Draft Pending Adoption

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Senior Issues (B) Task Force
Dallas, Texas
November 15, 2026

The Senior Issues (B) Task Force met in Dallas, TX, Nov. 15, 2026. The following Task Force members participated: Ned Gaines, Chair (NV); Jon Godfread represented by Chrystal Bartuska, Vice Chair (ND); Heather Carpenter represented by Sarah Bailey (AK); Mark Fowler represented by Dusty Smith (AL); Ricardo Lara represented by Ahmad Kamil (CA); Joshua Hershman represented by Tricia Davé (CT); Trinidad Navarro represented by Jessica R. Luff (DE); Michael Yaworsky represented by Alexis Bakofsky (FL); Scott Saiki represented by Kathleen Nakasone (HI); Dean L. Cameron and Shannon Hohl (ID); Ann Gillespie represented by Chris Heisler (IL); Holly W. Lambert represented by Alex Peck (IN); Vicki Schmidt represented by Craig Van Aalst (KS); Sharon P. Clark represented by Stephanie Bowker (KY); Timothy J. Temple represented by Charles Hansberry (LA); Marie Grant represented by Patricia Dorn (MD); Anita G. Fox represented by Julie Merriman (MI); Julia Dreier represented by T.J. Patton (MN); Angela L. Nelson represented by Jeana Thomas (MO); Mike Chaney represented by John Hornback (MS); Mike Causey represented by David Yetter (NC); Eric Dunning represented by Maggie Reinert and Martin Swanson (NE); D.J. Bettencourt represented by Michelle Heaton (NH); Susan Ochs represented by Michael Fahncke (NJ); Judith L. French represented by Kristin Cly (OH); TK Keen represented by Jesse O'Brien (OR); Michael Humphreys (PA); Suzette M. Del Valle (PR); Larry D. Deiter represented by Jill Kruger (SD); Amanda Crawford represented by Rachel Bowden (TX); Jon Pike represented by Tanji J. Northrup (UT); Scott A. White represented by Julie Blauvelt (VA); Kaj Samsom represented by Karla Nuissl (VT); Patty Kuderer represented by Andrew Davis (WA); Nathan Houdek represented by Darcy Paskey (WI); and Erin K. Hunter represented by Joylynn Fix (WV).

1. Adopted its Oct. 8 Minutes

The Task Force met Oct. 8. During this meeting, the Task Force adopted its 2027 proposed charges.

Kruger made a motion, seconded by Van Aalst, to adopt the Task Force's Oct. 8 minutes (Attachment One). The motion passed unanimously.

2. Discussed Various CMS Matters

Jerry Mulcahy (Centers for Medicare & Medicaid Services—CMS) said he is retiring effective Jan. 20, 2027, and introduced Acting Director of the Medicare Enrollment and Appeals Group Jennifer Smith as the incoming executive liaison to the NAIC for Medicare Advantage (MA) issues. He said Smith will assume contact responsibilities in January, and her portfolio alignment will cover critical NAIC work, including Medicare supplement insurance (Medigap) policy and enrollment operations, such as Special Election Periods (SEPs). He said the agency will determine a permanent replacement at a later date. He turned to Erin Sutton (CMS) to present data regarding current capacity limits.

Sutton said 16 parent organizations have submitted requests for enrollment caps, affecting 65 Plan Benefit Package (PBP) levels across 11 states: Arizona, Hawaii, Maine, Maryland, Massachusetts, Minnesota, Nebraska, New Jersey, New York, North Carolina, and Wisconsin. She said as of Nov. 12, 12 PBPs have officially met their caps and shut off enrollment. Regarding enrollment rules, she stated that plans cannot maintain waiting lists and must deny requests once capacity is reached. Requests are processed strictly in chronological order (i.e., no health-related discrimination). She said if an enrolled plan exceeds capacity during the Annual Enrollment Period (AEP), it cannot accept enrollments for 2027 but must continue processing 2026 SEP enrollments.

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Sutton said the Medicare Plan Finder will not explicitly state that capacity is met. Instead, it will disable the "Enroll" button and display the message "Contact plan to enroll." If plan capacity drops below the cap later, enrollment on the Plan Finder will reopen. She said plans are expected to use standard language to explain the cap to beneficiaries and are encouraged to update their websites promptly. Teams are actively communicating updates via state department of insurance (DOI) liaisons when caps are reached.

Reinert said Nebraska's State Health Insurance Assistance Program (SHIP) counselors have expressed frustration regarding the Plan Finder's inability to identify prescription drug plans for beneficiaries in long-term care (LTC) facilities and asked about the timeline for introducing this feature.

Mulcahy said he received this question from Swanson and confirmed that the Plan Finder tool does not currently collect data for or explicitly include LTC pharmacies. He said any LTC pharmacy that currently appears in the tool only shows up because it coincidentally also provides standard retail pharmacy services and the tool is on the list for a data-collection upgrade targeted for next year's AEP so LTC pharmacies can be separately identified. He said that in the meantime, a national team of pharmacists is available to provide phone counseling and explain the technical aspects of LTC pharmacy services.

Director Cameron said he is concerned about seniors' ability to access MA plans, specifically in areas where enrollment caps or capitation allowances might limit coverage options. He said he acknowledges the difficulty insurance carriers face in predicting enrollment, but there is a growing issue in his state where the number of counties with zero MA plan options has recently risen from one to around six. He asked if any analysis has been conducted to identify regions across the country where these financial and enrollment constraints are creating "deserts" or severe gaps in MA coverage for seniors.

Mulcahy said the ability for MA plans to request enrollment capacity limits has existed since the program's inception and was last utilized around the year 2000 during a market contraction to prevent remaining plans from being overwhelmed by members transferring from exiting plans. He said that last fall, market exits and changes to broker compensation led many organizations to request off-cycle capacity limits due to fear of an enrollment surge, and all off-cycle requests were denied because plans must legally request limits during the annual spring bid cycle. Additionally, no plan could prove an immediate, non-speculative threat to health and safety.

Mulcahy said currently plans are instructed to file capacity limit requests alongside their bids in June, and the agency currently lacks strict statutory or regulatory authority to set approval criteria or deny reasonable requests, relying instead on a "common sense" rule that limits cannot be lower than current enrollment. He said about 16 organizations requested limits as a defensive mechanism against potential market floods, despite not yet knowing their competitors' plans or bids.

Mulcahy said capacity limits restrict consumer choices in markets where options are already limited, but they protect enrollees from the poor customer service, overwhelmed provider networks, and appointment shortages that occur when a plan grows too fast. He said the agency is currently exploring options to define parameters around capacity limits in upcoming regulatory vehicles and encourages public feedback when a proposed rule is released.

Director Cameron said there is a trend of MA carriers contracting and pulling back from the market, which causes carriers to adopt strategies to avoid marketing plans, ultimately harming senior citizens. He asked if the current administration has a specific strategy to encourage more MA plans and carriers to participate in the market rather than shrink. He also asked what specific actions or strategies state governments should consider implementing to help manage this shared responsibility and stabilize the MA market.

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Mulcahy said he is a career person, not an appointed official, and cannot speak to the administration's strategy. He did, however, say the administration views MA as a priority, utilizing available rate-setting levers and actively engaging with sponsors to encourage program growth and participation. He said while formal state oversight is preempted, states can still actively court insurance organizations—leveraging existing commercial relationships—to encourage them to apply for local licenses and expand into their marketplaces. He said building provider networks remains a major hurdle for MA organizations due to strict non-interference provisions that prevent government meddling in plan-provider contracts, and mediating communication between the conflicting viewpoints of providers and health plans could help identify and resolve underlying contracting barriers.

Bartuska said CMS is in the MA space and the states are in the Medigap space, which should be acknowledged as a fact. She said she is concerned that regulatory changes and enrollment caps in the MA space will shift a large influx of seniors into the Medigap market because restricting the MA market simply moves the responsibility and financial risk from CMS over to state-level regulators. She said the sudden influx of enrollees into Medigap could create solvency concerns for carriers operating in that space, and, ultimately, this shift between "buckets" directly impacts seniors. She said she does not want CMS to lose sight of these consequences in its efforts to protect consumers and companies.

Mulcahy said he brought Smith to facilitate a handoff, as the federal perspective on medical operations falls under her responsibility. He asked the Task Force to share updates, concerns, and impacts regarding specific states, geographic locations, or plan areas so they can stay informed as the transition evolves. Sutton said she appreciated the Task Force's perspective regarding the overlap between the MA and Marketplace insurance segments. She said because CMS monitors companies operating across both markets, it is important to maintain a broad, big-picture view to effectively evaluate these companies' overall operational health, customer service capabilities, and financial solvency.

Swanson said regulatory changes to MA are putting a financial squeeze on seniors, and as seniors transition to the submarket, insurance carriers need consistent, predictable rules to properly rate risk, allowing department actuaries to adequately review and approve or deny rate filings. He said local markets, such as those in Nebraska, are experiencing a massive influx of seniors entering the MA or Medigap space. He said these seniors are highly confused and worried about recently implemented caps, pushing counseling appointment schedules far over capacity.

Swanson said while communication between the NAIC and federal officials has been strong and helpful, SHIPs on the frontline are not receiving timely answers from the Administration for Community Living (ACL), and because SHIPs see market problems first, he requested that federal representatives take a message back to their group to distribute information to these frontline programs much quicker.

Sutton said CMS meets with ACL and SHIP directors once or twice a week to discuss enrollment caps and technical issues, and CMS handles notifications directly with DOIs, SHIPs, and corporate entities. She said that individual insurance plans cannot serve as the "source of truth" for cap updates; changes must go through the official CMS validation process to avoid confusion, and the presentation slides regarding updates on plans hitting their caps have already been shared with all SHIP directors and are consistently updated through the ACL leadership of Melissa Simpson and Rebecca Kinney. Sutton said SHIPs and state officials have multiple escalation pathways for assistance if they experience long waiting lists, including their designated DOI liaisons, the 1-800 line, the Medicare customer solutions team, and direct access to CMS executives.

Commissioner Gaines thanked Mulcahy for previous assistance in Nevada and asked for clarification on how the regulatory review process handles network adequacy when a health insurance carrier terminates large groups of providers, especially given Nevada's existing severe doctor shortage.

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Mulcahy said the statute requires plans to maintain a sufficient number of providers based on local geographic areas and established care patterns. He added that regular reviews occur during the initial application and every three years, with ad hoc reviews triggered by complaints. He said if a plan network falls short, it must arrange for the beneficiary to see an out-of-network provider, and the plan must pay the provider the standard Medicare rate, while the patient only pays the standard in-network cost-sharing amount. Mulcahy said while this safeguard exists on paper and is communicated to plans during deficiency reviews, there is a lack of real-world evidence showing that plans actually enforce it. He said regulatory teams are working to bridge this gap by implementing stricter monitoring and requiring concrete evidence from plans to ensure beneficiaries are actually receiving this out-of-network care at the proper cost.

Sutton said CMS actively monitors network adequacy complaints and takes direct enforcement action against non-compliant plans. She added that when network adequacy issues are reported, CMS analyzes the situation through specialized teams and immediately communicates concerns to the plan. She said if the issue is not resolved after this analysis, and after ensuring the SEP and mandatory member communications are handled, CMS elevates its response. She said enforcement actions scale from initial notices of non-compliance up to formal warning letters, which are publicly listed on the CMS website.

Commissioner Gaines congratulated Mulcahy on his retirement and thanked him and Sutton for improving communication between the NAIC and CMS. He said the level of responsiveness and direct access is "night and day" compared to the past and greatly appreciates being able to get direct answers without being passed around to multiple people.

3. Discussed Next Steps Regarding LTC Riders to Life and Annuity Products

Commissioner Gaines said he wanted to kick off the discussion addressing state-by-state inconsistencies in life insurance and LTC regulations. He highlighted two main areas for feedback: standardizing consumer definitions by establishing clear, consistent definitions in consumer-facing materials to help buyers distinguish between a life insurance policy with an actual LTC rider and one with only accelerated death benefits; and managing LTC rate increases by evaluating the long-term impact (10–20 years out) of inconsistent state approval rules for rate increases, aiming to avoid the market challenges seen with traditional LTC policies.

Van Aalst said he agreed regarding future risks and noted that Kansas is currently deciding how to handle extension of benefit riders, aiming to avoid repeating past pricing mistakes over the next 10 to 20 years. Commissioner Gaines said the Task Force should consider beginning with definitions.

Yetter said while individual insurance products are regulated consistently through the Interstate Insurance Product Regulation Commission (Compact), group insurance forms vary widely in quality and lack uniform standards across states. He said states currently take very different approaches; some enforce strict rules, while others defer to how a judge might interpret the policies, which can leave consumer protections up to the courts. He said he spoke with Karen Schutter (Compact) and suggested creating Compact standards specifically for group LTC, extension of benefit riders, and restoration of benefits riders. He said establishing these uniform standards could resolve inconsistencies and address regulatory concerns, though he presented it strictly as an idea for group discussion.

Hohl said the Task Force is a great forum to have a discussion, but there are other groups at the NAIC that may be more appropriate to dive into the functionality of the NAIC's policies on these types of products. She said the Task Force should possibly involve NAIC leadership and/or the Life Insurance and Annuities (A) Committee. She said the Task Force may want to create a small working group involving various individuals, including policy experts

and actuaries, to talk through what these products are, best practices, what concerns that states might have, and where do we see this going.

Fix said she agreed with Hohl and liked the idea of Compact standards. She said it would be far more efficient and quicker than any consideration of reviewing the models. She said Compact standards would align everyone and deliver help to people much faster. She said it is important to first define the core approach, then apply it through Compact standards.

Commissioner Gaines asked if Task Force members are open to a short-lived working group under the Task Force to come up with some suggestions so there is a clear path of how to move forward.

Nakasone said she supports forming a smaller working group to clarify how states use existing laws to review LTC riders and allowing the Task Force to decide later whether to adopt their findings. Yetter said he agreed.

Hohl made a motion, seconded by Nakasone, to create a small, short-lived working group to come up with definitions and recommendations on the LTC riders issue and how to proceed. The motion passed unanimously.

Bonnie Burns (California Health Advocates—CHA) said she is very concerned about the lack of standardized regulations for life and annuity product riders, particularly contingent benefit riders sold as alternatives to LTC insurance. She said buyers frequently do not understand the hidden future costs, potential premium increases, or the exact amount of care these riders will actually fund, and there is vast variation in how different states review, classify (as life or health), and approve these complex financial products. Burns said with 20% of the U.S. population soon reaching age 65 and older, the lack of product standards risks leaving millions of aging citizens underfunded for medical care in 20 years. She said she supports the creation of a working group to investigate the market, establish uniform standards, and protect consumers.

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

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