NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Date: 2/5/24

Virtual Meeting

SENIOR ISSUES (B) TASK FORCE
Thursday, February 29, 2024
3:00 – 4:00 p.m. ET / 2:00 – 3:00 p.m. CT / 1:00 – 2:00 p.m. MT / 12:00 – 1:00 p.m. PT

ROLL CALL

Scott Kipper, Chair	Nevada	Chlora Lindley-Myers	Missouri
Peni Itula Sapini Teo, Vice Chair	American Samoa	Eric Dunning	Nebraska
		D.J. Bettencourt	New Hampshire
Mark Fowler	Alabama	Justin Zimmerman	New Jersey
Lori K. Wing-Heier	Alaska	Alice T. Kane	New Mexico
Ricardo Lara	California	Mike Causey	North Carolina
Andrew N. Mais	Connecticut	Jon Godfread	North Dakota
Trinidad Navarro	Delaware	Judith L. French	Ohio
Karima M. Woods	District of Columbia	Glen Mulready	Oklahoma
Michael Yaworsky	Florida	Andrew R. Stolfi	Oregon
Dean L. Cameron	Idaho	Michael Humphreys	Pennsylvania
Amy L. Beard	Indiana	Alexander S. Adams Vega	Puerto Rico
Doug Ommen	Iowa	Larry D. Deiter	South Dakota
Vicki Schmidt	Kansas	Carter Lawrence	Tennessee
Sharon P. Clark	Kentucky	Cassie Brown	Texas
Timothy J. Temple	Louisiana	Tregenza A. Roach	U.S. Virgin Islands
Timothy N. Schott	Maine	Jon Pike	Utah
Kathleen A. Birrane	Maryland	Kevin Gaffney	Vermont
Gary D. Anderson	Massachusetts	Scott A. White	Virginia
Anita G. Fox	Michigan	Mike Kreidler	Washington
Grace Arnold	Minnesota	Allan L. McVey	West Virginia
Mike Chaney	Mississippi	Nathan Houdek	Wisconsin

NAIC Support Staff: David Torian

AGENDA

1. Consider Adoption of its 2023 Fall National Meeting Minutes — Attachment A
   —Commissioner Scott Kipper (NV)

2. Hear a Presentation on Access to Medigap Coverage and Challenges for the Under and Over Age 65—*Bonnie Burns (California Health Advocates—CHA), Deborah Darcy (American Kidney Fund—AKF), Silvia Yee (Disability Rights Education & Defense Fund—DREDF) and Kara Nett Hinkley (The ALS Association)*

3. Discuss Any Other Matters Brought Before the Task Force
   —*Commissioner Scott Kipper (NV)*

4. Adjournment

Attachment A

Draft: 12/11/23

Senior Issues (B) Task Force
Orlando, Florida
December 1, 2023

The Senior Issues (B) Task Force met in Orlando, FL, Dec. 1, 2023. The following Task Force members participated: Barbara D. Richardson, Chair (AZ); Larry D. Deiter, Vice Chair (SD); Lori K. Wing-Heier represented by Sarah Bailey (AK); Ricardo Lara represented by Tyler McKinney (CA); Andrew N. Mais represented by Paul Lombardo (CT); Trinidad Navarro represented by Susan Jennette (DE); Doug Ommen represented by Andria Seip (IA); Dean L. Cameron represented by Shannon Hohl (ID); Amy L. Beard represented by Scott Shover (IN); Vicki Schmidt and Craig VanAalst (KS); Sharon P. Clark represented by Shawn Boggs (KY); James J. Donelon represented by Ron Henderson (LA); Gary D. Anderson represented by Kevin Beagan (MA); Kathleen A. Birrane represented by Mary Kwei (MD); Timothy N. Schott (ME); Anita G. Fox represented by Renee Campbell (MI); Chlora Lindley-Myers represented by Carrie Couch (MO); Mike Chaney (MS); Mike Causey represented by Ted Hamby (NC); Jon Godfread represented by Chrystal Bartuska (ND); D.J. Bettencourt and Jennifer Li (NH); Scott Kipper (NV); Judith L. French represented by Tynesia Dorsey (OH); Michael Humphreys represented by Shannen Logue (PA); Carter Lawrence represented by Scott McAnally (TN); Jon Pike represented by Shelley Wiseman (UT); Scott A. White represented by Julie Blauvelt (VA); Kevin Gaffney represented by Mary Block (VT); Mike Kreidler (WA); Nathan Houdek represented by Jennifer Stegall (WI); and Allan L. McVey represented by Joylynn Fix (WV).

1. Adopted its Oct. 30 and Summer National Meeting Minutes

The Task Force met Oct. 30 to adopt its 2024 proposed charges.

Commissioner Kreidler made a motion, seconded by Lombardo, to adopt the Task Force's Oct. 30 (Attachment One) and Aug. 14 (*see NAIC Proceedings – Summer 2023, Senior Issues (B) Task Force*) minutes. The motion passed unanimously.

2. Posed Questions to Representatives from CMS

Ashley Hashem (Centers for Medicare & Medicaid Services—CMS) took questions from Task Force members. VanAalst asked if the guidance from Aug. 27, 2022, is still being relied upon for innovative benefit designs and if so, what does CMS mean by "benefits that are not otherwise available." Hashem said that the 2022 guidance is the most recent.

VanAalst asked if this means within the standardized Medicare supplement plan options, or does it mean benefits are not available in the open market. He also said that the guidance says that innovative benefits shall be offered in a manner consistent with the goal of simplification (i.e. standardization). He asked how allowing carriers to add different benefits to standardized plans is consistent with the goal of simplification? He said Medicare Advantage advertising should be held to the same standards as Medicare supplement advertising. Hashem said this is not her area of expertise and that she will have to get an

answer later. Cabinet Executive Officer Richardson asked her to send her reply to David Torian (NAIC) so that it can be shared with the Task Force.

Hashem offered to update the Task Force on the newest Medicare Advantage marketing rules and regulations. She said new enforcements on third-party advertisements have been added and that while many of the television ads are still being aired, they are more generic and not targeted. She said CMS has disapproved two-thirds of the advertisements submitted. She said when those rejected advertisements are rewritten and resubmitted, many are then approved. Cabinet Executive Officer Richardson asked if CMS is just targeting third parties or also including lead generators. Hashem said they are focused on both.

Seip said the state struggles with communications with Medicare Advantage carriers and seeks more communication with CMS on what type of Medicare Advantage marketing and advertisement complaints are received. She said the state often does not know what counties the carrier is operating in. Additionally, she said when CMS conducts the network adequacy assessment, the state is not notified of whether the Medicare Advantage plan receives approval/denial to operate in the county. Hashem said they will send the list of CMS state contacts for Medicare Advantage plans.

VanAalst said Kansas is aware of a Medicare supplement carrier that asks medical questions during the open enrollment period, but the carrier claims it does not use those answers for determining eligibility. Rather, the carrier uses the answers for its own information. VanAalst asked if any other state has seen this and if this is permissible. Lombardo said Connecticut has not seen this but would definitely ask why the carrier would ask such questions. Fix said West Virginia has seen this and does not allow it.

Bonnie Burns (California Health Advocates—CHA) asked if CMS monitors or regulates the frequency of Medicare Advantage marketing ads. She said many of these ads are aired repeatedly in short periods of time. Hashem said CMS does not regulate or monitor the frequency.

3. Received an Update from the Long-Term Care Insurance (EX) Task Force on its Work on RBOs

Logue explained the Long-Term Care Insurance (EX) Task Force has worked on the matter of reduced benefit options (RBOs) and the guidance related to RBOs generally associated with long-term care insurance (LTCI) rate increases. She said reports have been adopted since 2020. She highlighted the RBO principles document, adopted in November 2020; the RBO communication principles document, adopted in November 2020; the RBO communication checklist document, adopted in November 2021 and amended in March 2023; and the LTC wellness issues document, adopted in December 2021. She said the checklist document had three buckets focusing on clarity, corrections, and robustness.

Jeff Czajkowski (Center for Insurance Policy and Research—CIPR) discussed the LTCI RBO choice selection experiment the CIPR conducted. He said this research builds on some previous work that has been done led by his research colleague, Brenda Rourke (CIPR). He said it also builds on from some of the work that Brenda J. Cude (University of Georgia) and Burns were involved with that was published last year that looked at talking to financial representatives on how people are thinking about RBOs and LTCI.

Czajkowski said this research is based upon a survey sent out by the Long-Term Care Insurance (EX) Task Force to state departments of insurance (DOIs) this past summer and went through the use of the three

broad response categories that Logue mentioned earlier (clarity, corrections, and robustness); RBO communication; and the RBO principals and checklists. The survey also asked some additional questions.

Czajkowski said 36 states responded to the survey, and 54% of the respondents are using some, if not all, of the RBO principles. He said 36% have incorporated some of the RBO communication principles into their review process. Of those, 13 states stated that the guidance and/or the checklist aided in completing the review and helped identify and correct issues with the insurer's communication. He said in the checklist, there are six major components, and the survey asked states if using the checklist, which of the components were most helpful. The top two were: 1) understanding policy options; and 2) understanding communication touch and tone. Czajkowski said these were helpful components of the checklist in terms of their review process.

Czajkowski briefly went through the communications checklist for the top two components. He said if people go to the slides and to the survey and click on the various components, they will see under communication touch and tone that it lays out in more detail, such as: Does the communication remind consumers to reflect on the original reason they bought the policy? He said the understanding policy options component has seven subsections within it, the top four being: 1) value of options; 2) the impact of decisions; 3) current benefits; and 4) personal decisions.

Czajkowski said there was another question that asked states if this has been helpful in terms of their review process. The survey asked if states saw any improvement by the companies as they are going through that review process with them. Nine of the 13 respondents said they are using it and are seeing improvement. He said this shows that roughly one-third of the states are using the checklist, and there are certain pieces of the checklist that they are finding most helpful. Those pieces are actually helping to improve communication back to consumers.

Czajkowski said another question asked where else would states would like the CIPR to focus in on its research. The top two responses were: 1) a better understanding of how consumers are making choices and what factors are influencing those outcomes; and 2) how well they understand and perceive these options. He said those responses were helpful to the CIPR to help guide it in the right direction, and it did align with the direction the CIPR felt it should go.

Czajkowski next discussed the RBO choice outcomes and illustrated an example of some choices that that came from a company that are presented to consumers. He said the consumers had five different choices, in addition to the default, with a number of pieces of information they have to decide from. Then they checked a box to make their choice for RBO. He said the hope in the research process is to understand not what choice is made but given the choice made, what drove that decision. He said based upon the questions responded to, the checklist is being used and is improving communication. He said the additional question to understand is whether that checklist and these best practices actually help influence the R.B.O. choice. He asked what the impact of that checklist is that the Long-Term Care Insurance (EX) Task Force or the DOIs are finding valuable.

Czajkowski next explained how the CIPR would answer that. He said the CIPR conducted a qualitative methodology where it asked 14 financial advisors and designed a hypothetical setting for a consumer of a certain age with an LTCI policy, and the consumer receives a letter that either follows or does not follow

the RBO communication principles—the former being the treatment and the latter being the control. He said if one looks at it from a medical perspective, this happens all the time with drug treatment. Some people get the treatment, and others get the placebo, and they're looking at how people respond to the drug over time. He said there are things that have not been figured out, and that is why CIPR is going to work further with the Long-Term Care Insurance (EX) Task Force on what that context should look like. What are state insurance regulators hearing from consumers on the cost of care? Is that cost of care too expensive in the state and that is why consumers cannot afford the RBO? Do the consumers have consistently poor health conditions and cannot give up the policy, or are they fed up with the series of rate increases from their company? Czajkowski said there is literature that looks at how consumers make choices about LTCI, not specific to RBOs but to LTCI take up. He said the CIPR hopes to leverage that data to model what the drivers of choice are and the impact of the treatment.

Czajkowski said the last slide illustrates an example of what the CIPR is working through as to what this treatment letter should look like, and the sample in the slide lines up with the impact of the decisions checklist where there should be a table that clearly defines how premiums are going to be laid out. He said that while not fully developed or finalized, the control would include language that would be stripped for the treatment, and the treatment would be pared down with three options: 1) pay the higher premium and coverage remains the same; 2) lower the premium by choosing to lower coverage limits; or 3) stop paying premiums.

Czajkowski said the CIPR is slated to present in a few weeks before the Long-Term Care Insurance (EX) Task Force the progress it has been making, with the goal of continuing to update the Task Force and get its feedback as the CIPR further develops the survey. He said the goal is to get this out into the field sometime in the first quarter of 2024. He said he would be happy to come back to the Senior Issues (B) Task Force if there is interest in additional updates.

Cabinet Executive Officer Richardson said she would like the CIPR to come back to the Task Force and provide updates on its progress.

4. Heard a Presentation from FTI Consulting on Minnesota's "Own Your Future" Initiative

Steve Schoonveld (FTI Consulting) gave a presentation on the progress of Minnesota's "Own Your Future" initiative. He said the Minnesota Department of Human Services (DHS) sought options to increase access to long-term care (LTC) financing, services, and support for Minnesotans. He said the primary objective and goals are to improve access to long-term services and support (LTSS) for Minnesotans who typically do not qualify for Medicaid, examine and evaluate integrated LTSS funding options, and transform the LTC funding system. He said there is an emphasis on options to enable older adults to receive care in their homes; improve the caregiver supply; develop a broad base of support for positive recommendations; consider revised roles for private LTCI for Minnesota's Medicaid program and other funding sources, including Medicare LTSS and federal Older Americans Act (OAA) programs; and explore new and innovative models of long-term care (LTC) financing and service delivery.

Schoonveld explained how Minnesota is building on what works. He said Minnesota's existing LTSS approaches include partnering with a wide variety of agencies; tapping all revenue streams, including private pay; and reaching older adults and family caregivers further upstream from Medical Assistance,

i.e., Medicaid. He highlighted what he called the "red box," which is the middle-income market in Minnesota. He said that the market consists of family incomes between $25,000 and $124,999. He said that population accounts for more than 60% of the Minnesota population.

Schoonveld discussed the range of policy options: 1) a "back end catastrophic" public program providing financial support for longer duration care situations—i.e., three or more years—and would require a waiting period or deductible dollar amount to be met before people could begin accessing benefits; 2) home and community-based services, which would be a public program providing funding for care and services for middle income older Minnesotans with more modest benefit levels and caps on the benefit duration to keep the program costs down. He said, similar to the first option, this program will have a waiting period or dollar deductible; 3) an early intervention benefit for Medicare recipients, which would be a public program providing modest, capped dollar, at-home benefits to Medicare recipients to delay or mitigate their need to spend out-of-pocket funds for paid care or spend down to be eligible for Medicaid; and 4) private LTCI incentives, which would strengthen the appeal and encourage innovation within private LTCI to help address gaps in funding and include regulatory or legislative modifications that can make private LTCI more affordable and more accessible to middle-income adults.

Schoonveld provided a sampling of potential designs under consideration. He said one option is early intervention and support, which is a state-developed program to provide a care support structure that would leverage existing services, provide strong awareness and education, and support informal caregivers. He said this option would also provide modest, capped, at-home benefits with the goals of delaying or mitigating their need to spend down to be eligible for Medicaid. Additionally, he said a care navigation service would focus on obtaining access to community services offered by waiver and alternative care programs and be the platform to support residents and their caregivers. He said the aim is to maintain a safe home environment and preserve the safety net.

Schoonveld said the second option is a mandatory state-sponsored LTSS program of one year of coverage, purchased by non-Medicaid eligible residents during Medicare enrollment or earlier. Participants would receive care support and preventive services coordinated with their Medicare plans. He said the program would also offer additional options to buy up for more than a year of coverage and purchase/funding options prior to age 65, and employer support may be offered. He said the approach is modeled after the comprehensive care coordination approaches of Managed Long-Term Services and Supports (MLTSS) plans.

Schoonveld said the third option is catastrophic coverage, which is a mandatory state insurance program to help pay for long-lasting, LTC expenses that exceed two years, without Medicaid's income and asset restrictions. He said the program will be self-funded by a state-specific payroll deduction for all workers 21 years of age and over, and the deductions will go into a restricted fund for this program's use only.

Cabinet Executive Officer Richardson said it does not look like the second choice was necessarily the best choice. However, in looking at the obligatory option and trying to figure out how one would go from being a Medicaid person, who is just over that threshold and does not have the money for private LTC because it is not priced on their income but it is priced on the benefit, she asked how do state insurance regulators help those people?

Schoonveld said to think about the segments in the red box and when consumers are on the bottom of the red box, they can afford the $100 a month. He said they probably want to buy more than a year and may buy a two-, three-, or four-year plan, like some are currently buying today. However, he said when they get closer and closer to that $50,000 of annual income as a retiree, it becomes less affordable. He said they have to find ways to subsidize that, and there are a couple of ways to do it. He said these individuals are going to dip into the Medicaid space if they have a lengthy claim, and these individuals have an opportunity to use elderly waiver programs and other community-based programs that can offset the costs. He said if they buy earlier at age 55 or 50 maybe with help from their employer, then they can keep those costs well below $100 a month, maybe even below $50 a month, so the opportunity is there to adjust for income.

Schoonveld said there was a product that Minnesota looked at called life stage a few years ago. It was meant for the middle-income population that might not have the same ability to do that but the standard short-term care, long-term care policy is going to benefit from that and keep the cost down for them.

Cabinet Executive Officer Richardson said it sounds like if consumers are in one of those segments in that red box, they potentially have to start their LTC or their retirement planning much earlier. Schoonveld said that would be one option. However, he said there is some room, especially for an obligatory program, to have some kind of means-tested premiums along that path and to start there and see if there are any ways to offset the intensity of the means-tested programs. He said one thing about payroll taxes is that it is a progressive tax, and there are some individuals that are paying premiums and paying taxes that are far more than the benefits could ever be in some of these designs. So, he said consumers have to watch out for that. He said that is an equity aspect of the discussion when it comes to those central criteria elements, but the report talks about the issues that do not provide the answer because FTI Consulting wants to let Minnesota decide what is good for it in terms of that obligatory program. He said there are plenty of designs that can make that work and leverage a public-private collaboration.

Commissioner Schmidt asked if the model considered or looked at hybrid plans. Schoonveld said FTI Consulting did not not consider hybrid plans and that in the private industry, and even public programs, there are a lot of options out there, and there are families that are broad enough that they have their own support structures that might not need as much coverage. He said there are other families that, based on income and other reasons, could offset and find other customizable products. He said what FTI Consulting wanted to do is make sure that this companion product would be inclusive of all solutions that are out there because what is right for one family might not be right for another. He said we FTI Consulting tries to take advantage of the differences out there and that there are hybrid products, LTC products, short-term care products, supplemental health products, paid family medical leave that actually provide some kind of benefits. He said rather than trying to replace those programs, FTI Consulting is trying to build them up and give them an opportunity. He said Minnesota is a strong state for LTCI and that a lot of strong carriers there participated in the study. He said FTI Consulting's idea was to be inclusive of those solutions and let them build and grow naturally rather than trying to replace them with a one-size-fits-all program.

Li asked how the long-term viability and sustainability are ensured. She asked if there is an ongoing evaluation program. Schoonveld said sustainability is one of the criteria elements. He said the first design is mainly a service option, and the only thing to be concerned about there is not bringing too many people to the elderly waiver older American programs that you end up hitting their budgets pretty badly or

reducing the coverage that they can provide. He said there are discussions in the report about those things but that the aim is to leverage public-private collaboration and not simply a stand-alone public option.

Schoonveld referred to the third recommendation. He said if that recommendation is a public program that everyone is in based on vesting through the payroll tax and that is a typical 75-year horizon, making sure that the projection of premiums and the projection benefits are there is part of it. However, sustainability might look great the first day one prices it and one sets it up, but one has to have risk mitigation measures going forward. He said that is why the first recommendation is relevant regardless of what funding mechanism is there. He said if someone came to him and said they want to do the third recommendation and not the first or second one, he would tell them to look the first recommendation because that will make the third recommendation affordable if people are helped on the front end.

Burns said there needs to be much more discussion about LTSS because by 2030, the baby boomers will be turning 85 years old. She said the Task Force needs to address this issue. She also raised the issue of opt-out policies in the life market that are being sold as ways for consumers to avoid tax provisions that may be part of a state LTSS program, akin to the WA Cares Fund. She said many of these policies are not right for many consumers, and California has issued a bulletin to highlight this matter. Schoonveld said Minnesota did not include an opt-out provision in its initiative.

5. Discussed Other Matters

Bartuska asked how other states have handled an issue that North Dakota has encountered. She said North Dakota has a company that is no longer able to sell Medicare Cost plans in certain areas, and consumers need to find new plans under guaranteed issue/discontinuance of a plan. She said, however, they are hearing from some consumers that some companies and producers are under the impression that they are not able to purchase Plan G because since they were eligible for Medicare prior to 2020. She said they are seeing companies pushing consumers into Plan F instead of allowing them into Plan G because premiums are higher on Plan F. She said this does not make sense as it is more than likely a closed block for most, but they are making more money off consumers on premiums versus deductibles. She asked if other states have encountered this and if a consumer is allowed a guaranteed issue window due to loss of coverage on a Medicare Cost plan?

Hohl said she recommends states review their Medicare supplement rules because they may have made changes from the model and may have handled the federal Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) change differently. She said, for example, Idaho's rules intend that beneficiaries have either-or, not both, options depending on when they became eligible for Medicare. She said she would welcome to discuss further with other states.

Harry Ting (Health Consumer Advocate) suggested the Task Force consider supporting giving Medicare Part D drug plan enrollees the same opportunities as Medicare Advantage enrollees to switch plans. He said this idea has the support of the Center for Medicare Advocacy and that both U.S. Sen. Bob Casey (D-PA) and Sen. Grassley (R-IA) have expressed support in reviewing this possible change.

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

2023 Fall National Meeting Minutes