Draft Pending Adoption

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Senior Issues (B) Task Force
Denver, Colorado
November 17, 2024

The Senior Issues (B) Task Force met in Denver, CO, Nov. 17, 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 Sanjeev Chaudhuri (AL); Andrew N. Mais represented by Paul Lombardo (CT); Karima M. Woods represented by Michael Ross (DC); Trinidad Navarro represented by Sally Frechette (DE); Michael Yaworsky represented by Alexis Bakofsky (FL); Doug Ommen represented by Andria Seip (IA); Dean L. Cameron represented by Randy Pipal (ID); Amy L. Beard represented by Alex Peck (IN); Vicki Schmidt represented by Julie Holmes (KS); Sharon P. Clark represented by Angi Raley (KY); Timothy J. Temple represented by Vicki Dufrene (LA); Michael T. Caljouw represented by Kevin Beagan (MA); Marie Grant 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 Jo LeDuc (MO); Mike Chaney represented by Bob Williams (MS); Mike Causey represented by Robert Croom (NC); Jon Godfread represented by Chrystal Bartuska (ND); Eric Dunning and Martin Swanson (NE); D.J. Bettencourt represented by Michelle Heaton (NH); Justin Zimmerman (NJ); Alice T. Kane represented by Blanca Ramirez (NM); Judith L. French represented by Laura Miller (OH); Andrew R. Stolfi represented by Numi Griffith (OR); Michael Humphreys represented by Dave Yanick (PA); 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 Jackie Myers (VA); 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 Oct. 21, Sept. 20, and Summer National Meeting Minutes

The Task Force met Oct. 21 and Sept. 20. During these meetings, the Task Force took the following action: 1) adopted its 2025 proposed charges and forwarded them to the Health Insurance and Managed Care (B) Committee for consideration; and 2) adopted a letter to the federal Centers for Medicare & Medicaid Services (CMS) regarding provider withdrawals from Medicare Advantage (MA) plans and the Medicare supplement insurance (Medigap) guaranteed issue (GI).

Kruger made a motion, seconded by Lombardo, to adopt the Task Force's Oct. 21 (Attachment One), Sept. 20 (Attachment Two), and Summer National Meeting minutes (*see NAIC Proceedings – Summer 2024, Senior Issues (B) Task Force*). The motion passed unanimously.

2. Discussed the Medicare Advantage/Medigap/SEP issue with the CMS

Molly Turco (CMS) said CMS appreciates and hears the recent feedback from state insurance regulators. She said CMS is working on improving communication and information sharing with regulators and stakeholders. CMS is creating a frequently asked questions (FAQ) document and updating its website to provide centralized information, and it will create a single point of contact mailbox for NAIC and state regulators to send issues and questions. It also plans to share important information with NAIC and state regulators, including enrollment changes and significant provider network changes, and it will work hard on improving communication and responsiveness based on feedback from participants throughout the year and especially at important inflection points, such as open enrollment.

Commissioner Kipper said the Task Force appreciates the willingness of CMS to work closer with state regulators and be a better partner on the information flow. He said there is a great deal of anticipation for the FAQ, which will hopefully be released tomorrow.

Director Dunning said state insurance regulators ask for more state regulation over MA plans on Capitol Hill, and there is more reason to advocate for state regulation of MA plans. He said that his state was fortunate to finally receive a response to its inquiries from the past six months, which came in the form of a four-paragraph letter.

Director Dunning said there are many communications from CMS in his state but many inaccurate answers. He said he has seen one communication go to one carrier but not to another, and conflicting answers go to different parties. This causes a great deal of confusion, and the State Health Insurance Assistance Program (SHIP) volunteers are thoroughly confused. They are trying to communicate answers to seniors in an open enrollment setting, but they are being tripped up by a lack of guidance from the federal government.

Kruger said she shares the sentiments of Director Dunning that he finally received a response but her state has not heard anything from CMS. She said she understands that these are difficult topics, and the CMS does not necessarily know the answers, but she said her state cannot abide by being ignored when information and guidance are sent and then requested in return, but no response is received. Turco appreciated the feedback, and CMS wants to ensure information is received on a timely basis. She said she is here to receive all feedback, negative and positive, and appreciates the Task Force's candidness. Her goal is to turn the feedback into action, and CMS is working on having an official process so states have the information and support they need.

Commissioner Kipper said there is no shortage of Task Force members and other state regulators ready to help CMS communicate better. He said most, if not every state, has a SHIP office or program that is very good at disseminating to affected consumers, and state regulators want to help CMS.

Fix asked if CMS has considered extending the open enrollment period because of all the confusion. Turco said CMS cannot respond to that at the moment; however, the end of open enrollment is rapidly approaching, and when there has been confusion in the marketplace, CMS extends the period, but currently, there is no discussion of an extension. There is less flexibility with Medicare due to federal law, but she will report any information back.

Bartuska explained that during the last open enrollment, a carrier in her state had to exit a county's market due to exceeding the Medicare Cost Plan population limit, a rule set by CMS. She believes this rule needs to be changed and also noted that the guidance CMS provided to North Dakota regarding the loss of an MA plan differs from the guidance given about losing a cost plan in a specific county.

Bartuska said the biggest issue is the difference between the Medicap C and F plans versus the Medigap D and G plans. Individuals who turned 65 before Jan. 1, 2020, are restricted to Plans C and F, and D and G are not available to them. She noted that Plan F is facing challenges due to the lack of new enrollees. Bartuska said that while recent discussions have focused on MA plans, it is important not to overlook the issue with cost plans, as they are similar concerns. She emphasized that CMS rules limit the number of carriers allowed in a single county. Seip said she echoed Bartuska's comments given the number of Medicare Cost Plans in Iowa.

Turco thanked North Dakota and Iowa for their feedback on the Medicare Cost Plans. Although she does not believe these issues are addressed in the FAQ, she will pass along the information to CMS and, hopefully, add information on these issues to the FAQ.

Turco moved on to address a few of the questions that were raised during the Task Force's Nov. 7 meeting. All of the questions will be answered in the upcoming FAQ, which will be about 10 pages long. One question that is

asked frequently is what criteria CMS uses to determine whether a network change is significant. CMS recognizes that each provider termination is unique and carefully evaluates the circumstances to determine its significance. The goal is to make timely decisions, ensuring beneficiaries are informed of their rights and options for changing plans or Medigap coverage promptly. CMS remains committed to this approach and will continue to communicate as needed.

Another question asked is how this criteria impacts people in employer-sponsored plans and how network change is determined, as people are being told by their providers about the network change. Turco said provider terminations that occur within an employer-sponsored MA plan are subject to the same CMS requirements and processes for determining whether a Special Enrollment Period (SEP) is applicable. MA plans, including employer-sponsored MA plans, are required to report to CMS any time they have experienced a significant network change. CMS then determines if the provider termination is significant and if it is, this would be communicated to the plan. Existing CMS guidance requires the plan to notify impacted enrollees if they are eligible for a SEP and Medigap GI rights. She said CMS is working on standardizing these communications to enrollees.

Turco explained that plans must notify enrollees of this change, regardless of SEP eligibility. CMS provides resources for plans to contact them with any process-related questions. She also noted that providers may not know if an enrollee's coverage is through an employer-sponsored plan. Enrollees in such plans should check with their employer to understand additional coverage options and how decisions might affect their employer-sponsored coverage.

Another question that was asked during the Nov. 8 meeting was that although determination is communicated quickly, how long does it take to make the determination? CMS thoroughly reviews each case and works quickly so that affected enrollees are notified as fast as possible. When CMS determines the network's change is significant, the plan must notify its affected enrollees of their eligibility for a SEP, including their GI rights and how to use a SEP. CMS provides model language for this notification, but this is another area where CMS is open to feedback about timeliness and other related issues.

Turco said that another question asked was who at CMS prompts the plans to send notifications to beneficiaries when a provider network decides to no longer accept MA plans. MA plans are required to report to CMS anytime they are experiencing a network change. CMS then works to determine if the provider termination is significant. If CMS determines it is significant, MA plans are then required to communicate this to their beneficiaries. These rules are in 42 CFR 422.11 and 4222.622B.

Turco said another question is if CMS can provide a link to the model notices that carriers must follow and if CMS checks the notices to ensure compliance. CMS provides a link that can be found in the marketing model standards documents and education materials. These are updated, and CMS encourages their use. CMS is in the process of updating the model notices, and they will be shared with the NAIC upon completion.

Another question asked was if CMS could provide a crosswalk and termination list that can be sorted by state and county. CMS is working to see if this is possible. Another feedback question was asked about zero-dollar ($0) commissions. Turco said $0 commissions happen every year, but CMS is seeing more this year both in the standalone prescription drug plan (PDP) market as well as in the Medicare Advantage Prescription Drug (MAPD) and Medigap markets. The feedback that was given when this question was asked during the meeting was that some carriers are providing $0 commissions for GI Medigap plans. This is an obvious attempt to discourage the sale of plans to consumers, and this should be kept in mind as more consumers are given GI rights. Turco said this issue is not addressed in federal regulation, and Medigap commissions are subject to state laws. The primary oversight and enforcement of Medigap sales are under the purview of the state.

A related question regarding MA plans is that some carriers are providing $0 commission for new MA sales, and does this violate the new federal rules on MA producer compensation? This question implicates aspects of the new agent and broker compensation regulation that CMS finalized in its April 2024 final rule. Certain provisions of this regulation are the subject of pending litigation. On July 3, 2024, the U.S. District Court for the Northern District of Texas issued preliminary injunctions in multiple cases nationwide. Therefore, the regulation language that was effective prior to the issuance of this final rule will be in effect, and essentially, the new regulations are not in effect due to the injunction and resorted back to the previous rules regarding MA compensation.

Turco said the language in CMS' regulation that is currently in effect provides that MA organizations and sponsors "may determine through their contracts the amount of compensation to be paid, provided it does not exceed limitations outlined in this section." This means CMS only determines what the maximum fair market value is for the initial and renewal amounts, not below that, so CMS is not mandating and does not have the authority to do so. It is within the plan's ability to have $0 commissions, and MA organizations determine the payment schedules through their contracts. A plan may set a range for that fair market value maximum, which could be zero, and they may adjust their compensation within that range.

Bartuska asked if the regulations or processes require a 90-day notice when a carrier plans to exit a market. She noted that most states require a 60- to 90-day notice from insurers and emphasized that states were not notified in this case. She added that while the federal government regulates MA, states have requested authority to do so, and if the federal government is in charge, clear timeframes should be established. Turco said she would follow up on the timeframe issue.

Swanson inquired about a situation where a significant event in a county allows people to get a SEP into Medicare and a GI into Medigap, but marketing of MA plans is still permitted in the same county. He asked if this is allowed, as it is currently happening. Turco clarified if Swanson was referring to marketing by the same plan, and Swanson confirmed. Turco explained that the confusion may stem from contracts that include multiple plans, with a SEP applying to only one plan within the contract. She noted that typically, only one plan is affected. Moving forward, she said CMS will clarify which enrollees are impacted in future communications, as it will not be all enrollees in the contract.

Swanson said that is not what the letters sent to Nebraska say. He said the letters told the two carriers that had MA in the county that they get a SEP back to original Medicare and GI back into Medigap. He said Turco's answer was confusing as well. Although there are multiple plans, one carrier was told to send this information out in a broad format, and the other one was not even communicated as having a GI.

Turco said she would be happy to discuss this specific Nebraska-Great Plains matter further, as she does not have the details in front of her now; however, it would not be accurate to say a plan would not be notified because they would be the ones communicating to the enrollees. Director Dunning said Nebraska would take the advice of the letter, and no additional conversations are necessary.

Fix acknowledged understanding CMS's point, but it is still not fully clear. She said CMS must understand that when a hospital system pulls out of a network, they have zero idea of what plans people are on. She said they pull out of the carrier, not a plan, so while the Task Force hears what CMS is saying, that is not what is happening on the ground.

Kathryn Coleman (CMS) said part of the confusion is that there are people enrolled in a plan for 2024, but it is also open enrollment for next year's plans and that plan still exists for 2025, so CMS is able to market to individuals. At the same time, there are people enrolled who are eligible for a SEP. It is challenging because there are overlapping election periods at the same time that people receive a SEP for their current plan.

Kruger explained that the confusion lies in how a SEP triggered by a significant network change in 2024 would allow someone to enroll in the same plan for 2025 if the network is still not viable. Coleman said there could be a significant network change, but it may not impact their ability to meet CMS's network standards. The 2025 plan may still meet the MA network standards and still be a plan in 2025 without that particular provider in their network. The standards are a floor, and many times, MA plans exceed that standard.

Kruger acknowledged that the question was answered, but pointed out that for rural states, the situation is challenging. Unlike urban areas with multiple hospital systems, rural areas often have only one hospital, so when that hospital leaves a network, it becomes nearly impossible to meet the required standards. This approach does not make sense for rural states. Coleman said they have different standards based on county type, and CMS looks at access based on that type of county. CMS has four different categories of counties: urban, suburban, rural, and counties with extreme access concerns. She said CMS would be happy to talk with South Dakota about this matter. Commissioner Kipper asked if that discussion could be shared with the other rural states.

Commissioner Kipper said the Task Force and the NAIC look forward to continuing this discussion with CMS. He said CMS clearly understands the frustration of regulators and recognizes the significant communication opportunities. He encouraged CMS to leverage the expertise around the table and reiterated that state regulators and the NAIC, as always, are ready to assist CMS in addressing these issues.

Bonnie Burns (California Health Advocates—CHA) said she supports the SHIPs in California with training materials and information. This has been a particularly difficult annual enrollment period for many different reasons, and due to the Presidential Election and Thanksgiving, many people have not even begun to think about the changes to their MA plan or enroll in an MA plan.

She explained that she has been addressing situations where individuals are entitled to a Medigap policy due to changes in their MA plan, such as being moved to another MA plan, their plan exiting the market, or significant network changes. She distributed a handout, with the first page showing a notice people would receive if there was a significant change to their MA network. The notice, dated August and sent anonymously, led her to question what might have prompted CMS to send this notice to MA plans.

Burns said that if CMS is expanding access to Medigap plans due to significant changes in the MA plan, the process for determining these changes is complex and time-consuming. With less than a month left in the annual enrollment period (AEP), many elderly individuals are confused about their Medicare benefits, and there is limited information from CMS to help guide them.

Burns said providers are dropping coverage and leaving MA plans in large numbers all over the country. She said there is a lot of flux in the market right now, and she is dealing with 80-year-old people who are trying to figure out what to do about their MA plans or their Medicare benefits.

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

Fall National Meeting Minutes