs to continue to work closely with SHIPs, both individually and collectively. He extended a regular invitation to SHIP directors to speak to the Task Force, as it continues to be incredibly supportive of federal funding for SHIPs.

3. Discussed Medigap Guarantee Issue and Provider Withdrawals from Medicare Advantage Plans

Commissioner Kipper said he hoped for representation from the Medicare Drug & Health Plan Contract Administration Group (MDHPCAG) at the meeting to answer questions from the Task Force, but no one from the group was in attendance. He said provider withdrawals from Medicare Advantage plans is a growing problem, and it was recently reported that seven Medicare Advantage plan participants are withdrawing from the plan, which leaves challenges for consumers. The Task Force has asked CMS and the federal government if the NAIC can offer greater oversight on Medicare Advantage plans, as a critical point for Medicare Advantage plans is approaching.

Swanson said since the Task Force's July 18 meeting, the Nebraska DOI learned that some hospitals in Western and possibly Eastern Nebraska have decided not to contract with their Medicare Advantage plans, which would leave beneficiaries in question. Hospital administrators are frustrated as they try to understand what the next steps are for enrollees, as well as SHIP administrators, agents, producers, departments, and others. He said there are many questions, including whether these beneficiaries are going to be able to get back into their original Medicare plans, whether they are going to get a guaranteed issue (GI) back into Medigap, and whether this is done on a case-by-case basis and how this process would work. Swanson said it has been wonderful to work with Derrick Claggett at CMS on this issue, but this is not his area of expertise, and unfortunately, he has been the one to handle many hospital administrators' questions. Swanson said the DOI is frustrated with the lack of answers and guidance from CMS on this issue.

Swanson said there are retirees with limited incomes who were placed on this plan based upon what their employer did, such as Union Pacific in North Platte, NE, which is a huge employer. He said it is unknown what will happen next. He said the offices of Rep. Adrian Smith (R-NE) and Sen. Deb Fisher (R-NE) have made inquiries, and there are many concerned people in Nebraska who need answers. Swanson suggested the Task Force write a letter to CMS asking what this process is, how these things are determined, and when it will make a final determination.

Henderson echoed Swanson's comments and has been seeing the same thing happen in Louisiana. He said a couple of the main plans are terminating contracts with rural health hospitals, which will cause a large problem going forward. He asked how the beneficiaries will be serviced in their communities when there is no hospital contracted with Medicare Advantage plans that they signed up with years ago.

Seip asked if any additional detail can be given as to why representation from MDHPCAG is not here and what is the delay in hearing from them. She asked if they are working on a response, or if they are just not being responsive. She said it would be helpful to know so the next steps can be planned

Commissioner Kipper said it was his understanding MDHPCAG simply backed out of sending any representation. He said he did not know if this was for budgetary reasons or if it was simply deliberate. He said he will ask Derrick Claggett (CMS) if he has any further information, but he does not want to unnecessarily castigate them but said it is interesting that they are not in attendance when they knew that this was going to be a bone of contention for the Task Force. He asked Torian if he had any additional information.

Torian said he did not have any additional information, but Claggett is in attendance, and he might be able to provide some insight. He said this is not his area and does not know why MDHPCAG backed out. Commissioner Kipper said Claggett has been a great mentor to the NAIC and, in his opinion, an honest broker, and the Task Force appreciates everything he has done for and with this Task Force and the NAIC. He said he knows this is not an easy couple of questions coming up, but he appreciates his attempt to answer them.

Claggett said he is a senior advisor for Medicare and CMS, and his group is responsible for all aspects of enrollment for Parts A, B, C, and D. He said his group manages the enrollment provisions that allow consumers to migrate in and out of Medicare. He said that his colleagues from MDHPCAG were originally scheduled to be here, but he found out a couple of days ago that they were not going to be able to attend, and he apologized for their absence. He said he understands the significance of the issue, the passion behind it, and the individuals who are affected and impacted in a very negative way.

Claggett said he can offer a peripheral answer as to how a significant provider network change occurs. He said his enrollment group is responsible for establishing special enrollment periods that allow people to migrate in and out of Medicare Advantage plans. However, this particular policy is linked to MDHPCAG's determination that a significant provider network change has occurred. Once that determination is made by MDHPCAG, a special election period (SEP) is automatically granted for the beneficiaries that are impacted. He said that SEP does, in the case of a significant network provider change, allow for GI into Medigap, and therefore, consumers are not required to move from one Medicare Advantage plan to another. They also have the option of moving back to Medicare. The SEP is granted automatically simply because a significant provider network change has occurred. Once MDHPCAG makes that determination, the plan then notifies the beneficiaries. The logistics occur within CMS, so states do not have the responsibility of notifying the individuals.

Claggett said there are plan notices, which include information on how the individual receives a GI into Medigap from any insurance company; however, it is all contingent upon what happens in MDHPCAG. He can only speculate

that MDHPCAG is reviewing a number of these significant provider network changes and could be encumbered with them, or it is examining particular nuances of the different significant provider network changes, and they are developing a comprehensive response. Some states have contacted their congressional representatives, and he has forwarded all that information to MDHPCAG. He said he does not know any further information about what is happening at MDHPCAG or why they have not responded.

CMS also has another SEP, where the secretary of the Department of Health and Human Services (HHS) has the authority to establish SEPs under exceptional circumstances. He is not sure if states are aware of this particular SEP, which is granted on a case-by-case basis. Claggett said CMS would grant this SEP on an individual basis if a beneficiary's access to services is impacted, if it is going to affect their continuity of care, or if it is going to prevent them from having a continuous stream of services. He said CMS would review supporting details and documentation to determine the eligibility for this SEP on a case-by-case basis, and individuals can call 1-800-Medicare and explain their situation, such as if their provider is leaving the network, and this would cause significant disruption. He said that particular SEP, when granted, will provide GI for that individual to join a Medicare Advantage plan.

Claggett said he wanted to make the Task Force aware that he knows this is peripheral to what happens in the black box with MDHPCAG, but he did want to offer whatever he could from an enrollment policy perspective that could be offered to individuals who are being impacted adversely by situations such as these. He said he is open to questions about the enrollment process but cannot address any of the issues around the determinations for significant provider network changes.

Bartuska asked if it is the insurer or if the plan is the one that needs to notify CMS that they are pulling out of a certain area or market. Claggett said typically the plan will notify CMS that there is a significant provider withdrawal in the middle of the year. Bartuska asked if that is when it triggers CMS to determine if that qualifies for open enrollment in that type of situation. Claggett said that is correct, and CMS would then work with the regional office and the area that is more familiar with the matter. There are boots on the ground in the regional offices to help determine whether or not it is deemed to be significant. Bartuska asked if there are guidelines and requirements for the carriers to notify CMS within a certain timeframe because this is happening to beneficiaries without knowledge that their plan is no longer in their area, and they are in the hospital. She said that does no good for them and asked if there are any guidelines that mandate carriers notify CMS within a certain time frame, such as 30 or 45 days, to get that process expedited to the beneficiaries. Claggett said he is unable to answer this because this would be in the purview of the MDHPCAG.

Swanson asked about the HHS secretary's ability to declare essentially an emergency and is that only on an individual basis, or can the secretary declare it without a request from an individual. Claggett said it is an individual case-by-case determination. He said the individual would call, and it could be that one individual is impacted adversely. For example, they were being treated for a chronic condition for the last three months, and their doctor is no longer available. He said this person can be granted an SEP, and it comes with the option to move to a Medicare Advantage plan or the option to go back to Medicare with GI. He said another individual could not have a chronic care condition but was treated by a doctor four months ago, and they may not get the SEP with GI. He understands the impact this is having on consumers and wants to make sure the Task Force, SHIPs, and other interested parties are aware of this option, and that it may work for beneficiaries who find themselves in this situation.

Seip said we are all well aware of how important this issue is and how detrimental it is to individuals. She said Iowa, being a rural state, is faced with provider contracting issues and the Medicare Select issue. She said she agrees with Swanson about sending a letter to CMS because she is concerned that key CMS leaders have not

offered support or a solution. She also supports regulators contacting their congressional delegation as an additional option.

Torian read a question from the WebEx chat from Arizona asking if there is a specific division that a beneficiary should contact to request this SEP. Claggett said beneficiaries can contact 1-800-Medicare, and they will route their call to the appropriate representative.

Dufrene responded to Bartuska's comments that the carriers do not have to send a letter to the beneficiaries that are going to be affected by the termination, and that it is incumbent upon the facility. She said in their annual notice of change letters that will be coming out in late September or early October, that information should be outlined; however, most consumers do not go through every single piece of mail. It is going to be incumbent upon SHIPs to work with the providers that they know are being terminated to get that information out to beneficiaries to let them know what their options are moving forward.

Bill Schiffbauer (Schiffbauer Law Firm) said there are a couple of things to consider when thinking about a letter. The number of solutions that have been discussed is dependent on individual case-by-case issues, which means the individual has to be aware. He asked if the department or SHIP is aware when it is an individual case. He said a general public statement from the administration about solutions is needed. Schiffbauer pointed to the *Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act* (#651), which all states have adopted and is a federal minimum standard because it is incorporated into the Social Security Act (SSA). There are several provisions that allow the HHS secretary to specify special circumstances or guidelines in some of these cases, such as when an individual changes their place of residence or other changes in circumstances that are specified by the secretary. He said another provision in Model #651 states that the individual can demonstrate, in accordance with guidelines established by the secretary, that the Medicare Advantage plan violated a provision of the organization's contract or misrepresented plans and provisions.

Schiffbauer said Section 12B(2)(e) of Model #651 states, "The individual meets such other exceptional conditions as the Secretary may provide." He said it seems to be a general statement that could be made, and it does not say it has to be by a rule, so it could be a bulletin or a letter that is more of general applicability based on these exceptional conditions, which these seem to be unanticipated changes, particularly with providers deciding to get out of the network versus the Medicare Advantage plan withdrawing.

Schiffbauer said that could be one of the considerations if a letter asks the administration for a more general statement that doesn't depend on the individual realizing that they have a right to the bureaucracy to make a determination for that one individual.

Claggett said this provision, U.S. Code Section 1882(s)(3)(B), is where the secretary may provide all of these provisions that have been discussed today, including the significant provider network change, and they are codified as exceptional circumstances that are outside of the typical GI that was discussed, such as in the choosing a Medicare policy guide, the trial rights and the 12-month trial right for Medicare Advantage at the inception of enrollment in Medicare, then the first-time trial right, then bankruptcy and insolvency, and then moving out of the area's network if it is select. He said those are codified specifically by statute, and these and many other exceptional circumstances are actually written regulations to support those exceptional circumstances. He said if the Task Force wishes to request the secretary to expand it in this particular case or to expand the provisions under the significant provider network change, they certainly can.

Seip made a motion, seconded by Swanson, to send a letter to CMS seeking information, guidance, and clarification on this topic to help states help their beneficiaries. The motion passed.

4. Discussed the Impacts of Section 1557 of the ACA and the Application of Nondiscrimination Rules to Medigap

Brian Webb (NAIC) said the final Section 1557 rule was published on April 26, 2024, and it prohibits discrimination on the basis of race, color, national origin, sex, age, and disability. He said the big difference with this new rule is that it applies to all carrier plans that receive money from the federal government. He said the scope is much broader. For example, if a carrier receives ACA funding, it would apply to all the plans it offers, including Medigap plans, excepted benefit plans, and short-term, limited-duration (STLD) plans. He said the effective date generally is July 5, but the NAIC is most concerned about the provisions for plan years beginning on or after Jan. 1, 2025.

Webb said regulators are considering the rates and designs for these plans and are approving these plans for sale, reissuance, or renewal after that date. Regulators are receiving questions from carriers as to how these various provisions apply to plans beginning next year, such as asking if they cannot discriminate based on age They are asking if they can rate based on age after that initial period, or if they can rate based on health status, such as a disability, or if they can rate based on gender. They are asking if the rule means they can have a plan that only provides benefits to those over 65.

Webb said there are eligibility rules, and many states allow for some plans to be sold only to people aged 65 and over. Carriers are questioning if that is discriminatory. He said the rule also includes network adequacy and asked what it means to have adequate networks to prevent discrimination based on all of these considerations. The NAIC has contacted the HHS Office of Civil Rights (OCR) for answers since they are the primary enforcers of this rule.

Webb said in the NAIC comment letter sent two years ago when this original rule was proposed, the NAIC asked for clarification on how this would impact Medigap plans, as well as excepted benefit plans and others. He said the final rule states that when the OCR is investigating a discriminatory design feature in Medigap, it will evaluate the covered entities' legitimate non-discriminatory reasons for the challenge feature. He said the OCR is the enforcer, and when a discriminatory complaint is filed, it will review the plan to see if it has discriminatory designs. If the reason for the discrimination is based on a federal or state law requirement where the state law allows rating based on age or health status, for example, the OCR will take this information into account when evaluating the design feature. He said that the OCR has made it clear that Section 1557 would preempt a state's Medigap requirement law that compelled conduct prohibited by Section 1557.

Webb said state regulators have asked many questions, and the NAIC has reached out to the OCR, asking for clarification and guidance. As the NAIC receives plans and rates or plans that will be renewed next year or sold next year, he asked what the rules are. He asked what state regulators should be looking for, what is prohibited, or if it is going to be on a case-by-case basis, as this paragraph seems to imply. He said the NAIC has received no guidance.

Webb said the NAIC has talked to the leaders in charge of policy at the OCR since April, trying to get clarification, and the NAIC was recently bumped up to the director's office of the OCR. It has been attempting to meet with them to receive clarification so state regulators know what they should be enforcing. This rule would impact network adequacy, so clarification is needed there as well. He asked what the OCR would be doing about the network adequacy of Medigap plans in states and what they are expecting from state regulators. He said there are a lot of questions, and the NAIC has zero answers at this point.

Hohl said with Medigap, the network is Medicare, so then Medicare would be the network, unless it is a special type of Medigap. She asked whether Medicare’s network is adequate. Webb said Hohl was correct. Outside of the special Medigap plans, that network would not apply to Medigap.

Jackson Williams (Dialysis Patient Citizens—DPC) said the scenario that should concern regulators is one where an under aged 65 beneficiary in a state with no GI for under aged 65 beneficiaries could apply for a policy and, if denied, make a complaint to the OCR. He said he wants to make clear his organization has no plans to do something like this. However, any lawyer or rights-conscious person who comes down with an illness and becomes qualified for Medicare could do that. If the OCR upheld the violation, health insurers subject to Section 1557 would have to sell to disabled beneficiaries under age 65, but life insurance companies would not. He said this would fracture the Medigap market in those states to only have GI for primarily health insurance companies but not life insurance or property/casualty (P/C) companies that also sell Medigap, and health insurers who object to Section 1557 would probably have to drop out of the Medigap market. He said he does not believe Section 1557 prohibits age rating for Medigap, but an outright refusal to deal with a consumer based on them being under the age of 65 should be illegal, and the best way to prevent problems like this is for every state to enact laws or regulations guaranteeing issue to under aged 65 beneficiaries.

Schiffbauer said there is a fundamental issue with Section 1557. The provision that extends the reach of Section 1557 to all operations of a company is not in the statutory language of Section 1557. It is in the predecessor language of the Civil Rights Act amendments. He said if one applies the principles of the *Loper Bright Enterprises v. Raimondo* ruling by the U.S. Supreme Court, missing statutory text is a very important issue that has been created. He said in the regulation itself, in the preamble, the OCR extends this provision to all operations by saying it is reasonable to infer that these provisions in other sections of the statute, which are not in the statutory language of Section 1557, can be applied. He said under the Loper Bright ruling, the court would look at the statutory language and say this language is missing. Then there is a situation where the OCR has fractured the Medigap market with an inference, and the resolution of this is not an easy one to contemplate.

Schiffbauer said one option are for plans, within both the Medicare Advantage and the Medigap markets, could be to sue on the basis of Loper Bright, but there would be a lot of reluctance because of the optics. He said another option would be for the OCR to withdraw that provision and recognize what the Loper Bright decision has done, but that seems highly unlikely. He said a third option could be for the OCR to issue a regulation or amendment that gives an exception to actuarially based medical underwriting, and that it is not intended to be discriminatory but is based on actuarial principles in terms of cost, age, and the medical needs and claims that are anticipated.

Schiffbauer said the fundamental issue here is that the OCR has overreached by not having a statutory text as the basis of this, and they are making an inference saying it is in these other statutes that were enacted in 1984. He said there is a fundamental issue that has to be dealt with, and there are no easy answers, but this situation is caused by an over-exuberant bureaucracy that thought it could make an inference it really cannot anymore.

Meghan Stringer (AHIP) said AHIP is supportive of the underlying principles of this rule to ensure access to affordable health care for everyone but is also very concerned about the potential impacts of this rule both on the affordability of premiums and the ability of its members to continue to offer these products and stay competitive in the market. It is clear there are many questions both covered entities and regulators have about what exactly this means for Medigap carriers and the Medigap product in states. She said AHIP members want to sell products that they know are compliant with the law and do not want to guess and hope for the best. She said they want to start out with compliance and hope the OCR will provide some type of guidance and clarification. AHIP has shared these concerns with the agencies.

Stringer said additional clarification is needed around age rating and the way the final rule incorporates the age act exceptions via reference. AHIP wants to know what that means, how it works for each of these plans, and the way their rating systems are set up. She said many of its members with plans that are covered entities under this rule may be reaching out to regulators to file new products, and she said AHIP asks that the NAIC work with it

closely as they make their best efforts to comply with this rule, even though there is still pretty substantial uncertainty about what full compliance looks like.

Commissioner Kipper asked Webb what options are available to question this final rule or make suggestions. Webb said an option is to send a letter to the OCR, asking for further guidance on how these provisions are to be implemented and enforced. He said the rule is in place but still has to be enforced, and there may be some leeway to figure out how it will be applied and the role of state laws. Webb said this is not just a Medigap issue, as there are other questions on STDL plans and network advocacy more broadly, so this is an option for state regulators.

Swanson made a motion, seconded by Commissioner Teo, to send a letter to the OCR seeking answers and guidance on Section 1557 and non-discrimination. The motion passed.

5. Discussed Other Matters

Kruger and Bartuska, on behalf of the Dakotas and the Task Force, wished Swanson a happy birthday. Swanson thanked them and asked the Task Force and others to keep in contact with SHIPs about the DME scams. He said they are ramping up again big time, and everyone should be aware. If anyone has these scams in their jurisdictions, they should work with SHIPs and fraud units and notify the OIG.

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

Summer National Meeting Minutes