

Draft Pending Adoption

Draft: 8/17/22

Senior Issues (B) Task Force
Portland, Oregon
August 10, 2022

The Senior Issues (B) Task Force met in Portland, OR, Aug. 10, 2022. The following Task Force members participated: Marlene Caride, Chair (NJ); Jon Pike, Vice Chair, and Tomasz Serbinowski (UT); Lori K. Wing-Heier represented by Sarah Bailey (AK); Mark Fowler represented by Jennifer Li (AL); Ricardo Lara represented by Ahmad Kamil (CA); Andrew N. Mais represented by Paul Lombardo (CT); Karima M. Woods represented by Howard Liebers (DC); Trinidad Navarro represented by Frank Pyle (DE); David Altmaier represented by John Reilly (FL); Colin M. Hayashida represented by Kathleen Nakasone (HI); 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 Craig VanAalst (KS); Sharon P. Clark represented by Rob Roberts (KY); James J. Donelon represented by Ron Henderson (LA); Kathleen A. Birrane represented by James Williams (MD); Timothy N. Schott represented by Marti Hooper (ME); Anita G. Fox represented by Renee Campbell (MI); Grace Arnold represented by Julia Drier (MN); Chlora Lindley-Myers represented by Carrie Couch (MO); Mike Causey represented by Robert Croom (NC); Jon Godfread represented by Chrystal Bartuska (ND); Eric Dunning represented by Laura Arp (NE); Barbara D. Richardson represented by Jack Childress (NV); Judith L. French represented by Daniel Bradford (OH); Andrew R. Stolfi represented by Tricia Goldsmith (OR); Michael Humphreys (PA); Larry D. Deiter represented by Jill Kruger (SD); Carter Lawrence represented by Brian Hoffmeister (TN); Cassie Brown represented by Chris Herrick (TX); Scott A. White represented by Julie Blauvelt (VA); Kevin Gaffney represented by Pat Murray (VT); Mike Kreidler represented by Todd Dixon (WA); Nathan Houdek represented by Jennifer Stegall (WI); and Allan L. McVey represented by Erin K. Hunter (WV).

1. Adopted its June 7, May 11, and Spring National Meeting Minutes

The Task Force conducted an e-vote that concluded June 7 to adopt a letter to the federal Centers for Medicare & Medicaid Services (CMS) asking for assurances that there will be coordination between the CMS and the U.S. Social Security Administration (SSA) should the proposed rule to simplify Medicare enrollment and expand access be made final and implemented, and work with state insurance regulators to minimize any possible gaps in coverage for beneficiaries.

The Task Force met May 11 and examined the proposed rule promulgated by the CMS to simplify Medicare enrollment rules and agreed to send a letter asking for assurances that there will be coordination between the CMS and the SSA should the proposed rule to simplify Medicare enrollment and expand access be made final and implemented, and work with state insurance regulators to minimize any possible gaps in coverage for beneficiaries.

Mr. Lombardo made a motion, seconded by Mr. Croom, to adopt the Task Force's June 7 (Attachment One); May 11 (Attachment Two); and March 17 (*see NAIC Proceedings – Spring 2022, Senior Issues (B) Task Force*) minutes. The motion passed unanimously.

2. Heard a Presentation Regarding Medicare Part D and Auto-Enrollment

Harry Ting (Health Consumer Advocate) presented an issue that poses difficulties for State Health Insurance Assistance Program (SHIP) counselors and the harm inflicted on Medicare Part D enrollees. He said he is asking the Task Force to endorse some actions and contact the CMS regarding this problem.

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Dr. Ting said the situation arises when an insurer discontinues one of its Medicare prescription drug plans (PDPs) for the next calendar year and the beneficiary is then crosswalked to another of the insurer's PDPs. He said enrollees are notified via the Annual Notice of Change (ANOC) mailing in September, and in 2021, 3.2 million PDP enrollees were crosswalked into a different PDP for 2022.

Dr. Ting said many of these ANOCs are confused with junk mail and thrown out by the beneficiary. He said the same ANOC formats are sent out every year to all Medicare Part D enrollees, but the choice they are presented with is confusing, and the beneficiaries are not given proper guidance. He provided an example of a client being crosswalked from the Mutual of Omaha Rx Value Plan and thus being switched from one of the lowest cost plans in the beneficiary's area to one of the highest. He said the change in premium for this client went from \$22.20 a month to \$77.90 a month. He said it is not the fault of the insurance plan but rather a problem with the CMS' rules and regulations.

Dr. Ting said the ANOC tells beneficiaries to check the changes to the benefits and costs to see if they affect the beneficiary. He said this is difficult for many beneficiaries to do. For example, he said one client of his takes 43 different medications and drugs, and the ANOC tells the beneficiary to go to the online drug list if there are changes. He said the online drug list is a 45-page formulary for seniors to go through. He said the ANOC asks whether one's drugs are in a different tier with different cost sharing and points out that there are five tiers with 10 cost-sharing categories. He said the ANOC asks whether one's drugs have new restrictions, and it instructs seniors to call their insurer; if the senior can use the same pharmacy, the senior is instructed to go to a website or call to obtain a directory. He said there is no mention of Medicare or SHIP resources, and the section entitled "additional resources" tells seniors to call their insurer, which is not helpful when seeking unbiased and objective answers.

Dr. Ting said there are three changes the CMS can do to address this issue, and he asks that the NAIC act in contacting the CMS to implement these changes. He said the first change is for the CMS to notify crosswalked Medicare Part D enrollees directly so the ANOC letters are not confused as junk mail and the beneficiary has notice from the CMS about upcoming changes. He suggested a sample letter that the CMS could implement. He said the second change is to modify the ANOC template currently being used. He said additional language should be made available beyond the current standard language that this document is available in (e.g., Spanish, Braille, and large print). He suggested that the section start with advising beneficiaries to call their SHIP or the 800 Medicare number, as well as provide the Medicare.gov web page.

Dr. Ting said the first two suggestions can be done by the CMS through its current rules. He said the third suggestion is for the CMS to allow crosswalked Part D plan enrollees to switch Part D plans during the January through March period, the same as Medicare Advantage (MA) enrollees. He said he believes this can be implemented through the CMS' regulations, but if not, he would propose it as an amendment. He said he would like the Task Force and the NAIC to support the three suggestions and ask the CMS to modify its Medicare Part D ANOC template to include objective resources and tell the CMS to give crosswalked Medicare Part D drug plan enrollees the same protections as those in MA plans.

Mr. Lombardo asked Dr. Ting if he has reached out to the CMS and, if so, what response has he received, if any. Dr. Ting said he has reached out several times and has to date received no response. Ms. Seip asked if Dr. Ting has reached out to the SHIP offices and programs about this matter. Dr. Ting said he has spoken to many SHIPs as they are in some states better equipped to address the problems than departments of insurance (DOIs) and they are aware, but the work is on a case-by-case basis.

Commissioner Caride asked if a letter from the Task Force to the CMS to help get a response to Dr. Ting might be in order and asked if there was any objection. Mr. Henderson and Mr. Lombardo both agreed a letter is a good idea, at least to let the CMS know that state insurance regulators are aware of this matter. Mr. Dixon said a letter

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is a good idea and pointed out that many SHIP counselors are volunteers and, in most cases, cannot lobby or advocate to the CMS. Commissioner Caride asked David Torian (NAIC) to work with Dr. Ting to draft language.

3. Heard a Discussion About Medicare and COBRA

Bonnie Burns (California Health Advocates—CHA) said the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal law giving one the legal right to keep their employer's health benefits that might otherwise end due to job loss, divorce, or death. She said employers of a certain size are required to offer COBRA when one retires or leaves an employer, and this is the same health plan coverage one had while working. Yet federal health benefit payment rules that apply while one is working and eligible for Medicare are not the same after one stops working and is eligible for COBRA and Medicare at the same time.

Ms. Burns said CMS' recent rule establishing a new special enrollment period (SEP) for health plan or employer error provides relief in instances where individuals can demonstrate that their employer or health plan, or agent materially misrepresented information related to enrolling in Medicare timely. She said the benefits of this narrow SEP are: 1) it avoids waiting to enroll during the general enrollment period (GEP); 2) it avoids late enrollment penalty avoids gap in coverage; and 3) it provides Medigap guaranteed issue.

Ms. Burns said individuals would be required to provide the SSA or CMS evidence that shows what misinformation was initially provided by the employer, group health plan (GHP), or representative. She said those tasked with providing information and guidance—employers and their agents, including human resources (HR) firms and agents/brokers—often do not understand the complex rules involving Medicare and COBRA coverage and material misrepresentation is difficult to document and prove. She said most information about COBRA occurs in verbal conversations with HR or other representatives, and employers are unlikely to state misrepresentation in writing.

Ms. Burns provided as an example a 76-year-old client who left employment and signed up for Medicare Part A at age 65 but did not sign up for Part B as he was still working. She said the employer is large group health benefits consultant, the employer provided eight months free COBRA as part of his separation agreement, and he was provided a lot of verbal instruction. She said the COBRA carrier is large group health benefits company and paid the COBRA primary benefits, but at six months, the carrier discovered eligibility for Medicare but not enrolled for benefits. She said the client had large medical expenses, and the carrier sought recovery for \$80,000 of primary COBRA paid benefits.

Ms. Burns said COBRA is the same as primary health benefits as employed. She said the former employee pays 100% of premium plus an administrative fee. She said with or without Medicare benefits, Medicare Secondary Payer rules do not apply. She said COBRA is automatically secondary and added there is a disconnect between Social Security and Medicare.

Ms. Burns said the NAIC *Coordination of Benefits Model Regulation* (Model #120) exception pertaining to people who are eligible or who could be eligible for Medicare benefits is unfairly discriminatory. She said the NAIC should delete the exception for Medicare Part B in Model #120 as there is no rationale for this exception in the NAIC historical record, and it unfairly penalizes and discriminates against Medicare beneficiaries. She said the action specified in the exception, "is or could have been covered," produces a result that is expressly prohibited in the same subsection for any other form of health benefits. Ms. Burns recommended changes to parts of Section 5 of Model #120.

Commissioner Caride suggested that the Task Force hold an open meeting solely on this issue to discuss the matter further, and invite relevant stakeholders to help state insurance regulators decide if Model #120 should be opened and edited. Commissioner Pike asked if Ms. Burns knew how many states follow the model law and how

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widespread the problem is. Ms. Burns said she does not know how many states follow the model but that most states have their own regulation or laws on coordination of benefits. Ms. Blauvelt raised a similar issue involving the Affordable Care Act (ACA) small group plans, not COBRA, but that there are parallel similarities as it pertains to Model #120. She said she had inquired if other states have guidance or information regarding coordination of benefits with marketplace consumers of Medicare age who not enrolled in Medicare for either residency ineligibility (recently immigrated to the U.S.); insured to pay Part A premium; and/or eligible but not yet enrolled.

4. Disbanded the Long-Term Care Insurance Model Update (B) Subgroup

Commissioner Caride asked Mr. Torian to explain the situation. Mr. Torian said since the previous chair of the Subgroup had left in December 2021, a new chair has not been found. He said in that time, there has been only one inquiry into the status of the Subgroup. He said the anticipated work from the Long-Term Care Insurance Reduced Benefits Options (EX) Subgroup never materialized, and that Subgroup is not disbanded. He pointed out that the charge of the Long-Term Care Insurance Model Update (B) Subgroup is to determine whether the *Long-Term Care Insurance Model Act (#640)* and the *Long-Term Care Insurance Model Regulation (#641)* retain their flexibility to remain compatible with the evolving delivery of long-term care (LTC) services and the evolving long-term care insurance (LTCI) marketplace. He said it appears by the lack of interest in the status of the Subgroup that there may be a feeling that the models do retain their flexibility to be compatible with the evolving delivery of LTC services and the evolving LTCI marketplace, and the purpose of this agenda item is for the Task Force to discuss the future of the Subgroup and whether it should be repurposed or disbanded.

Mr. Lombardo said he thinks that the lack of inquiry into the status of the Subgroup leads towards disbanding the Subgroup and that he would support that move. Ms. Arp said that the models do work and that the work of the Subgroup did not make much of an impact. Mr. Serbinowski said the Subgroup did a lot of work, and it should not end in this manner without some wrap-up or summary of the work done. He said the Subgroup did go section by section through Model #640 and part of Model #641 and offered some good suggestions to address products and changes in the marketplace that are not reflected in the model, such as hybrid products and revision issues. Ms. Burns agreed with Mr. Serbinowski.

Commissioner Caride agreed the work of the Subgroup should not be dismissed so easily but asked the Task Force what should be done.

Mr. Lombardo made a motion, seconded by Mr. Hoffmeister, to disband the Long-Term Care Insurance Model Update (B) Subgroup. The motion passed.

5. Discussed Any Other Matters

Commissioner Caride informed the Task Force that the previous night, she received a response from the CMS to the March 17 letter sent by the Task Force seeking guidance from the CMS on the issue of the treatment of nonparticipating durable medical equipment (DME) suppliers under Medicare's "Limitation on Beneficiary Liability." She said the CMS response was sent out to Task Force members, interested state insurance regulators, and interested parties, and it has been posted on the Task Force's web page.

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

[SharePoint/NAIC Support Staff Hub/Member Meetings/B CMTE/SITF](#)

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Attachment One

Draft: 6/21/22

Senior Issues (B) Task Force
E-Vote
June 7, 2022

The Senior Issues (B) Task Force conducted an e-vote that concluded June 7, 2022. The following Committee members participated: Marlene Caride, Chair (NJ); Jon Pike, Vice Chair (UT); Lori K. Wing-Heier (AK); Jim L. Ridling (AL); Alan McClain (AR); Peni Itula Sapini Teo (AS); Ricardo Lara (CA); Michael Conway (CO); Andrew N. Mais (CT); Trinidad Navarro (DE); David Altmaier (FL); John F. King (GA); Doug Ommen (IA); Dean L. Cameron (ID); Amy L. Beard (IN); Vicki Schmidt (KS); James L. Donelon (LA); Gary D. Anderson (MA); Kathleen A. Berrane (MD); Timothy N. Schott (ME); Anita G. Fox (MI); Grace Arnold (MN); Chlora Lindley-Myers (MO); Troy Downing (MT); Mike Causey (NC); Jon Godfread (ND); Eric Dunning (NE); Barbara D. Richardson (NV); Judith L. French (OH); Glen Mulready (OK); Michael Humphreys (PA); Carter Lawrence (TN); Cassie Brown (TX); Scott A. White (VA); Kevin Gaffney (VT); Mike Kreidler (WA); Nathan Houdek (WI); and Allan L. McVey (WV).

1. Adopted a Letter Asking the CMS to Coordinate on its Proposed Rule and Mitigate Possible Gaps in Coverage

The Task Force conducted an e-vote to: 1) consider adoption of a letter to the federal Centers for Medicare & Medicaid Services (CMS) asking for assurances that there will be coordination between the CMS and the U.S. Social Security Administration (SSA) should the proposed rule to simplify Medicare enrollment and expand access be made final and implemented; and 2) work with state insurance regulators to minimize any possible gaps in coverage for beneficiaries.

Without objection, the Task Force adopted the comment letter by a vote of 37 to 1. (Attachment One-A)

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

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Attachment One-A

June 8, 2022

Hon. Chiquita Brooks-LaSure - Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Administrator Brooks-LaSure:

The National Association of Insurance Commissioners (NAIC), the standard setting organization representing the chief insurance regulators in the 50 states, the District of Columbia, and the United States territories, is writing to you regarding the CMS proposed rule to simplify Medicare enrollment and expand access (**CMS-4199-P**). We applaud the proposed rule and CMS' attempt to simplify the Medicare enrollment process. However, as state insurance regulators, we do have concerns about possible and potential gaps in coverage for beneficiaries.

The new special enrollment periods (SEPs) are good and we are pleased to see CMS recognized the need for an SEP to coordinate with the termination of Medicaid coverage that would allow individuals to enroll after termination of Medicaid eligibility. But beneficiaries trying to get a Medicare Supplement (Medigap) plan may experience gaps in coverage while they try to come up with documentation of their dates of Medicare eligibility and try to coordinate with an application for Medigap, or to join a Medicare Advantage (MA) plan. Since the Social Security Administration (SSA) is in charge of eligibility, we hope there will be coordination between CMS and SSA to minimize the possibility of creating gaps in coverage for Medigap or MA plans and to address the delays of beneficiaries receiving their Medicare cards.

We were pleased with the discussions NAIC staff had with CMS and SSA regarding the inquiry made last year about delay issues of beneficiaries receiving their Medicare cards. As you are aware, the initial application for cards starts with the SSA, not CMS. Both CMS and SSA explained that under the current process SSA mails out (usually initiated by a phone call) the application and receives and processes the application then sends to CMS to send the Medicare card to the enrollee. Because SSA field offices were closed due to the pandemic, almost all applications were being mailed to seniors, then they were required to mail the application and supporting materials back to SSA.

CMS and SSA told NAIC staff they have found that serious mail delays (3-4 weeks for each mailing) have resulted in significant delays in the final application being received by SSA. Once a complete application is received by SSA, it usually takes about 24 hours for the information to be forwarded to CMS (through daily data dumps) and then CMS mails the card within a day, but mail delivery problems have caused most of the delay problems. CMS and SSA told NAIC staff they have identified some issues on their ends that have delayed the review and approval of applications and transferring to CMS for final action, and they are working to address these issues.

We would like assurances that there will be coordination between CMS and SSA should this proposed rule be made final and implemented and that Federal agencies will work with state insurance regulators to minimize any possible gaps in coverage for beneficiaries.

Sincerely,

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Attachment Two

Draft: 5/18/22

Senior Issues (B) Task Force
Virtual Meeting
May 11, 2022

The Senior Issues (B) Task Force met May 11, 2022. The following Task Force members participated: Marlene Caride, Chair, represented by Chanell McDevitt; Jon Pike, Vice Chair (UT); Lori K. Wing-Heier represented by Mayumi Gabor (AK); Jim L. Ridling represented by William Rodgers (AL); Alan McClain represented by Jimmy Harris (AR); Ricardo Lara represented by Tyler McKinney (CA); Michael Conway represented by Peg Brown (CO); Andrew N. Mais represented by Paul Lombardo (CT); Trinidad Navarro represented by Susan Jennette (DE); David Altmaier represented by Chris Struk (FL); Colin M. Hayashida represented by Kathleen Nakasone (HI); Doug Ommen represented by Andria Seip (IA); Dean L. Cameron represented by Shannon Hohl (ID); Amy L. Beard represented by Mary Ann Williams (IN); Vicki Schmidt represented by Craig VanAalst (KS); Sharon P. Clark represented by Stephanie McGaughey-Bowker (KY); James J. Donelon represented by Ron Henderson (LA); Gary D. Anderson represented by Rebecca Butler (MA); Kathleen A. Birrane represented by Fern Thomas (MD); Timothy N. Schott represented by Marti Hooper (ME); Anita G. Fox represented by Renee Campbell (MI); Grace Arnold represented by Julia Dreier (MN); Chlora Lindley-Myers represented by Cynthia Amann (MO); Mike Causey represented by Ted Hamby (NC); Jon Godfread represented by Yuri Venjohn (ND); Eric Dunning represented by Laura Arp (NE); Barbara D. Richardson represented by Jack Childress (NV); Judith L. French represented by Laura Miller (OH); Glen Mulready (OK); Michael Humphreys represented by Michael Gurgiolo (PA); Larry D. Deiter represented by Lisa Harmon (SD); Carter Lawrence represented by Vickie Trice (TN); Cassie Brown represented by Rachel Bowden (TX); Scott A. White represented by Bob Grissom (VA); Michael S. Pieciak represented by Mary Block (VT); Mike Kreidler represented by Molly Nollette (WA); Nathan Houdek represented by Jennifer Stegall (WI); and Allan L. McVey represented by Samantha Chase (WV). Also participating were: Eric Anderson (IL); Chris Nicolopoulos (NH); Bogdanka Kurahovic (NM); Sarah Allen (NY); Patrick Smock (RI); Tomasz Serbinowski (UT); and Mavis Earnshaw (WY).

1. Discussed the CMS' Proposed Rule on Medicare Part B Enrollment

Commissioner Pike said the purpose of this Task Force meeting is to examine the proposed rule promulgated by the Centers for Medicare & Medicaid Services (CMS) to simplify Medicare enrollment rules and whether there is an impact on Medicare supplement and guaranteed issue (GI). Commissioner Pike asked William Schiffbauer (Schiffbauer Law Offices) to explain the summary he prepared and shared with the Task Force.

Mr. Schiffbauer said the proposed rule includes changes with respect to: 1) Part B enrollment simplification and new Special Enrollment Periods (SEPs); 2) extended Part B coverage limited to immunosuppressive drugs for certain end-stage renal disease (ESRD) beneficiaries; 3) simplification changes to Medicare enrollment forms; and 4) Medicaid state buy-in of Medicare premiums. He said of interest to Medigap carriers and beneficiaries are proposals relating to: 1) "simplifying" changes to Part B enrollment with respect to the effective dates for Part B entitlement; and 2) new Part B SEPs for "exceptional conditions."

Mr. Schiffbauer said the statutory amendments did not change the open enrollment and GI requirements applicable to Medigap health insurance. He said the SEPs in the proposed rule affect the Medigap GI provision and that current laws are maintained with respect to Medigap open enrollment. He said the proposed rule creates some uniformity for Medicare enrollment timing, making it bit more consistent, and that current federal and state laws remain in place and unaffected by the proposed rule.

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Bonnie Burns (California Health Advocates—CHA) asked Mr. Schiffbauer if any those GI events under the new SEPs create a problem to access Medigap. Mr. Schiffbauer said no. He said the new SEPs in the proposed rule all are entries into Medicare, so once one is enrolled in Part B, it would trigger their Medigap open enrollment. He said all of the same GI provisions for Medigap remain the same. Ms. Burns asked if it is the case where a person who exercises an SEP and is 65 years of age or older is the only person who would have access to Medigap. Mr. Schiffbauer said that is dependent on state law, so if state law provides access to open enrollment or GI to those under 65, that state law remains in place, and this proposed rule does not change that. He said everything current regarding Medigap open enrollment and Medigap GI remains the same. He said this proposed rule would begin entitlement to Medicare Part B a little earlier as there has been for some a couple months delay depending on when the person signed up for their initial or general open enrollment for Medicare. He said the proposed rule moves the start date into a more uniform setting across the board.

Ms. Burns said that raises another issue because the time frame for a person to apply and to get Medigap is shortened and that can create a doughnut hole for benefits between the time a person is eligible for Medicare and when Medicare begins and the time the person is actually issued coverage under Medigap that has a different effective date. Mr. Schiffbauer said it is a matter of what evidence Medigap requires today to demonstrate that a person is enrolled in Medicare Part B, which remains the same, and so CMS will have to move faster in getting the enrollment cards or the evidence of enrollment to the beneficiaries within that time frame.

Ms. Burns said therein lies the problem as those cards come out of the Social Security Administration (SSA) and not CMS, and it is well-known the delay problem SSA is encountering with Medicare cards, so this could exacerbate the problem. She said she could envision greater problems for Medicare beneficiaries in proving that they are eligible for Medicare and in getting an effective date for Medigap that is going to coordinate with Medicare.

Mr. Schiffbauer said where CMS is seeking comments from the beneficiary community is on the new SEP and employer information and what is the burden on the beneficiary in getting the needed evidence from the employer to show that they are eligible to enroll in Medicare now. Ms. Burns said this is a place for the NAIC to weigh in and comment on behalf of consumers, as well as the timing issue for getting Medigap under this proposed rule.

Commissioner Pike asked Ms. Burns if SSA were able to address the Medicare enrollment card issue and found a way to get the cards out in a timely fashion, would this rule still be troublesome. Ms. Burns said the proof of eligibility is very important, and the gap that could occur between the time a person is eligible for Medicare and when Medicare begins and the time the person is actually issued coverage under Medigap is of concern. She said she is glad CMS has broad authority regarding the SEPs. Mr. Schiffbauer said CMS has the authority, which is statutory, and has said that if someone does not fall within the specific SEPs, then CMS will consider that person's circumstances on a case-by-case basis and that authority of CMS does not prevent CMS from coming up with other SEPs in the future.

Harry Ting (Health Consumer Advocate) said he is an NAIC consumer representative and State Health Insurance Assistance Program (SHIP) counselor. He said the overall changes in the proposed rule are excellent. He pointed out that the proposed rule would extend coverage for immunosuppressive drugs for people who had kidney transplants and were on ESRD coverage under Medicare for dialysis, which Medicare Part B only covers for 36 months; this new rule would extend coverage indefinitely.

Dr. Ting said there is one area of the proposed rule that he has concerns about, which Mr. Schiffbauer raised earlier, and that is where there is employer misrepresentation on providing information about enrolling in Medicare Part B. He said the proposed rule would create an SEP to allow an individual who can demonstrate that they were misinformed by their employer about enrolling in Medicare Part B, and he cited himself as an example

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of being told to choose Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) coverage and to continue under his employer's plan. He said although it initially sounded reasonable when he did research, it was clear that COBRA was much more expensive than getting coverage under Medicare and then getting Medigap and a drug plan. He said most people do not know this or know how to research this, and they rely on the information their employer's human resources (HR) department provides. He said the problem with this SEP is that in order to qualify, the person has to demonstrate that their employer sent them information in writing that gave false or bad information, and that information influenced their delay in enrolling in Medicare Part B. He said most information and guidance from HR departments are verbal, as was in his case, and there would be no written misinformation to provide as evidence. He said the rule should allow for a person who is enrolled in COBRA to be allowed to get into this new SEP until their COBRA expires.

Commissioner Pike asked if any regulators have any questions especially as it may relate to state laws. Ms. Hohl said the proposed rule is a good starting point and perhaps taking a look at the *Coordination of Benefits Model Regulation (Model #120)* may not be a bad idea although that is not the issue currently. She said her concern is that there is no mention of SSA in the proposed rule and how SSA will implement this proposed rule. She said she has seen issues with Idaho SHIP offices and their difficulties to work with SSA, which is the gate keeper for Part B enrollment. She said the SHIP offices see problems where beneficiaries seek equitable relief, which is separate topic, but that there are great challenges in working with the SSA. She said often times CMS is not really involved in the conversation, and it is just the beneficiary and the SSA. She said if the Task Force decides to comment, it may want to consider ask CMS: 1) what guidance will be provided to SSA; 2) where does a beneficiary go if they cannot work with SSA; or 3) how to appeal a decision. She said SSA tends to have a lot of authority in these decisions.

Ms. Burns said she would ask and encourage the NAIC to comment on the proposed rule on behalf of beneficiaries and consumers.

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