Draft: 3/25/24

Senior Issues (B) Task Force
Virtual Meeting
March 16, 2024

The Senior Issues (B) Task Force met Mar. 16, 2024. The following Task Force members participated: Scott Kipper, Chair (NV); Peni 'Ben' Itula Sapini Teo, Vice Chair (AS); Lori K. Wing-Heier represented by Sarah Bailey (AK); Ricardo Lara represented by Emily Smith (CA); Andrew N. Mais represented by Paul Lombardo (CT); Karima M. Woods represented by Mike Ross (DC); Trinidad Navarro represented by Susan Jennette (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 Scott Shover (IN); Vicki Schmidt represented by Julie Holmes (KS); Sharon P. Clark represented by Shaun Orme (KY); Timothy J. Temple represented by Ron Henderson (LA); Gary D. Anderson represented by Kevin Beagan (MA); Kathleen A. Birrane represented by Kathryn Callahan (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 represented by Martin Swanson (NE); D.J. Bettencourt represented by Jennifer Li (NH); Alice T. Kane represented by Viara Ianakieva (NM); Judith L. French represented by Kyla Dembowski (OH); Glen Mulready represented by Andrew Schallhorn (OK); Michael Humphreys represented by David Yanick (PA); Alexander S. Adams Vega (PR); Larry D. Deiter (SD); Carter Lawrence represented by Scott McAnally (TN); Jon Pike (UT); Scott A. White represented by Julie Blauvelt (VA); Tregenza A. Roach (VI); Kevin Gaffney represented by Anna Van Fleet (VT); Mike Kreidler represented by Todd Dixon (WA); Nathan Houdek represented by Jennifer Stegall (WI); and Allan L. McVey represented by Joylynn Fix (WV).

1. Adopted its Feb. 29 Minutes

The Task Force met Feb. 29. During this meeting, the Task Force took the following action: 1) discussed access to Medigap coverage and challenges for those under and over the age of 65.

Lombardo made a motion, seconded by Commissioner Teo, to adopt the Task Force's Feb. 29 minutes (Attachment One). The motion passed unanimously.

2. Heard an Overview of the Provisions of the New Prescription Drug Law in the Federal IRA

Eman Kirolos (Centers for Medicare & Medicaid Services—CMS) explained to the Task Force the key provisions of the new drug law in the Inflation Reduction Act (IRA) and how it affects Medicare beneficiaries. She said the IRA was signed into law in August 2022, and the new law makes improvements to Medicare that will expand benefits, lower drug costs, and improve the sustainability of the Medicare program for generations to come. Kirolos said the law provides meaningful financial relief for millions of people with Medicare by improving access to affordable treatments and strengthening Medicare, both now and in the long run.

Kirolos highlighted the timeline of the Inflation Reduction Act provisions, including that on Jan. 1, 2023, a $35 monthly out-of-pocket cap was placed on Medicare-covered insulins under Part D, and on July 1, 2023, placed on Part B. She said that in 2023, the Advisory Committee on Immunization Practices (ACIP)-recommended vaccines were made free under Medicare Part D prescription drug coverage. In October 2023, state Medicaid and Children's Health Insurance Program (CHIP) programs were required to provide coverage for approved adult vaccines recommended by the ACIP (and its administration) without cost sharing. Kirolos said that in 2022 and

2023, the provisions required manufacturers to pay rebates to Medicare if their price increases for certain drugs exceeded inflation and made Medicare Part D prescription drug coverage more affordable.

Kirolos said that in 2024, people with very high prescription drug costs will no longer pay once they reach the "catastrophic phase," and the full low-income subsidy will be expanded for people with low incomes, thereby lowering premiums and out-of-pocket costs for their prescription drug coverage. She said that in 2025, everyone with Medicare Part D will have a $2,000 annual out-of-pocket cap on their drug costs. She said the new provisions allow Medicare to negotiate the price of certain high-cost, brand-name prescription drugs.

Kirolos said the drug inflation rebate provisions require drug companies that raise prices for certain products faster than the rate of inflation to pay Medicare Part B or Part D a rebate, and these rebates are calculated quarterly (Part B) or annually (Part D). She said the liability for rebates began Oct. 1, 2022, for Part D and Jan. 1, 2023, for Part B. She said beneficiaries might pay reduced inflation-adjusted coinsurance rates for 48 Part B rebatable drugs. She said the provisions require monitoring drug prices during the applicable period, comparing them to the benchmark price (adjusted for inflation), making adjustments in certain cases (e.g., drug shortages), and invoicing manufacturers for the remaining difference. She said that under the rebates provisions, if the Medicare payment amount for a calendar quarter exceeds the inflation-adjusted payment amount, beneficiary coinsurance is equal to 20% of the inflation-adjusted payment amount.

Kirolos explained the expansion of the Extra Help Program and said that since Jan. 1, 2024, nearly 300,000 low-income people with Medicare currently enrolled in the Extra Help Program are newly eligible for expanded benefits, including no deductibles, no premiums, and fixed, lowered copayments for certain medications. She said an additional 3 million people could benefit from the Extra Help Program now but are not currently enrolled. She said it also expands eligibility for the full low-income subsidy (LIS) benefit to individuals with limited resources and incomes up to 150% of the federal poverty level, and people with Medicare who are currently enrolled in partial Extra Help have been automatically converted to full Extra Help so they do not need to take any action.

Kirolos explained the Part D Improvements Redesign and the revisions of its parameters. She said people with very high prescription drug costs will no longer pay once they reach the "catastrophic phase." The redesign provides for Part D premium stabilization beginning this year by capping base beneficiary premium increases per year to no more than 6% through 2029. She said that beginning in 2025, people with Medicare prescription drug coverage will benefit from a yearly cap ($2,000 in 2025) on what they pay out-of-pocket for covered prescription drugs, and they will also have the option to pay their prescription costs in monthly amounts spread over the year, rather than all at once. She said the new discount program will require drug manufacturers to pay discounts on certain brand-name drugs and other types of drugs called biologics and biosimilars, both in the initial coverage phase and in the catastrophic phase of the Medicare prescription drug benefit, and manufacturers must provide a 10% discount in the initial phase and a 20% discount in the catastrophic phase.

Commissioner Kipper asked CMS to please reach out if there is any role for the states and state insurance commissioners to assist with these new provisions.

3. Heard a Presentation from California on its LTCITF

Smith said the statutory mandate of California's Long-Term Care Insurance Task Force (LTCITF) is to recommend options for a public long-term care insurance (LTCI) program in the state. She said a feasibility study recommending potential program designs was issued Dec. 14, 2022, and an actuarial analysis assessing the cost and viability of the recommended designs was issued Dec. 21, 2023. Smith said the members of the LTCITF included 15 volunteers and state agency representatives with expertise relating to long-term care (LTC) or LTCI.

Smith said the process of the LTCITF included 24 public meetings with public comment; early discussions on covered structure, coordination/interaction, eligibility/enrollment, benefits/services, administration, financing, workforce, and access; three Actuarial Subcommittee meetings; individual polling of LTCITF members and the public between meetings to align on design preferences; consultation with other state agencies and WA Cares Fund representatives; and multiple drafts of reports.

Ryan de la Torre (California) explained the status of the LTCITF Program (Program) and said the California State Legislature may or may not choose to proceed with legislation to establish a public LTC program in California, and if it does proceed with legislation, it may choose to adopt some, all, or none of the Task Force's recommendations. He said that, as of right now, the Legislature has not made any decisions about a public LTC program in California.

De la Torre said the notable benefit recommendations include two-of-six activities of daily living (ADLs) or severe cognitive impairment eligibility criteria; a five- or 10-year vesting period, with partial vesting after three or five years, respectively; reimbursement benefits in all designs and 50% cash alternative in Designs 2, 4, and 5; benefit inflation based on Consumer Price Index (CPI); reimbursement for informal or family caregivers (subject to a training requirement); coverage for minor home modifications and home assessment; and partial to full domestic and international portability in all designs.

De la Torre said the notable financing recommendations include progressive payroll tax (and income-based tax for self-employed individuals); contribution cap at $400,000 in most designs, indexed with inflation; contribution waiver of first $30,000 in all designs, indexed with inflation; and contribution rates split 50/50 between employee and employer.

De la Torre said the interactions with private LTCI include that private LTCI pays before the Program; the Program pays before Medi-Cal (Medicaid); an opt-out is available if eligible LTCI coverage is purchased before the Program effective date; a reduced contribution rate is available if eligible LTCI coverage is purchased after the Program effective date; a recurring recertification is required; and a recommendation to establish a working group to explore supplemental private insurance options.

Stephanie Moench (Oliver Wyman) explained the five different Program Designs. She said Design 1 is supportive of LTC benefits, with a .60% contribution rate, and includes $36,000 over two years for those over age 18. She said examples of supportive services include caregiver support, adult day care, meal delivery, transportation, durable medical equipment, home assessment, and minor home modifications. She said formal home care and facility care are not covered. She said Design 2 is home care and residential care facility (RCF) benefits for older adults, with a 1.15% contribution rate, and includes $110,400 over two years for those aged 65 and older. She said the covered services are the same as Design 1, plus formal home care and care in an RCF, limits duplication with Medi-Cal by excluding low-income individuals with no contributions or vesting credit, and individuals below income limit in some years will still vest if they accumulate enough vesting credits over their working life.

Moench said Design 3 is lower-range comprehensive long-term services and supports (LTSS) benefits, with a 0.65% contribution rate, and includes $36,000 over one year for those over age 18. She said this design includes covered services that are the same as Design 2 and are inspired by the WA Cares Fund design, with select updates. Moench said Design 4 is mid-range comprehensive LTSS benefits, with a 1.6% contribution rate, and includes $81,000 over 18 months for those over 18. She said the covered services include those from Design 3, plus care in a skilled nursing facility, and benefits can be shared with spouses/domestic partners. She said Design 5 is higher-range comprehensive LTSS benefits, with a 3% contribution rate, and includes $144,000 over two years for those over age 18. She said covered services are the same as Design 4, and benefits can be shared with spouses/domestic partners.

Dustin Plotkin (Oliver Wyman) provided a summary of some of the Program's design features. He said the maximum benefits in Designs 1–5 are $1,500/month; $4,600/month; $3,000/month; $4,500/month; and $6,000/month, respectively. He said Designs 2 and 5 include reimbursement, like the other designs, but with up to 50% as cash. He said only Designs 4 and 5 include a coverage shared pool for spouses/domestic partners. He said Designs 1, 4, and 5 include full international portability, but Designs 2 and 3 only include partial international portability with a grade of 50% over five years.

Plotkin said that only Design 4 has no contribution cap, whereas the other designs have no contributions on income above $400,000. He said only Design 2 has no contributions or vesting credit if income is below $30,000, whereas the other designs have no contributions on the first $30,000 of income. He said Design 1 has no applicable private insurance coordination, whereas the other designs have an opt-out option for eligible private insurance purchased prior to the Program effective date and reduced contributions for eligible private insurance purchased after the Program effective date.

Plotkin explained the key cost drivers of the Program. He said the investment strategy includes a recommendation from the LTCITF that the Program funds be invested in bonds (excluding California municipal bonds), stocks, and other equities. He said it may be challenging to obtain the state constitutional amendment required for this investment strategy. He said the LTCITF recommends that the Program tax rate be split 50/50 between employees and employers, and he said it may be challenging to garner support for an employer-paid tax from the business community. He said the Preliminary Program tax rates are set to achieve a zero-ending Program fund balance in 2099 and said prolonged solvency requires additional upfront funding. Plotkin said estimated contribution rates are materially higher if these elements are altered.

Smith said some of the anticipated additional steps include conducting public outreach and education; determining coordination with private insurance; pursuing a federal demonstration waiver from CMS to allow the state to retain federal Medicaid savings; addressing LTSS workforce issues; and considering coverage options for current retirees.

Jennette said that this seems similar to what CMS proposed with the Community Living Assistance Services and Supports (CLASS) Act in the Affordable Care Act (ACA), which did not take off. She asked how this is different from what they proposed and what might be the minimum requirement for this being started and anticipating enrollment.

Moench said the CLASS Act was repealed because it was deemed invaluable due to the program's voluntary nature. She said the Program's five Designs are mandatory, and there would be no voluntary elements except in Design 5, where there is a voluntary option to opt up benefits if one is able to fully vest prior to retirement. She said the choice to keep the Program mandatory is a lesson learned from the CLASS Act and other programs where, if made voluntary, one would anticipate a high anti-selection or adverse selection, which can create a very large cost requirement.

Jennette asked if, since it is mandatory, any size employer group is required to participate in this program. Moench said there were elements of the five designs considering a small employer exemption, which was one of the sensitivities that were tested, but unless an individual, not an employer, was eligible to opt out via the purchase of eligible private insurance, then they would be required to participate in the payroll tax or self-employed income tax; therefore, those who are not employed are not enrolled. Other than those people, the enrollment would include everyone except those allotted that opt-out.

4. Heard a Presentation on the WA Cares Fund

Ben Veghte (WA Cares Fund) said the WA Cares Fund provides working Washingtonians a way to earn access to LTC benefits that will be available to eligible individuals when they need them. He said the Fund is an earned benefit, self-funded by worker contributions, and works like an insurance program. He said people only contribute while they are working, everyone is covered at the same rate regardless of pre-existing conditions, there are no copays, no deductibles, and claims never have to be filed. He said the typical income is $50,091, and the typical contribution is $291 per year.

Veghte said the Fund is the product of a 2019 law, the LTSS Trust Act, which, among other things, created the LTSS Trust Commission. He said the Commission's report reached a set of recommendations on the structuring of a supplemental private long-term care insurance (SPLTCI) market, organized into six areas: 1) consumer protection; 2) a venue for filing policies; 3) a benefit trigger and elimination period; 4) transition issues for near-retiree cohorts; 5) continuity of covered care settings and providers; and 6) coordination of benefits between the WA Cares Fund and SPLTCI policies.

Veghte highlighted three of the six areas. He said the goal of consumer protection is to ensure that consumers are aware of cost and benefit tradeoffs involved in choices around policy design features, particularly for a product that claims to supplement WA Cares Fund benefits. He said issues regarding filing venue could create barriers to market entry by private LTCI carriers, and the recommendation is that the state should endeavor to work through the logistical challenges for allowing "mix and match" to reach the agreed-upon goal of facilitating the development of a vibrant and competitive SPLTCI market.

Veghte said the challenges for a benefit trigger and elimination period are the potential gaps in coverage related to the benefit trigger and elimination period. He said the recommendations to tackle this challenge are that: 1) the SPLTCI deductible should be equal to the WA Cares Fund full maximum lifetime benefit, which starts at $36,500 and should be automatically adjusted for inflation; 2) the WA Cares Fund annual benefit inflation adjustment should be automatic, rather than an annual discretionary determination; and 3) carriers may not require that a client undergo a functional assessment or satisfy a benefit trigger in order to determine that an SPLTCI elimination period has begun or ended. He also highlighted that SPLTCI policies' elimination period may include, in addition to the monetary component—i.e., the deductible—a time component, such as three, six, nine, or 12 months, but not to exceed 12 months.

Veghte also said a new SPLTCI consumer guide, Statewide Health Insurance Benefits Advisors (SHIBA) counseling, and disclosures should support consumers in assessing tradeoffs between various elimination period options and price points and educate consumers about the importance of budgeting their WA Cares Fund benefits carefully to reduce the likelihood and size of a potential hole.

Lombardo asked whether, because the WA Cares Fund benefit identifies there should be a reduction in premium on the supplemental LTC policies, there is an estimate of what that reduction in premium is due to the WA Cares Fund. Veghte said he does not have an estimate, but the Commission discussed this. He said every carrier has its own actuarial analysis, so it would be up to the carrier to determine. He said the Commission did not do modeling on this, and perhaps it could have or should have, but he said he would bring that question back to the Commission.

Bonnie Burns (California Health Advocates—CHA) said she was appreciative of the presentations. She reminded the Task Force of the Feb. 19 letter from the NAIC Consumer Representatives asking it to explore proposals to create state programs to finance LTC and to monitor and regulate the current marketing and sales of insurance products to circumvent participation in state programs that do not yet exist.

Burns said the number of aged Americans is increasing at a rapid rate, and by 2032, every baby boomer in the U.S. will have reached the age of 65. She said in just two short years from now, baby boomers will begin to reach their 80s, a decade of life when the need for LTC often begins, and the future demand for LTC services is likely to have a profound impact on state budgets and state Medicaid programs. She said it is imperative that the NAIC seriously examine this issue.

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

SITF Spring Minutes - Phoenix

Attachment One

Draft: 3/6/24

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February 29, 2024

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5. Adopted its 2023 Fall National Meeting Minutes

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

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

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

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

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

that allow access through a state high-risk pool, to some with voluntary sales with health underwriting, to those states with no access to those under age 65.

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

Burns asked how the three states that require the same Medigap plans as age 65 with no change in premiums can do this. She asked what the Medigap experience is in those states in relation to premium costs, medical and claims experience, and loss-ratio experience. Burns asked how they compare to other states. She suggested the NAIC should collect data to inform states and policymakers. She said such data should include the impact of state rules on access to Medigap, Medigap rates, loss ratios, state high-risk pools, and the Medicare/Medicaid dual-eligible populations, both under and over age 65. She said the NAIC should also collect insurer data, including health underwriting in voluntary markets and pricing data.

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

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

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

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

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

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

AKF, this is especially important for dialysis patients. Darcy said that people who have kidney failure and only have a traditional Medicare Advantage plan without a secondary plan (with the secondary plan being a retirement or Medigap plan) will not be considered fully insured and will not be placed on the transplant waiting list. Therefore, being fully insured is very important.

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

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

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

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

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

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

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

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

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

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

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

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

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

