SENIOR ISSUES (B) TASK FORCE

Senior Issues (B) Task Force August 13, 2026 Minutes
Senior Issues (B) Task Force May 21, 2026 Minutes (Attachment One)

Draft: 8/18/26

Senior Issues (B) Task Force
Columbus, Ohio
August 13, 2026

The Senior Issues (B) Task Force met in Columbus, OH, Aug. 13, 2026. The following Task Force members participated: Ned Gaines, Chair (NV); Jon Godfread represented by Chrystal Bartuska, Vice Chair (ND); Heather Carpenter represented by Sarah Bailey (AK); Joshua Hershman represented by Tricia Davé (CT); Trinidad Navarro represented by Jessica R. Luff (DE); Michael Yaworsky represented by Alexis Bakofsky (FL); Scott Saiki represented by Kathleen Nakasone (HI); Doug Ommen represented by Andria Seip (IA); Dean L. Cameron (ID); Ann Gillespie represented by Jeff Varga (IL); Holly W. Lambert represented by Scott Shover (IN); Vicki Schmidt represented by Craig Van Aalst (KS); Sharon P. Clark represented by Angela Raley (KY); Timothy J. Temple represented by Ron Henderson (LA); Marie Grant represented by Patricia Dorn (MD); Anita G. Fox represented by Kevin Dyke (MI); Angela L. Nelson represented by Jeana Thomas (MO); Mike Chaney represented by Bob Williams (MS); Mike Causey represented by Robert Croom and David Yetter (NC); Eric Dunning represented by Martin Swanson (NE); D.J. Bettencourt represented by Michelle Heaton (NH); Susan Ochs represented by Michael Fahncke (NJ); Judith L. French represented by Christina Reeg (OH); TK Keen represented by Jesse O'Brien (OR); Michael Humphreys represented by Richard L. Hendrickson (PA); Suzette M. Del Valle (PR); Larry D. Deiter represented by Jill Kruger (SD); Amanda Crawford represented by Rachel Bowden (TX); Jon Pike represented by Tanji J. Northrup and Tomasz Serbinowski (UT); Scott A. White represented by Julie Fairbanks (VA); Kaj Samsom represented by Karla Nuissl (VT); Patty Kuderer represented by Andrew Davis (WA); Nathan Houdek represented by Darcy Paskey (WI); Erin K. Hunter represented by Joylynn Fix (WV); and Jeff Rude represented by Tana Howard (WY).

1. Adopted its May 21 Minutes

The Task Force met May 21. During this meeting, it took the following action: 1) adopted its Spring National Meeting minutes; and 2) discussed the Medicare Supplement (Medigap) birthday rule.

Kruger made a motion, seconded by Henderson, to adopt the Task Force's May 21 (Attachment One) minutes. The motion passed unanimously.

2. Discussed the Task Force's LTC Riders Survey on Life Insurance Products and Variable Plans

Commissioner Gaines asked Yetter to give a summary of the Long-Term Care Actuarial (B) Working Group's July 14 meeting. Yetter said stand-alone long-term care (LTC) product sales peaked around 2005 and dwindled in 2015, with stand-alone LTC products being less commonly sold than hybrid life LTC products.

Yetter said the Working Group heard a presentation on hybrid LTC products and discussed the advantages of combination products, such as offering protection at different stages of a policyholder's life, providing life insurance coverage during younger years, and LTC coverage in later years. The group also discussed that there is a benefit for employers in offering this coverage on a guaranteed-issue basis rather than offering a stand-alone group LTC, which would require underwriting. He said the acceleration of benefits does not create much extra risk for the insurer, but the extension of the benefit rider adds to the LTC benefits because it lasts beyond the standard acceleration, and the premium associated with the LTC

component for the hybrid products is typically between 15% and 40%, and the hybrid products are more attractive to younger consumers.

Yetter said that the Working Group chair asked the presenters whether there were any reasons to change the statutes or rules beyond the current or future products. It was suggested that the *Valuation Manual* addresses certain life insurance assumptions but does not necessarily focus as much on the LTC assumptions.

Bartuska noted that Yetter had sent a survey with additional questions in addition to the survey that the Task Force had sent, and although he has received some responses, it would be helpful if more states could respond so those results could be added to the initial Task Force survey. Seip asked Yetter's questions to be resent. Commissioner Gaines said the Task Force plans to hold an interim meeting in late September or early October to discuss this further.

Bonnie Burns (California Health Advocates—CHA) thanked the Task Force for conducting the survey but noted that it was unclear which riders were included in the survey, as there is only one LTC rider. She said chronic illness riders are not LTC and cannot be marketed or sold as LTC. She said there are many variations across states in how these riders are reviewed and approved, with some states treating riders as a health product and approving or reviewing them separately, while others do not. She suggested that the Task Force examine this more closely, along with the information that consumers receive about these riders.

3. Heard a Presentation on Health Care Services Migrating from Hospitals to Outpatient Services and Medigap Cost Impact Plans

Burns said Medigap policies face access and cost challenges that differ from under-65 insurance, and the focus often centers on sick people driving up costs. However, many healthy seniors need Medigap due to changes in retiree plans, life events such as widowhood, or leaving Medicare Advantage (MA) plans. She said rising Medigap costs are driven largely by systemic shifts in medical care, specifically services moving from inpatient (Part A) to outpatient (Part B) settings.

Burns said that regarding access to Medigap, there are mixed messages. There is a push for high accessibility, yet Medigap discussions often focus on limiting access to control premiums. She said people need Medigap for structural reasons, not just because they are already sick. Seniors also seek Medigap due to failing MA plans, employer retiree benefits that are ending, or sudden income drops after losing a spouse. She said standard health checks can block seniors with managed chronic conditions, even if they do not currently need active care.

Burns said the shifting of Medicare costs from Part A to Part B is a problem. Part A, which is inpatient, is free for most workers and carries no late penalties, while Part B, which is outpatient, requires a monthly premium and carries late penalties. She said advanced medical technology has shifted many traditional inpatient procedures into outpatient settings, and this structural shift moves expenses from Part A to Part B, directly raising the costs covered by Medigap plans.

Deborah Darcy (American Kidney Fund) said Medicare costs are shifting from inpatient care to outpatient sites. This change increases the need for affordable supplemental coverage, such as Medigap. She said there are a variety of reasons for this, including key outpatient sites and services, such as hospital outpatient departments, ambulatory surgical centers, ambulatory care centers, specialized surgical

centers, standard doctor visits, medical and surgical procedures, Part B drugs and infusions, radiological and diagnostic cardiology tests, and ambulance transportation.

Darcy said these services are moving from inpatient to outpatient settings, which increases Medicare Part B cost-sharing, and Medigap must pay these higher costs. Some examples are the two-night rule, where, since 2013, stays under two nights are billed as outpatient observation status, and billing changes, whereas inpatient stays use Part A, but observation stays use Part B. She said there is a financial burden because Part B requires a 20% coinsurance for services and does not cover post-acute skilled nursing facility care.

Darcy said the second reason services have shifted from inpatient to outpatient care is that technological advances have enabled less invasive surgeries, allowing procedures to happen outside hospitals. She said inpatient volumes for nine of the 20 most common procedures dropped from 2018 to 2022, and hip and knee replacement inpatient procedures fell by approximately 40%. She said over half of 287 analyzed physician-administered drugs required beneficiary cost-sharing of around $1,000, and medications for cancer and macular degeneration heavily drive these out-of-pocket expenses. She said that by 2031, one in five Americans will be aged 65 or older, expanding the insurance pool, and that regulators have actionable steps available to address these rising Medigap and insurance costs.

Burns said state insurance regulators must take a stronger stance to protect Medigap consumers from rising costs and predatory industry practices. She said some options are to audit how companies calculate loss ratios and structure premiums, prevent companies from closing older plans to open cheaper sister-company plans, which traps older policyholders in high-rate pools, oversee plan commission assignments to stop agents from unfairly steering enrollment, and tighten rules on medical underwriting and explore state-level risk adjustment procedures to spread costs.

Burns said Medigap costs are driven by rising medical care costs across the entire health care industry. Rising premiums are beyond the control of individual companies and consumers, and regulators should resist the temptation to blame the people who need access to care, as well as consumers who are proposing that states allow people greater access to coverage when they need it.

Director Cameron thanked Burns and all the consumer representatives for their efforts over the years. He said that they have been outstanding stewards and spokespersons for seniors.

Director Cameron said there is agreement on stronger enforcement of Medigap plans, but there is a challenge in balancing MA plans with Medigap plans while maintaining even, balanced regulation of both entities to protect consumers. He said that if a consumer has a UnitedHealthcare card, they may not understand whether it is a Medigap or an MA plan, or if they have a Blue Cross and Blue Shield card.

Director Cameron noted that representatives from the Centers for Medicare and Medicaid Services (CMS) are present at the meeting and expressed gratitude for their work and diligence in helping regulators more effectively regulate those products. He asked Burns if she had thoughts on how regulators might maintain this balance, because if regulators are too harsh on Medigap plans, they may inadvertently steer people to MA plans that may not have the same protections from one state to the next.

Burns said balancing medical access and regulatory costs is a complex challenge that impacts both consumer advocates and regulators. She said expanding medical access naturally increases costs, and while consumer advocates and the insurance industry often disagree on exactly how much costs will rise,

regulators are responsible for evaluating these projections. She said Medigap plans act as a budgeting tool, and consumers pay higher monthly premiums but have strict limits on unpredictable out-of-pocket expenses. MA plans offer lower or zero monthly premiums, but consumers must pay out of pocket each time they use a medical service.

Burns said rising Medigap premiums inadvertently push seniors toward MA plans because they appear cheaper upfront, but many consumers do not fully understand that they are trading steady premiums for per-service fees. She said consumer representatives and regulators must constantly balance the consequences of policy changes with the ongoing need to educate seniors on how to realistically manage and spread out their health care costs.

4. Heard a Presentation from Envision Benefit Specialists on LTCI Riders on Life Insurance Products and Variable Plans

Lori Martin (Envision Benefit Specialists) said that hybrid LTC plans can go by multiple names, including asset-based plans or linked benefit plans. These hybrid options are heavily favored by financial planners and now outsell traditional LTC insurance (LTCI), as they cover LTC expenses. However, if the policy is never used, a death benefit is paid out to beneficiaries, and the premium rates for these plans are fully guaranteed and will not increase.

Martin said hybrid LTC insurance plans offer fixed premiums and flexible cash benefits that help navigate the modern caregiving shortage. Rates are fixed, avoiding the volatile lifetime premium increases common in traditional LTC plans. Policyholders receive a monthly cash payout once they qualify, and unused funds can be banked for future use to extend the policy's term. She said home care agencies now mandate strict four-to-six-hour daily minimums due to staffing shortages, and cash payouts bypass these restrictions. Cash can pay neighbors, church members, or family members at lower hourly rates rather than expensive agencies, and funds can be spent freely on home modifications (e.g., widening doors for wheelchairs) or standard maintenance, such as lawn care. She said policy illustrations break down life insurance versus LTC costs, and the LTC portion of the premium is often tax-deductible, especially for business owners. Plans typically include short payment periods, inflation protection, and waiting periods ranging from zero to 90 days.

Martin said life insurance policies featuring an LTC rider now account for over 40% of all life insurance sales. These hybrid structures have surged in popularity because they offer an affordable alternative to traditional stand-alone LTC policies, which generally carry an entry age requirement of at least 40.

Martin said some of the key benefits and strategic advantages include a lower entry cost, where younger applicants (e.g., those in their early 30s) lock in drastically reduced premiums. These riders were widely utilized in Washington state as a legitimate mechanism to opt out of the Washington Cares Act payroll tax. She said that because there is no coordination of care restrictions, you can buy as many policies from different providers as you want, and unlike traditional "use-it-or-lose-it" LTC insurance, any money not spent on health care is paid out to beneficiaries as a tax-free death benefit.

Martin said there are, however, structural limitations. While cost-effective, life insurance LTC riders lack the robust health protections found in stand-alone or dedicated hybrid plans, such as a maximum health care benefit that is strictly limited to a percentage of the policy's base death benefit. Once that specific portion of the death benefit is exhausted, the health care coverage terminates completely, and the benefit

amount is locked at the time of purchase and will not grow to keep pace with rising medical costs. Martin said for consumers under 40, a life insurance plan with an LTC rider is an excellent, low-cost baseline tool to lock in a low rate and satisfy state tax mandates; however, after age 40, it is highly recommended to purchase a secondary traditional or hybrid LTC policy that includes robust inflation protection and extended benefit pools to fully cover late-life health care needs.

Martin said worksite LTC and group life plans are growing at employers. They offer strong benefits, such as care extensions, benefit restorations, and inflation protection. She said these portable plans cost less than traditional policies and let workers keep the same price if they leave their jobs. She said middle-income workers can buy these plans through their employers when traditional care is too costly. Plans include LTC riders, benefit restorations, and inflation protection. She said workers keep the exact same price when they leave the job, and employers may pay all or part of it, or offer voluntary employee funding.

Martin said life insurance policies with chronic illness riders are often sold as LTC plans, but they are not the same and cannot be marketed as LTC plans. She said these riders may lack coverage for cognitive issues, such as dementia, and "free" riders use a discounted death benefit that severely lowers the actual monthly payout. Consumers must always read the contract carefully because chronic illness riders are life insurance plans, not traditional LTC policies. She said many riders only cover physical needs and exclude mental decline, such as Alzheimer's disease. The built-in "free" riders calculate payouts using a discounted death benefit, cutting expected funds in half, and the rest of the death benefit may be lost if it is used for chronic care.

Martin said underwriting for hybrid LTC plans is just as strict as traditional plans, making proactive pre-qualification essential to avoid surprises or policy denials. Underwriting requirements are virtually identical between traditional and hybrid, although a few hybrid plans offer slightly more flexible height-weight charts, and standard life insurance policies generally feature less stringent medical screening. The screening process involves carriers evaluating both LTC needs and mortality risks, using phone calls and in-person interviews. She said the standard for applicants over age 65 is usually conducted face-to-face at home, and providers request full prescription histories and attending physician statements (APS).

Martin said the value of pre-qualification is that it is necessary for all clients, whether healthy or managing medical issues, and it prevents unexpected policy rejections or premium increases and helps match clients to the right product, including hybrid life policies with LTC riders or asset-based annuities.

Yetter asked Martin to elaborate on the lack of extended LTC benefits. Martin said that with hybrid policies, most people will choose to get an LTC extension on those policies, and in the first two years, the person is using up the death benefit to pay for care; however, two years is not a long period of time. She said most individuals will get an extension of LTC benefits by another two to six years on their life insurance policies with the LTC rider. However, it is not made clear that the death benefit is being used to pay for the care. Once the death benefit is used, the policy terminates.

Yetter asked where the extension of benefits comes from and whether it is a separate stand-alone policy or part of the rider. Martin clarified that it is part of the rider and not a separate policy. When a person chooses the benefits on a hybrid policy, they use the death benefit first, then choose an extension of LTC benefits for a certain period.

Yetter noted that this presentation highlights the confusion about what this product actually is. Regarding guaranteed premiums, he said that he has seen filings that are guaranteed renewable. Martin asked if that was on hybrids. Yetter said yes, and the extension and restoration of benefits will come in with a guaranteed renewable premium on a non-cancellable term policy. Martin asked if that was the work site or an individual. Yetter said it is mostly the work site. Martin said that makes it a different product.

Yetter said the presentation also noted that individual plans typically do not offer inflation protection for the extension and restoration of benefits, but, based on the Task Force's survey results, about 30% of states would require such protection. He said this was an excellent presentation, and participants should note that regulators and the industry are on the same page.

Martin noted that many new plans are constantly coming out in the group market and at the worksite. She said she works with about five plans, is always looking for guaranteed-issue plans, and noted that it makes sense that there are different plans. However, she said it makes it more difficult because there is a variety of benefits and what is offered.

Seip asked whether, when hybrid products are priced, the premium is increased based on the LTC plans or LTC benefits. She also asked whether Martin sees those as set premiums or if they increase over time on the hybrid side.

Martin said the premiums are guaranteed, but hybrid plans are more expensive than traditional ones. There is more dollar value with traditional LTC insurance plans, and that cash benefit, which is extremely valuable, also makes the plan a lot more costly. She said it also depends on how many years one adds to that LTC extension to continue paying benefits past the first two years of using the death benefit.

Seip cautioned the Task Force when setting parameters for hybrid life insurance policies with LTC benefits. She said the Task Force should not treat pricing these hybrid structures exactly like stand-alone LTC products, and that they should protect elderly policyholders from experiencing massive premium increases, such as 50%, later in life. She said it's important to keep the products viable as life insurance policies so they remain reliable and affordable 30 years down the road when policyholders actually need the benefits.

Fix said the presentation was very helpful and useful, and said that states are all over the place. She said that, as a state that is probably not doing this very well, if the Task Force could host a state that could offer a high-level, regulator-only overview of what states should know about these products.

Commissioner Gaines said that this is an excellent idea and that the Task Force would consider it. Yetter said he has a slide deck with images that may help Task Force members. Bartuska said the slide deck is excellent and, as a non-actuary, extremely helpful.

Bartuska said that if states have adopted the *Long-Term Care Insurance Model Act* (#640), not just the regulation, it includes a robust definition of LTCI and defines riders. The act discusses riders and includes those associated with life and annuity products. Therefore, the model gives states regulatory authority to go after bad-actor agents and companies that are not marketing these products properly.

Bartuska said states should begin reviewing their old laws, which could help them put these into different buckets, because the model's definition specifically excludes a rider designed for the chronically ill and

does not fall under the LTC bucket, nor does the accelerated benefit piece. She said the model separates these buckets for states.

Yetter said this is an issue because, in Model #640, while it does spell it out as Bartuska said, it also states that if it contains accelerated benefits, extra consumer protections are not necessary. He believes states disagree on how to interpret that.

Yetter said hypothetically, a life insurance product is sold to a consumer, and they later realize they need LTC benefits. If they are sold a stand-alone LTC policy, it automatically includes key consumer protections, such as inflation protection and non-forfeiture riders; however, if we package these two solutions together into a hybrid product with a restoration-of-benefits rider, those original consumer protections disappear, even though the core benefits remain identical. He said that, as state insurance regulators, our stance on this is inconsistent, and before this conversation continues, we need to decide whether this discrepancy is a compliance or product risk we need to address.

Serbinowski said he is concerned about the lack of clear guidelines regarding which types of life insurance policies can feature LTC riders. He noted several risks, such as policy termination where riders attached to term insurance may expire (e.g., at age 100 or earlier), leaving older individuals without needed LTC coverage, or decreasing benefits if the underlying life insurance policy features a decreasing death benefit, which could inadvertently reduce the attached LTC benefit. He said there are potential rising costs where term policies structured with yearly renewable term (YRT) premiums can become unaffordable over time, forcing policyholders to drop their coverage and lose their LTC benefits and while some filings successfully decouple decreasing death benefits from the LTC rider, a broader regulatory discussion is needed to determine which product structures should be permitted.

Martin said she agrees, although some group worksite LTC plans are based on a term chassis, in which the benefit is guaranteed to age 120, not 100, though not on every plan. She said these life insurance policies with the LTC rider will become extremely valuable to consumers, as states observe what happened in Washington State and work on a payroll insurance plan for their residents. She said there are three states with bills similar to Washington's, although unsurprisingly, none of those bills passed, but that will change.

Martin said states are considering allocating funds to establish committees and conduct research studies, as the aging population and Medicaid are common issues. She said consumers will be looking at these plans at a younger age and will consider them so that they can opt out of a payroll tax and receive an LTC benefit, perhaps on a life insurance policy with an LTC rider that costs them less.

Commissioner Gaines said the Task Force will look at holding a regulator-only meeting for states to exchange information on how they review these filings and will hold an interim open meeting before the Fall National Meeting.

5. Heard a Federal Legislative Update

David Torian (NAIC) said State Health Insurance Assistance Programs (SHIPs) funding is fully funded for the current fiscal year at $55,242,000. He said the U.S. House Appropriations Committee passed its fiscal year (FY) 2027 Labor-HHS Appropriations Bill on June 9, which funded SHIPs at the same amount of $55,242,000. The U.S. Senate Appropriations Committee has not taken any action on its FY 2027 Labor-

HHS Appropriations Bill. He said that the U.S. Senate passed a continuing resolution (CR) before leaving for its August recess, funding the government through Dec. 11. The House will consider the CR after it returns from its August recess. He said the NAIC remains committed to its strong support for SHIP and has expressed strong support to the House and Senate leadership, as well as the House and Senate Appropriations chairs/ranking members.

Torian said U.S. Rep. Troy Downing (R-MT), former Montana Insurance Commissioner, and U.S. Rep. Lloyd (D-TX) introduced legislation to empower state insurance regulators to enforce federal standards for Medicare Advantage plans. He said under this legislation, state enforcement of federal regulations would maintain a single set of standards for Medicare Advantage plans nationwide while allowing state officials to respond to Medicare Advantage plan practices that affect their constituents and local providers. Under the bill, federal and state enforcement would be coordinated and clarified through collaborative agreements. He said the bill number is H.R. 8726 and is entitled the Protecting Authority and Restoring Tools Necessary for Enforcement by Regulatory States Act of 2026 (PARTNERS Act).

Torian said Rep. Doggett and 44 of his Democratic House colleagues introduced broad, comprehensive health care legislation that also includes language permitting state insurance commissioners to enter into agreements with CMS to share enforcement authority over Medicare Advantage plans. That bill number is H.R. 9544 and is called the Saving Medicare Enrollees from Deceptive Insurers and Creating Ample Resources for Everyone Act (Saving MEDICARE Act)

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

Draft: 5/28/26

Senior Issues (B) Task Force
Virtual Meeting
May 21, 2026

The Senior Issues (B) Task Force met May 21, 2026. The following Task Force members participated: Ned Gaines, Chair, represented by Jack Childress (NV); Jon Godfread, Vice Chair, represented by Chrystal Bartuska (ND); Heather Carpenter represented by Sarah Bailey (AK); Ricardo Lara represented by Tyler McKinney (CA); Joshua Hershman represented by Eric Vieweg (CT); Trinidad Navarro represented by Jessica R. Luff (DE); Michael Yaworsky represented by Alexis Bakofsky (FL); Scott Saiki represented by Arlene Ige (HI); Doug Ommen represented by Andria Seip (IA); Dean L. Cameron represented by Shannon Hohl (ID); Ann Gillespie represented by Jeff Varga (IL); Holly W. Lambert represented by Kim Burdick (IN); Vicki Schmidt represented by Julie Holmes (KS); Sharon P. Clark represented by Stephanie Bowker (KY); Timothy J. Temple represented by Ron Henderson (LA); Michael T. Caljouw represented by Kate McCann (MA); Anita G. Fox represented by Renee Campbell (MI); Grace Arnold represented by T.J. Patton (MN); Angela L. Nelson represented by Camille Anderson-Weddle (MO); Mike Causey represented by Angela Hatchell (NC); Eric Dunning represented by Martin Swanson (NE); D.J. Bettencourt represented by Michelle Heaton and Roni Karnis (NH); Susan Ochs represented by Austin Hopkins (NJ); Judith L. French represented by Tynesia Dorsey (OH); Glen Mulready represented by Ray Walker (OK); TK Keen represented by Joshua Blakey (OR); Michael Humphreys (PA); Larry D. Deiter represented by Lisa Harmon (SD); Amanda Crawford represented by Rachel Bowden (TX); Jon Pike represented by Tanji J. Northrup (UT); Scott A. White represented by Julie Blauvelt (VA); Kaj Samsom represented by Sara Teachout (VT); Patty Kuderer represented by Amy Figoni (WA); Nathan Houdek represented by Darcy Paskey (WI); Allan L. McVey represented by Joylynn Fix (WV); and Jeff Rude represented by Tana Howard (WY). Also participating was: Pamela Stutch (ME).

1. Adopted its Spring National Meeting Minutes

Hohl made a motion, seconded by Swanson, to adopt the Task Force's March 24 minutes (*see NAIC Proceedings – Spring 2026, Senior Issues (B) Task Force*). The motion passed unanimously.

2. Discussed the State Medigap Birthday Rule

Patrick Fleming (AmeriLife) said Medicare supplement (Medigap) plans have no network requirements and allow members to access any provider accepting Medicare patients, unlike Medicare Advantage plans. He said Medigap plans, especially Plan G, provide comprehensive Medicare coverage, with no out-of-pocket expenses besides the annual premium and the Part B deductible. He said Medigap plans have predictable costs, and coverage is guaranteed renewable. He said the Medigap population grew steadily before 2020, with approximately 14.5 million members in 2019. However, growth has slowed considerably, with current membership at around 14.1 million members, compared to Medicare Advantage with about 35 million members.

Fleming said Medigap high loss ratios have steadily increased from 72% in 2020 to an all-time high of just over 85% in 2025, and carriers are in a negative margin position when loss ratios exceed 82%. He said several small to mid-size Medigap carriers have exited the market in the past few years, and multiple large carriers have shut down unprofitable blocks of business.

Fleming said nearly 20 states have rules on guaranteed issue, the birthday rule, or other time periods, resulting in higher rates, reduced compensation, and fewer carriers competing in those states. He said there is little consistency between states regarding which plans the member can switch, the time period during

which the Medigap member can switch plans on a guaranteed issue basis, and to which carrier the member can switch their coverage. He said the results of these rules have been larger rate increases and higher rates than other states and less carriers competing. He said states with the birthday rule have fewer carrier options and that rates increased at an outsized pace post-guaranteed issue adoption. He highlighted this in a chart comparing three states with the birthday rule to a "national view" of the top five states in volume without the rule.

Fleming said the birthday rule lives are displacing lower-loss-ratio underwritten, and open enrollment business, resulting in an estimated 10% to 20% increase in overall loss ratio. He said the birthday rule states have fewer carrier options, and rates increased at an outsized pace post-guaranteed issue adoption. He said pre-implementation of the birthday rule consisted of 49% open enrollment, 36% underwritten, and 5% guaranteed issue, resulting in a 90% weighted average loss ratio whereas post-implementation open enrollment dropped by 12 points to 37%, and underwritten business dropped by 12 points to 24%. He said the result is that birthday rule policies replaced those lost segments, taking up 25% of the total. He said the introduction of the birthday rule business caused the overall weighted average loss ratio to spike from 90% to just over 99%, and replacing healthier, medically underwritten lives with birthday rule lives leads to an estimated 10% to 20% increase in overall claims costs.

Dwane McFerrin (Med Solutions) said implementing the birthday rule creates significant market risks, but alternative policy solutions can help protect both carriers and consumers. He said allowing carriers to charge extra fees during guaranteed issue windows, modeled after Minnesota legislation, is an option. He said pairing High-Deductible Plan G (HDG) with a hospital indemnity plan or using separate policies or riders can cut consumer out-of-pocket expenses in half.

McFerrin said some states may restrict stand-alone hospital indemnity and ancillary product sales. However, packaging a hospital indemnity plan strictly with an HDG plan may be a solution, and this combined package offers a stable, budget-friendly third alternative to standard Plan G or Plan N. He said standard plans see regular rate increases, while ancillary products historically maintain stable pricing for budget-conscious consumers, and the lower-cost package provides crucial insurance choices in rural areas facing high standard rates and limited options. He said this strategy avoids returning to banned first-dollar coverage (like Plan F) because consumers still self-insure the high deductible, and it helps carriers stay competitive and manage risk in states with the birthday rule.

McFerrin said in response to a question from Texas about states like Louisiana and Illinois, which have stricter regulations regarding policy switching, stricter rules favor large, established insurance carriers because they hold massive existing customer bases. He said carriers struggle to compete with old, closed blocks of business because only the healthiest clients can qualify to leave, and unhealthy clients stay with old carriers because they can only move under guaranteed issue rules, which drives up costs. He said allowing premium surcharges during guaranteed issue periods—similar to Minnesota's policy—would help carriers price risk accurately and boost market competition. He said traditional Plan F and Plan G policies dominate the market, while newer options like HDG paired with hospital indemnity make up less than 10% of total sales.

Bartuska said North Dakota does not have the birthday rule. One reason she is interested in this issue is the old Medigap Plan F closed block, which has seen significant rate increases. Because no new business is entering those blocks, policyholders continue to age, and claims are expected to rise. She said that the

birthday rule might not be a complete solution and asked what options are available for those closed blocks. She said all states are struggling with the same issue: determining how to address these closed blocks.

Fleming said closed insurance blocks face major issues from unmanageably high loss ratios, and states may want to look at improving oversight during initial and late filings to stabilize rates and protect remaining policyholders.

McFerrin said market pressure forces insurance carriers to offer unsustainably low introductory rates to attract new business. When states approve these underpriced filings, it disrupts the market, forces competitors to underprice, and inevitably triggers massive, unjustified premium hikes later.

Teachout asked whether it is possible to require risk rating across all lines of business within a state that would eliminate the gaming between closed blocks and offering new ones. She said the issue is risk across the entire marketplace, but risk within a carrier's book of business in each market. She said requiring carriers to rate across their entire book of business would remove the incentive to close one block down and open another one with younger, healthier policyholders.

McFerrin said that in states with community rating, relatively few people buy Medigap. He said that in New York, for example, the market is largely driven by Medicare Advantage, so when those rates are merged, Medigap can become unaffordable for many, which is the risk of community rating.

Walker asked if a state eliminates the birthday rules currently in place, what would prevent seniors from ending up in the same situation—trapped in a high premium plan with no alternative options. Bartuska said this goes back to her earlier question about Medigap Plan F and whether the birthday rule is necessary because these individuals are effectively stuck.

McFerrin said that is why he proposes the surcharge option that Minnesota has issued, and to allow a carrier to price for some of this anti-selection. Otherwise, carriers would exit the market, rate increases would continue, and, in the long term, the entire state would suffer.

Stutch asked how one can be certain that the large rate increases are due to the birthday rule rather than rising underlying medical costs. Bartuska said that is a good question because North Dakota does not have a birthday rule, and she has seen high increases. She said she believes underlying medical costs are a major factor and not just the birthday rule.

Fleming said requested rate actions of 10% to 30% vastly exceed actual medical inflation, and carriers intentionally low-ball initial rates to win market share, creating future instability. He said initial underpricing guarantees that consumers will face massive premium spikes later. He said carriers have a responsibility not to low-ball, but state insurance departments should verify rate adequacy to block artificially low filings.

McFerrin said delayed medical procedures and rising cancer claims continue to drive up Part B insurance costs. Combined with the regulatory impact of the birthday rule, these soaring claims create significant pressure that forces carriers to adopt highly conservative business strategies simply to survive.

Henderson said the current closed block of business faces limited competition, keeping existing customers insulated within their current company. He said that eliminating protections like the birthday rule forces consumers to switch to entirely new insurance companies. Transitioning to new insurers exposes

individuals to medical underwriting rejections and higher premium costs, and new insurance companies have no financial incentive to compete for this specific, closed book of business.

McFerrin said maintaining the status quo will cause Medigap premiums to become unaffordable. Additionally, unchecked rate increases will reduce the number of people covered, damaging the overall market. He said if the birthday rule remains, insurance carriers need financial relief to offset high-risk enrollees. Allowing a temporary premium surcharge, similar to Minnesota's, helps insurers absorb adverse selection costs.

Fix asked if seniors understand what pairing a hospital indemnity plan with Plan G. Fleming said he thinks seniors understand what that means because that would be included in an explanation by the agent. He said they would still have Medigap coverage, although it would not be the same as an HDG plan. Because the plan has a high deductible, it can significantly reduce Medigap costs. He said a hospital indemnity plan can help cover part of the Plan A deductible that the high-deductible plan does not pay, along with some additional benefits. Overall, he said this approach offers a less expensive way to provide Medigap coverage while adding some extra protection to fill a portion of the remaining gaps.

McFerrin said it is awkward that the high-deductible Plan G is auto-adjudicated for claims and the hospital indemnity plan is not. He said that if a senior-specific hospital indemnity plan were introduced so that when the high-deductible Plan G pays, the hospital indemnity plan also pays, the claim could be auto-adjudicated within the carrier's system. He said this would eliminate separate claim filing and reduce confusion.

Fix said she appreciates the response and is curious what the consumer representatives think about this. Bartuska agreed and said that, whether in the ACA market right or the senior market, she is curious how that approach would work and how Medicare and Medigap would respond.

Childress said a few carriers did leave the market after the birthday rule was implemented. However, because almost all rate increases are determined based on national experience due to credibility issues, it is difficult to determine if the rate increases seen in Nevada are due to the birthday rule.

Bartuska agreed and said that, as a smaller and more rural state, another factor is the credibility of the data. Bonnie Burns (California Health Advocates—CHA) said hospital indemnity only addresses Part A costs, not Part B, and would only be helpful if one actually landed in the hospital. McFerrin said an innovative HI product could include, if approved by the state, lowering that exposure on the $2,950 for the high-deductible Plan G. Fleming said it would only be available combined with that high-deductible plan.

Bartuska asked whether the Minnesota surcharge is in statute and if it is a flat surcharge across all consumers, such as the entire block, or applied to the one consumer who is going into that new plan. Fleming said it begins at 15% and goes up 5% annually to a cap, and it is for the individuals who choose to move into that plan during the open enrollment period in Minnesota. Bartuska said she has been told it is in statute.

Hohl said some interested groups believe the birthday rule is the problem. She said she would like the presenters to speak on the impact of Medicare Advantage plans leaving areas, the number of big groups of enrollees having those guaranteed issue rights move over to Medigap, and whether they see that as an

impact, because while separate from the birthday rule, it does create an impact on the Medigap market when it happens.

McFerrin said that the birthday rule is one factor, but the Medicare Advantage market is also in its third year of contraction, particularly with the loss of preferred provider organizations (PPOs). He said litigation over

prior authorization is added pressure on Medicare Advantage carriers, narrowing margins and contributing to carrier exits across the country. He said United HealthCare (UHC) announced this week that it plans additional exits next year, which would mark a fourth year of contraction. Fleming said one of the slides presented showed the typical loss ratio for guaranteed issue business and that it has a significant negative effect on Medigap blocks in those situations.

Burns said she encourages the Task Force to continue meeting on this topic.

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

