SENIOR ISSUES (B) TASK FORCE

Senior Issues (B) Task Force Dec. 10, 2025, Minutes
- Senior Issues (B) Task Force Oct. 24, 2025, Minutes (Attachment One)
  - Senior Issues (B) Task Force 2026 Proposed Charges (Attachment One)
- Senior Issues (B) Task Force Sept. 4, 2025, Minutes (Attachment Two)
  - Letter from the Senior Issues (B) Task Force to the Federal Centers for Medicare and Medicaid Services (CMS) and the Medicare Drug and Health Plan Contract Administration Group (Attachment Two-A)

Draft: 12/16/25

Senior Issues (B) Task Force
Hollywood, Florida
December 10, 2025

The Senior Issues (B) Task Force met in Hollywood, FL, Dec. 10, 2025. The following Task Force members participated: Ned Gaines, Chair (NV); Jon Godfread represented by Chrystal Bartuska, Vice Chair (ND); Heather Carpenter represented by Sarah S. Bailey (AK); Maria Ailor represented by Gio Espinosa (AZ); Ricardo Lara represented by Ahmad Kamil (CA); Jared Kosky 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); Holly W. Lambert represented by Alex Peck (IN); Vicki Schmidt represented by Craig Van Aalst (KS); Sharon P. Clark represented by Angi Raley (KY); Michael T. Caljouw represented by Kevin P. Beagan (MA); Marie Grant represented by Laurie Thurtle (MD); Robert L. Carey represented by Marti Hooper (ME); Anita G. Fox represented by Renee Campbell (MI); Angela L. Nelson represented by Jo LeDuc (MO); Mike Chaney and Bob Williams (MS); Mike Causey represented by Robert Croom (NC); Eric Dunning and Martin Swanson (NE); Justin Zimmerman (NJ); Judith L. French represented by Christian Reeg (OH); Glen Mulready represented by Brian Downs (OK); TK Keen represented by Jesse O'Brien (OR); Larry D. Deiter represented by Jill Kruger (SD); Jon Pike represented by Tanji J. Northrup (UT); Scott A. White represented by Julie Blauvelt (VA); Kaj Samsom (VT); Patty Kuderer represented by Andrew Davis (WA); Nathan Houdek represented by Darcy Paskey (WI); Allan L. McVey represented by Joylynn Fix (WV); and Jeff Rude represented by Lela Ladd (WY). Also participating was: Ron Henderson (LA).

1. Adopted its Oct. 24, Sept. 4, and Summer National Meeting Minutes

Gaines said the Task Force met Oct. 24 and Sept. 4. During its Oct. 24 meeting, the Task Force adopted its proposed 2026 charges. During its Sept. 4 meeting, the Task Force adopted a letter to be sent to the to the Centers for Medicare and Medicaid Services (CMS) and the Medicare Drug and Health Plan Contract Administration Group regarding the continuing issues and problems states are experiencing with withdrawals from Medicare Advantage (MA) plans, the issues with provider network changes, the subsequent process for beneficiaries to request a return to traditional Medicare and Medicare supplement insurance (Medigap) coverage, and the process granting a Special Enrollment Period (SEP) for those beneficiaries impacted.

Swanson made a motion, seconded by Williams, to adopt the Task Force's Oct. 24 (Attachment One), Sept. 4, (Attachment Two) and Summer National Meeting (*see NAIC Proceedings – Summer 2025, Senior Issues (B) Task Force*) minutes. The motion passed unanimously.

2. Heard a Presentation on Unfair Trade Practices in Marketing Insurance Products to Idahoans Eligible for Medicare

Director Cameron stated that Idaho's action on the issue of unfair insurance marketing practices was prompted by the fact that some MA plans are withdrawing from counties or completely leaving the Idaho market. Remaining plans are concerned about absorbing additional risk and have taken actions to limit enrollment. Some plans have removed access to applications from agent portals, while others have denied access to paper applications. Some plans have ceased paying commissions mid-year and near or after the start of open enrollment, including making last-minute amendments to agent contracts.

Director Cameron said this has led to confusion and chaos in the market about which plans are available and how to enroll in them. Agents are conflicted about enrolling members in plans if they cannot be listed as the agent of record and are not receiving commissions, and there is potential for bad actors to take advantage of the confusion.

Director Cameron said he issued Idaho Department of Insurance (DOI) Bulletin 25-06, which clarifies the department's perspective on unfair trade practices and applies to all carriers and producers who offer any health insurance plans, including MA and Medigap plans. He said to maintain fair competition in these markets, the bulletin states carriers must: 1) make available and easily accessible applications for enrollment in all forms, including printed, online, and through appointed agents; 2) not engage in convincing or suggesting their products not be sold, marketed, or otherwise discouraging enrollment; 3) not change compensation or commissions mid-year; and 4) provide compensation or commissions if the product they filed had built compensation into its rate development.

Director Cameron said cease and desist orders (C&Ds) are necessary due to the timing of Medicare Open Enrollment, plan discontinuations, and potential harm to Idahoans' access to coverage. He said the C&Ds instruct plans to: 1) stop making changes to agent contracts, given timing with open enrollment; 2) stop removing access and creating barriers to enrollment; and 3) stop engaging in any other practices that harm the market and Idahoans. He said his department continues to receive referrals and complaints related to multiple companies, and investigations are ongoing. The underlying issues in the Medicare marketplace are affordability and accessibility, funding, marketing, and oversight.

Director Cameron said Idaho had to take action to protect its senior citizens. He said he appreciates the response from CMS, but CMS does not have the authority to regulate unfair trade practices, which is within a state's purview. He asked if the state cannot use its own laws to protect its senior citizens, and CMS does not have the power either; then, who does?

Ronnell Nolan (Health Agents for America—HAFA) expressed gratitude to all the states that have issued a bulletin similar to Idaho's, and she thanked Director Cameron for initiating the process. She said Medicare is very complex and complicated, and seniors deserve to choose an agent if they want to, and today's environment is largely unregulated.

Nolan said carriers are doing things that have never been done before, and no one is stopping them. She said the day before open enrollment, insurance agents were prepared to take care of seniors and an insurance company will say we've decided not to pay you. She said that when a client calls for help, agents respond because that is their role. Agents often have no real choice. She noted that many agents across the country worked without compensation throughout the entire open enrollment period.

Nolan said HAFA wants to see every state join Director Cameron in this fight because seniors deserve assistance, and generic support channels, such as 1-800 numbers, are not an effective solution.

Seip said she echoes the sentiments of Idaho and noted that it is very important to sort through and explain how this aligns with the NAIC's *Unfair Trade Practices Act* (#880), which is helpful to understand. She stated that Iowa is facing challenges in both the MA and Medigap markets, and that these issues warrant close attention.

Kruger said South Dakota is facing similar issues and has heard about carriers not paying commissions. She said that this is unfair to agents and seniors. The environment is currently tumultuous for companies, as they are not only concerned about solvency issues but also about the number of new people they can take on at a time, successfully enroll and manage them, and provide the care they need to effectively manage their insurance.

3. Heard a Presentation on LTC Riders on Life Insurance Products and Variable Plans

Roger Moore (National Association of Insurance and Financial Advisors—NAIFA) said NAIFA supports the efforts of Idaho and other states to address unfair practices in agent compensation. Moore introduced NAIFA's new president, Christopher Gandy.

Gandy said there has been a dramatic decline in the amount of training new insurance advisors receive. He said that 26 years ago, advisors spent about 80% of their time on product education, receiving around five to six hours of training per week. He said today, new advisors reportedly receive only five to six hours of training in their entire first year. The marketplace has changed, leading some companies to exit the market, and in the traditional insurance world, many products have become unsustainable due to being underpriced initially. He stated that as a result of inadequate pricing, insurance companies increased costs and premiums, forcing clients to choose between paying a higher premium or accepting a lower benefit for the same initial cost. He said the industry is now focusing on creating "hybrid" solutions to address these market challenges and make products work effectively.

Gandy said NAIFA advocates for improved education within the insurance industry, stressing that companies must better inform consumers and agents about their products. He suggests that the NAIC develop a standardized educational summary for complex items, such as long-term care (LTC) and riders, due to the confusing terminology. He said there is significant misinformation out there and cited an example of a client who misunderstood how a life insurance policy with an LTC rider functions, particularly regarding the utilization sequence of benefits.

Gandy said the current insurance market reflects a move away from traditional LTC policies, and to manage risk, the limited number of remaining carriers have eliminated lifetime benefits, setting coverage limits at five, seven, or 10 years. He said the Task Force could be helpful in trying to standardize and clarify information regarding insurance products to eliminate consumer confusion.

Gandy said that as insurance companies adopt artificial intelligence (AI) and reduce the need for human customer service roles (e.g., 1-800 numbers), the role of a human advisor becomes increasingly critical, particularly during the complex claims process. He emphasized the urgent need for a partnership between the industry and the NAIC to establish clear educational standards and ensure clients can intentionally purchase suitable products with correct information.

Bartuska asked if Gandy felt that these products are streamlined enough to warrant the development of a one-page document or explanation that encompasses them all. Gandy said he believes so because there are not many out there. He said there are whole life riders and annuity riders, and that is about 90% of the terminology. He said the key is the way it is being used in the marketplace, and that it is difficult for a client to understand the difference even when they have the product.

Bartuska said some states do not allow rate increases on life and annuity products because pricing is fixed based on mortality and morbidity tables but other states permit rate increases specifically on associated riders and while it can be appreciated that these riders are attempting to address the struggles of the traditional LTC market and asked if these fixes will lead to the same sustainability issues experienced by traditional LTC products in 15 to 20 years. She asked how regulators can prevent these new rider products from repeating past market failures.

Gandy said a possible solution could be that insurance carriers must accurately price their products from the outset, adhering strictly to actuarial science and mortality data. He said companies could annually release new versions of products (e.g., a 2025 version or a 2026 version) priced for that specific year's risk profile, which could prevent carriers from needing to retroactively raise rates on older blocks of business. This is the current source of consumer dissatisfaction and regulatory concern.

Bartuska asked if Gandy sees challenges in the space of life and annuity products with these riders in underwriting. She said if a 40- or 50-year-old wants to buy an LTC product, there is no underwriting. She said they just buy it, pay for it, and plan to use it in 30 or 40 years. Gandy said he has concerns that carriers are currently prioritizing market share over sound underwriting practices. To attract younger clients (under age 45 or 50, who were previously denied coverage), companies are potentially underpricing products and relying on "algorithmic underwriting." He said he believes some individuals who are actually uninsurable are obtaining the best rates through this automated system, violating fundamental actuarial principles (the "law of numbers"). He said the recommendation for a stricter process involves: 1) correcting product pricing; 2) better education for advisors; and 3) a more structured purchasing process for clients.

4. Heard a Presentation from NABIP on Medicare Advantage and Medigap

Nicole LePetri (National Association of Benefits and Insurance Professionals—NABIP) stated that NABIP supports the actions taken by Idaho and other states in addressing unfair trade practices in agent compensation. She said NABIP is honored to represent professionals within the Medicare industry and emphasizes the essential role of agents and brokers in supporting beneficiaries throughout the year. She said the key takeaways for the Task Force to consider are that agents and brokers serve one-third of all Medicare beneficiaries, providing critical guidance in selecting the right health care coverage, especially during recent tumultuous annual enrollment periods (AEPs). The industry faces new market dynamics, and existing research on past market realities needs to be updated to reflect current challenges. There have been over 900 examples of plan suppressions communicated nationwide, indicating significant market changes that beneficiaries must navigate. She thanked Director Cameron and the other state insurance commissioners for issuing bulletins and taking action against unfair market practices.

Chalen Jackson (NABIP) said that in the Medicare market, several market dynamics have led to a destabilization of the private plans available to Medicare beneficiaries. He said high utilization has created inflationary pressures, and federal legislation has had several unintended consequences. He said that some of those dynamics, including post-COVID medical loss ratio trends, increased claims, and high utilization, are creating inflationary pressures that affect both Medigap and MA products. The Inflation Reduction Act (IRA) has unintentionally complicated plan development for carriers, and the expansions of guaranteed issue (GI) rights for Medigap plans have led to some carriers leaving markets, increased premiums, and reduced availability in certain states. Additionally, research shows that most agents act appropriately, and that studies painting a "grim picture" of agent conduct often rely on limited data sets.

Jackson said that policy research studies and media coverage often publish conclusions about a market that no longer exists, casting doubt on whether agents are necessary. Insurers have limited enrollment methods, service areas, plan options, and agent compensation, which can slow down sales of long-term, non-viable products during the AEP. He said several states have published bulletins on standards to ensure fairness, transparency, and accountability in the Medicare market. He said 35 states have fewer Medicare Advantage plans than in 2025, and five states have fewer than 10 options. For Medicare Part D, the number of total prescription drug plans (PDPs) has decreased by half since 2024, and states now have eight to 12 available plans, down from 19 to 27 in 2022.

LePetri reiterated the ongoing concerns about the Medicare insurance market, thanking states that have taken action and highlighting the problem of abrupt notification when plans are suppressed or become non-commissionable. She emphasized that agents and brokers are essential and deserve compensation, citing over 14,000 beneficiary testimonials that detail the crucial support they provide, including assistance to those in rural areas or without internet access, as well as help in resolving complex claims issues. She urged commissioners to request more state-specific data on plan suppressions and beneficiary testimonials to better understand market realities and inform future actions.

Jackson told the story of "Janine," a new retiree who received generic advice from her former company's human resources department to use Medicare.gov. She unknowingly enrolled in an inadequate Medicare Advantage plan that was later subject to a service area reduction. Janine discovered she was effectively uninsured for her thyroid cancer treatment in February. While Janine eventually found an agent and used an SEP triggered by the service area reduction to enroll in a suitable plan (though non-commissionable and suppressed from typical enrollment platforms), she was forced to navigate the complexities of future enrollments while undergoing treatment. He said beneficiaries should not have to navigate this complex system on their own, and that agents and brokers are essential for guiding them through the complex Medicare system. He also noted that access barriers, such as plan suppression from enrollment platforms, hinder their ability to help consumers make informed, potentially life-saving choices.

Hohl requested clarification on why the "birthday rule," previously advocated for by agents, is now a source of concern within the agent community regarding Medigap, as its implementation is expanding in several states. Jackson said that states that adopt expanded GI rules for Medigap plans, such as birthday or anniversary rules, experience a reduction in the number of carriers in the market. He said those states also see premiums increase at a faster rate compared to states without these rules, with data suggesting up to 10% of carriers may exit and premiums rising about 12% faster over the initial five years.

Hohl asked if enrollment numbers had been reviewed and what steps had been taken to increase enrollment in Medigap in those states. Jackson said in most states, these enrollment periods do not necessarily shift enrollment significantly from Medicare Advantage to Medigap, for example, as most of these rules are designed around allowing people to switch from one Medigap policy to another, not from Medicare Advantage back to Medigap on a GI. He said there have been a few proposals to do that as well, but in the vast majority of states, these rules allow individuals who are already on a Medigap plan to switch to another one, so it has a relatively minimal impact on the overall insured rates for Medigap versus Medicare Advantage, for example.

5. Discussed the Presentation and Heard Additional Comments

Bonnie Burns (California Health Advocates—CHA) said the last two presentations illustrate that there are very complicated issues, and consumer representatives are concerned about the effect that it has on consumers. She thanked the commissioners for raising all the issues surrounding Medicare Advantage and the agent-broker conversation, but consumer representatives have a couple of requests for the Task Force. She said the Task Force must consider the complexity of these two topics and establish working groups for each, allowing them to be explored in greater detail. She said that when it comes to LTC, there is a large variety of riders available on various life insurance platforms that need to be discussed to help people understand those benefits. She said on the Medicare/Medigap side, the consumer representatives are very concerned about a variety of issues, and there needs to be a deeper exploration and a more comprehensive conversation with the Task Force at future meetings.

Ashley Hashem (CMS) said the proposed rule for Medicare Advantage and Part D for calendar year 2027 was issued on Nov. 25. She said the proposal addresses SEPs and star ratings calculations. She said the proposed changes to the MA prescription drug plan star ratings system include two primary adjustments. First, the proposal

suggests eliminating 12 administrative measures from the current total of 43 measures. She said this would make the star ratings system focus more on a clinical overview and rating of the plans, and these removed measures were found to have only slight variations across different products. She said secondly, the proposal also recommends against implementing the "excellent health outcomes for all reward," previously known as the Health Equity Index (HEI) reward.

Hashem said regarding SEPs, the proposed changes involve two key items. She said the proposed rule would formally codify certain current practices for specific SEPs, requiring approval from CMS to use them. She said the most significant proposal is the creation of a new SEP when a health care provider or facility leaves a Medicare Advantage plan's network. She said currently, a beneficiary only qualifies for a SEP in this scenario if the provider termination is deemed "significant." She said the new rule would allow any beneficiary who had used the terminating provider or facility for a certain period of time to qualify for an SEP, regardless of whether the termination is deemed significant. She said this SEP would allow the beneficiary to switch to a different Medicare Advantage plan, return to original Medicare with a Part D plan, and include GI rights for selecting a Medigap plan.

Swanson expressed caution and nervousness regarding the proposed expansion of the SEP for provider terminations, and CMS needs to rethink its approach if the rule is finalized. He said he understands why an SEP is necessary for a major network disruption, such as a hospital closing in North Platte, Nebraska, but raised serious concerns that the proposed rule would trigger an SEP even for the termination of a single, non-essential provider, such as a chiropractor. He stated that this broad SEP access would have an adverse impact on Medigap carriers and that this change would put upward pressure on Medigap rates, as more beneficiaries would utilize the GI rights provided by the SEP to switch plans, ultimately leading to rate increases in that market segment.

Hashem said this is a proposed rule, and this is the type of feedback CMS wants to hear. The deadline for comments is Jan. 26, 2026.

Swanson asked why the proposed rule is eliminating references to State Health Insurance Assistance Programs (SHIPs) and asked David Torian (NAIC) to elaborate. Torian said the proposed rule plans to remove references to SHIPs as a source of information and direct seniors to Medicare.gov, and regulators want to know why. Swanson stated that the Nebraska SHIP program assisted over 43,000 Nebraskans in the previous year. He said every appointment this year was filled to the point that no more appointments could be made. He said if CMS moves forward where folks do not get commissions, does not allow consultants to sell, and denigrate and ignore SHIPs, where are seniors going to go?

Hashem said the proposal does not aim to discourage the use of SHIPs but rather seeks to clarify how SHIP information is outlined within the specific context of the third-party marketing organization (TPMO) disclaimer, and encouraged those with concerns to submit their comments to the proposed rule

Bartuska stated that there needs to be clarification on the definition of a “third party” within the proposed rule, as the current wording implicitly includes SHIPs, despite CMS's stated intent to support and value these programs. She said there is a contradiction between the stringent requirements and hoops that SHIPs must navigate to qualify for grants and funding, and the way the rule broadly defines third parties. She said that if CMS genuinely intends to exclude or treat SHIPs differently from other TMPOs, the regulatory language must be explicitly clarified to reflect that intent.

Hohl said she would be interested in CMS’s perspective on how the proposed rule aligns with the enabling legislation that created SHIPS and the congressional intent in creating the SHIP program.

Fix said she is bewildered that a state with a high concentration of Medicare-eligible residents would require its SHIPs to use a disclaimer, given the extensive, trusted work performed by these non-third-party government agency programs. She said the CMS folks present at this meeting must immediately take back the day's feedback—from regulators, consumer representatives, and directors—and reconsider the proposed disclaimer rule. She said the proposal is mind-numbing because it risks diminishing access to trusted SHIP personnel for seniors and strongly urged that new guidance on the matter be issued as soon as possible, as it cannot wait for the next national meeting.

Hashem said she appreciates the comments on SHIPs and clarified that CMS does not administer SHIP funding. She said that flows through a different agency within the U.S. Health and Human Services (HHS). She said that CMS will relay all these comments to its HHS partners and encouraged everyone again to provide their feedback to the proposed rule before the January deadline.

Bartuska asked for clarification regarding the Medigap options available to an 80-year-old beneficiary who turned 65 before the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requirements took effect. She asked if such an individual utilizes a SEP to return to original Medicare, is their only Medigap option Plan F, because of their age at the time they became Medicare-eligible? She expressed concern that forcing an 80-year-old into a closed, and potentially expensive, Plan F block would leave them with no other viable options.

Marie Gutierrez (CMS) said under the Medigap Open Enrollment Period (OEP) that a beneficiary in their initial Medigap OEP chooses any available Medigap policy, and under the MA SEP, a beneficiary, when using an Medicare Advantage-related SEP, such as the proposed provider termination SEP, gains specific guaranteed issue rights. She said under the proposed rule, that SEP would allow a beneficiary to purchase Medigap Plans A, B, C, D, F, G, K, or L.

Seip asked if those plans are listed in the final rule. Gutierrez said no, it is specified in Section 1882 of the statute and the NAIC *Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act* (#651). Gutierrez also noted the publication on Medicare.gov, titled "Choosing a Medigap Policy," which is jointly reviewed and updated annually by the NAIC. She said the publication includes a useful grid and specifies when a consumer receives GI rights, including the Medigap policies available for that specific GI right scenario and the corresponding time frames.

Hohl stated that, although federal guidance and the NAIC model exist regarding Medigap GI, individual states may have implemented their own variations. She said Idaho has stressed the importance of consulting specific state regulations. She said there remains ambiguity around the phrasing "Plans C or D and G or F," specifically regarding the use of "or," and that states should review their own rules and regulations to determine their interpretation. She noted that this language relates to the MACRA changes applicable to beneficiaries newly eligible for Medicare as of Jan. 1, 2020.

Swanson asked if there is a set date for when the provider contracts have to be signed. He said he presumes it must be before open enrollment, but he is not familiar with how that works in the Medicare Advantage space. Hashem said it is on a flow basis between the health plan and the provider, so there is no set date for CMS.

Bartuska said this is an issue because SHIP directors have been informed that network changes could be made as late as "literally midnight before open enrollment starts." She said this revolving door of provider contracts leads to a broken process because transparent communication is not guaranteed. She said SHIP directors are forced to handle phone calls from confused beneficiaries during the start of OEP without current information, as network status changes may have occurred just hours prior. She suggested that CMS consider implementing a stricter deadline for network finalization, approximately 30 days prior to OEP, to address this issue.

Jerry Mulcahy (CMS) stated that while every Medicare Advantage plan's contract is based on its negotiation timeline, CMS lacks the statutory authority to interfere in contract negotiations or dictate terms, such as aligning them with an annual cycle. He said regarding provider termination provisions and the example Swanson gave about the chiropractor, CMS stated that only enrollees who saw a terminating provider recently, within the last three months, would receive a termination letter and be eligible for a SEP. He said CMS's data indicates that only about 20% of those eligible for a provider termination SEP actually switch from Medicare Advantage to fee-for-service, with the majority remaining in their current plan.

Harry Ting (Consumer Advocate) said he echoes Burns' comments and reiterated that the Task Force should establish specific working groups to address the issues raised by Burns, as well as the proposed 2027 Medicare Advantage rules on SEPs and those who are under age 65, and deceptive advertising that still exists in Medicare Advantage.

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

Draft: 10/18/25

Senior Issues (B) Task Force
E-Vote
October 24, 2025

The Senior Issues (B) Task Force conducted an e-vote that concluded Oct. 24, 2025. The following Task Force members participated: Jon Godfread, Vice Chair (ND); Heather Carpenter (AK); Mark Fowler (AL); Maria Ailor (AZ); Ricardo Lara (CA); Andrew N. Mais (CT); Trinidad Navarro (DE); Scott Saiki (HI); Doug Ommen (IA); Dean L. Cameron (ID); Vicki Schmidt (KS); Sharon P. Clark (KY); Michael T. Caljouw (MA); Marie Grant (MD); Robert L. Carey (ME); Anita G. Fox (MI); Grace Arnold (MN); Angela L. Nelson (MO); Mike Causey (NC); Eric Dunning (NE); Judith L. French (OH); Glen Mulready (OK); TK Keen (OR); Michael Humphreys (PA); Suzette M. Del Valle (PR); Jon Pike (UT); Scott A. White (VA); Patty Kuderer (WA); Nathan Houdek (WI); and Allan L. McVey (WV).

1. Adopted its 2026 Proposed Charges

The Task Force conducted an e-vote to consider adoption of its 2026 proposed charges. A majority of the Task Force members voted in favor of adopting its charges (Attachment One-A). The motion passed.

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

Draft: ??/??/25
Adopted by the Executive (EX) Committee and Plenary, _____, 2025
Adopted by the Health Insurance and Managed Care (B) Committee, _____, 2025
Adopted by the Senior Issues (B) Task Force, Oct. 24, 2025

2026 Proposed Charges

SENIOR ISSUES (B) TASK FORCE

The mission of the Senior Issues (B) Task Force is to: 1) consider policy issues; 2) develop appropriate regulatory standards; and 3) revise, as necessary, the NAIC models, consumer guides, and training material on Medicare supplement insurance, long-term care insurance (LTCI), senior counseling programs, and other insurance issues that affect older Americans.

Ongoing Support of NAIC Programs, Products, or Services

1. The **Senior Issues (B) Task Force** will:
   A. Develop appropriate regulatory standards and revisions, as necessary, to the NAIC models, consumer guides, and training material on Medicare supplement insurance, senior counseling programs, and other insurance issues that affect older Americans. Work with federal agencies to advance appropriate regulatory standards for Medicare supplement and other forms of health insurance applicable to older Americans. Review the *Medicare Supplement Insurance Minimum Standards Model Act* (#650) and the *Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act* (#651) to determine if amendments are required based on changes to federal law. Work with the federal Centers for Medicare & Medicaid Services (CMS) to revise the annual joint publication, *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare*.
   B. Monitor the Medicare Advantage and Medicare Part D marketplace. Assist states, as necessary, with regulatory issues. Maintain dialogue and coordinate with the CMS on regulatory issues, including solvency oversight of waived plans and agent misconduct. Assist states and serve as a clearinghouse for information on Medicare Advantage plan activity.
   C. Provide the perspective of state insurance regulators to the U.S. Congress, as appropriate, and the CMS on insurance issues, including those concerning the effect and result of federal activity on the senior citizen health insurance marketplace and regulatory scheme. Review and monitor state and federal relations with respect to senior health care initiatives and other impacts on the states.
   D. Monitor developments concerning State Health Insurance Assistance Programs (SHIPs), including information on legislation affecting the funding of SHIPs. Assist the states with issues relating to SHIPs and support a strong partnership between SHIPs and the CMS. Provide the perspective of state insurance regulators to federal officials, as appropriate, on issues concerning SHIPs.
   E. Monitor, maintain, and review, in accordance with changes to Model #651, a record of state approvals of all Medicare supplement insurance new or innovative benefits for use by state insurance regulators and others. Review state-approved new or innovative benefits and consider whether to recommend that they be made part of standard benefit plan designs in Model #651.
   F. Develop appropriate regulatory standards and revisions, as necessary, to the NAIC models, consumer guides, and training material on LTCI, including the study and evaluation of evolving LTCI product design, rating, suitability, and other related factors. Monitor ongoing research and maintenance of guidance regarding reduced benefit options (RBOs) and make necessary modifications to the *Long-Term Care Insurance Model Act* (#640) and the *Long-Term Care Insurance Model Regulation* (#641). Work with federal agencies, as appropriate.

SENIOR ISSUES (B) TASK FORCE *(Continued)*

G. Examine examples of health-related financial exploitation of seniors and work with other NAIC committees, task forces, and working groups on possible solutions.
H. Examine systemic inequities and discrimination on access, affordability, and outcomes for older insurance consumers.

NAIC Support Staff: David Torian

Draft: 9/9/25

Senior Issues (B) Task Force
E-Vote
September 4, 2025

The Senior Issues (B) Task Force conducted an e-vote that concluded Sept. 4, 2025. The following Task Force members participated: Ned Gaines, Chair (NV); Jon Godfread, Vice Chair (ND); Heather Carpenter (AK); Mark Fowler (AL); Peter M. Fuimaono (AS); Ricardo Lara (CA); Andrew N. Mais (CT); Trinidad Navarro (DE); Doug Ommen (IA); Holly W. Lambert (IN); Vicki Schmidt (KS); Sharon P. Clark (KY); Michael T. Caljouw (MA); Marie Grant (MD); Robert L. Carey (ME); Anita G. Fox (MI); Grace Arnold (MN); Mike Causey (NC); Eric Dunning (NE); D.J. Bettencourt (NH); Remedio C. Mafnas (NMI); Judith L. French (OH); Glen Mulready (OK); TK Keen (OR); Michael Humphreys (PA); Cassie Brown (TX); Jon Pike (UT); Scott A. White (VA); Kaj Samsom (VT); Patty Kuderer (WA); Nathan Houdek (WI); and Allan L. McVey (WV).

1. Adopted a Letter to Send to CMS

The Task Force conducted an e-vote to consider adoption of a letter from the Task Force to the Centers for Medicare and Medicaid Services (CMS) and the Medicare Drug and Health Plan Contract Administration Group regarding the continuing issues and problems states are experiencing with withdrawals from Medicare Advantage plans, the issues with provider network changes, the subsequent process for beneficiaries to request a return to traditional Medicare and Medicare supplement insurance (Medigap) coverage, and the process granting a Special Enrollment Period (SEP) for those beneficiaries impacted.

A majority of the Task Force members voted in favor of adopting its letter to CMS (Attachment Two-A). The motion passed.

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

NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

September 5, 2025

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services (CMS)
Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Administrator Oz:

We are writing on behalf of the National Association of Insurance Commissioners' (NAIC) Senior Issues (B) Task Force (SITF) regarding provider withdrawals from Medicare Advantage (MA) plans, carriers leaving networks, and the subsequent process for beneficiaries to request a return to traditional Medicare and Medicare Supplement Insurance (Medigap) coverage.

The NAIC is the standard setting organization representing the chief insurance regulators in the 50 states, the District of Columbia, and the United States territories. The NAIC's SITF is charged with considering policy issues; developing appropriate regulatory standards; and revising, as necessary, the NAIC models, consumer guides, and training materials on Medigap, long-term care insurance (LTCI), senior counseling programs, and other insurance issues that affect older Americans.

At the recent NAIC Summer National Meeting in Minneapolis, the SITF requested representatives from the Medicare Drug and Health Plan Contract Administration Group (MCAG) to come in-person and explain the process of determining provider network changes and the options available to MA enrollees who have lost access to their providers. We seek guidance on several aspects of the process and have a recommendation that could mitigate some of the problematic situations we are encountering.

As open enrollment (OE) is rapidly approaching, we are requesting a Regulator-Only meeting with you and your staff as soon as possible, ideally within the next couple weeks, to discuss these issues.

State regulators in several states are seeing hospitals and crucial provider groups making decisions to no longer contract with any MA plans, which can leave enrollees without ready access to care. In some cases, the provider groups and carriers attempt to renegotiate their

contracts until the last day of the current contract and when negotiations fail the provider group can become an out-of-network provider overnight. This can have an immediate and direct impact on consumers who may already have services scheduled with the now out-of-network provider. Consumers are faced with either paying the increased out-of-network costs or rescheduling their necessary medical services with another provider who may not have prompt availability. A delay in access to medically-necessary services is likely to result in patient harm. There is considerable confusion and soon will be more as to what patients' options are, and we request guidance from CMS so we can help our constituents. Lack of CMS guidance could result in unnecessary financial or medical injury to America's seniors.

As we understand it, MCAG determines whether a significant provider network change has occurred and, once that determination is made by MCAG, a special election period (SEP) is automatically granted for the beneficiaries who are impacted. We also understand that the SEP allows for guaranteed issue (GI) into original Medicare and Medigap. How is that determined? Is it on an individual enrollee basis? Are time and distance standards utilized? Once a determination is made, how is that communicated to affected constituents and state insurance regulators? Can state insurance regulators assist MCAG in making rapid determinations? Additional information about what states can and should do would be very helpful as states are on the front line of consumer complaints and calls, despite the fact that states do not have jurisdiction over MA plans.

Once the determination is made, it is unclear what steps follow that decision. For example, is it an automatic reversion in original Medicare for all the individuals involved? Does the individual have to contact CMS on an individual basis? If so, this would seemingly cause an undue burden on a beneficiary and could lead to individuals who don't respond, for whatever reason, having coverage that may be nominal at best. We do not believe such a burden should be placed upon consumers.

The Secretary of the Department of Health and Human Services (HHS) has the authority to establish SEPs under exceptional circumstances on a case-by-case basis and we suggest that CMS consider a blanket SEP into original Medicare and a Medigap GI when a hospital or provider group exits an MA network contract.

We seek guidance on how the current process works and answers to questions raised at the SITF meeting:

- How is CMS made aware of providers leaving a network? Is it only through enrollee inquiries or must MA plans notify CMS of the changes? What is the timeframe within which the plans are required to notify CMS?

- Once CMS is made aware that a provider and/or a carrier are no longer going to contract with each other, what are the steps in evaluating and determining the eligibility

for original Medicare and then guarantee issue into Medigap? Does guarantee issue apply to all Medigap plans or only select ones?

- What role can state regulators play and what information can be provided to state regulators in identifying provider network changes and requesting an SEP?

- How long does the review and consumer notification process typically take?

- After the CMS evaluation, how are notifications provided to the policyholders? Are the notifications just done via the MA plan?

- Are state departments of insurance (DOIs) and state health insurance assistance program (SHIPs) offices to be notified about the communication so our staff(s) can be prepared for calls and, if we do get calls, where do we refer consumers about the issue?

- Will MA plans be expected to offer continuity of care protections for individuals who experience the loss of a key provider?

Several states had specific questions and concerns regarding the CMS Plan Finder. A number of generic prescriptions failed to appear on plan formularies even though they were covered. Additionally, many of these prescriptions did not consistently show up in clients' drug lists (i.e. they were entered but the system would not save them). Similarly, the prescriptions would not pull up on the list of prescriptions when the comparisons were run. Other issues included:

- Issues with zip codes. Use of some zip codes would bounce SHIP staff & counselors out of Plan Finder or would result in an error message saying zip code could not be found.

- Changes to the Plan Finder, which only allowed one person to be logged in to a client's Plan Finder account, is extremely problematic. Previously more than one person was allowed, which meant SHIP counselors providing phone counseling sessions could be logged in to the account while the client was also logged in. States would like CMS to change the system back to allow more than one person in a consumer's account so we can continue our advocacy efforts in a transparent manner and with the consumer following along.

- Plan Finder pricing does not include pricing for LTC pharmacies and many consumers are in nursing homes and use LTC pharmacies. Is there a way to change this?

- Serious concerns exist about a mandatory email requirement. We understand CMS is running an evaluation to assess the impact of making email addresses mandatory in Plan Finder. Previously a client was able to opt out if they did not have an email

address. Requiring an email address to set up an account would impact a person's ability to set up a medicare.gov account and their ability to enroll in a plan through Plan Finder. We know based on counselor feedback that a significant number of older consumers, and consumers in rural areas, do not use email and/or have access to the internet. In addition to creating new barriers for seniors, we believe that making email addresses mandatory will create additional unnecessary issues, including 1) creating security issues as persons who wish to use Plan Finder and do not have email may create random email accounts that could create a security risk, and 2) reducing the number of persons who can be served as SHIP counselors are forced to assist with the creation of email addresses. This is especially important during a short timeframe such as OE when demand for services already surpasses supply. We respectfully request that CMS not implement any policies that require use of an email to create either a Medicare or Plan Finder account.

State DOIs across the country are fielding consumer inquiries about the withdrawal of their providers from MA plans and since states do not regulate these plans, DOI staff are unable to offer recommendations to consumers beyond referring them to CMS or the administrator of their MA plan. Without clear guidance or a resolution from CMS, these consumers are left with few options. We are open to a dialogue with your office and appropriate CMS personnel and would appreciate answers to these questions and guidance on how we may best assist our beneficiary constituents.

Sincerely,

Ned Gaines, Chair
Senior Issues (B) Task Force
Acting Commissioner
Nevada Division of Insurance

Chrystal Bartuska, Vice Chair
Senior Issues (B) Task Force
Division Director
North Dakota Insurance Department

Cc: Kathryn Coleman, Director, Medicare Drug and Health Plan Contract Administration Group (MCAG)