

Draft Pending Adoption

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Senior Issues (B) Task Force
Seattle, Washington
August 13, 2023

The Senior Issues (B) Task Force met in Seattle, WA, Aug. 13, 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); Mark Fowler represented by Willard Smith (AL); Andrew N. Mais represented by Paul Lombardo (CT); Trinidad Navarro represented by Jeffry Schott (DE); Doug Ommen represented by Andria Seip (IA); Dean L. Cameron represented by Shannon Hohl (ID); Amy L. Beard represented by Alex Peck (IN); Vicki Schmidt represented by Julie Holmes (KS); Sharon P. Clark represented by Angi Raley (KY); James J. Donelon represented by Ron Henderson (LA); Gary D. Anderson represented by Kevin Beagan (MA); Kathleen A. Birrane represented by Jamie Sexton (MD); Timothy N. Schott (ME); Anita G. Fox represented by Renee Campbell (MI); Grace Arnold represented by T.J. Patton (MN); Mike Causey represented by Ted Hamby (NC); Jon Godfread represented by Chrystal Bartuska (ND); Eric Dunning represented by Martin Swanson (NE); D.J. Bettencourt represented by Jennifer Li (NH); Justin Zimmerman (NJ); Scott Kipper represented by David Cassetty (NV); Judith L. French represented by Laura Miller (OH); Andrew R. Stolfi (OR); Michael Humphreys represented by Lindsy Swartz (PA); Carter Lawrence represented by Scott McAnally (TN); Cassie Brown represented by Rachel Bowden (TX); Jon Pike represented by Shelley Wiseman (UT); Scott A. White represented by Julie Blauvelt (VA); Kevin Gaffney represented by Anna Van Fleet (VT); Mike Kreidler represented by Todd Dixon (WA); Nathan Houdek represented by Rachel Cissne Carabell (WI); and Allan L. McVey represented by Erin K. Hunter (WV).

1. Adopted its April 14 and Spring National Meeting Minutes

Director Deiter made a motion, seconded by Henderson, to adopt the Task Force's April 14 (Attachment One) and March 22 (*see NAIC Proceedings – Spring 2023, Senior Issues (B) Task Force*) minutes. The motion passed unanimously.

2. Heard a Presentation Regarding New MA Marketing Rules and Regulations

Nyetta Patton (federal Centers for Medicare & Medicaid Services—CMS) and Ken Garnder (CMS) gave a review of CMS's Medicare Advantage (MA) marketing rules and regulations. Nyetta Patton said regarding communications, it is defined as activities and the use of materials created or administered by the plans or any downstream entity to provide information to current and prospective enrollees. She said activities and materials aimed at prospective and current enrollees, including their caregivers, are "communications" within the scope of the regulations. She said the definition of marketing is a subset of communications and must, unless otherwise noted, adhere to all communication requirements. She said to be considered marketing, communications materials must meet both intent and content standards. She said in evaluating the intent of an activity or material, the CMS will consider objective information, including, but not limited to, the audience, timing, other context of the activity or material, and other information communicated by the activity or material, and the organization's stated intent will be reviewed but not solely relied upon.

Nyetta Patton said the CMS issued an updated interpretation of marketing to include content that mentions any type of benefit (emphasis added) covered by the plan that is intended to draw a beneficiary's attention to a plan or plans, influence a beneficiary's decision-making process when selecting a plan, or influence a beneficiary's decision to stay enrolled in a plan—i.e., retention-based marketing—and thus subject to review. She said it is critical that state departments of insurance (DOIs) keep in contact with their CMS liaison offices and work together when problems arise.

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Gardner said the CMS's plans for marketing and communications oversight improvements for 2024 include prohibiting marketing unless the names of MA organizations or marketing name(s) of entities offering the referenced products or plans, benefits, or costs are identified in the marketing material. He said MA organizations cannot use the Medicare name, logo, and card image in a misleading way, and the use of the Medicare card image is permitted only with authorization from the CMS. He said it also includes the prohibition of unsubstantiated statements without supporting data in the marketing piece, advertising benefits not available in the service area where the marketing appears, and marketing "savings" not realized; i.e., MA organizations cannot advertise about savings available that are based on a comparison of typical expenses for uninsured individuals, unpaid costs of dually eligible beneficiaries, or other unrealized costs of a person with Medicare.

Gardner said the improvements also include clarification of unsolicited door-to-door knocks, opt-out notices, and the prohibition of marketing events taking place within 12 hours of an education event. He said there will be a requirement that prior to an enrollment, the CMS's required questions and topics regarding the individual's needs in a health plan choice are fully discussed. He said a section is to be added to the pre-enrollment checklist (PECL) explaining the effect of enrolling in a new plan, and there will be a requirement that medical benefits be listed in specific order and at the top of a plan's Summary of Benefits.

Gardner said there is an update to the Third-Party Marketing Organization (TPMO) Disclaimer that State Health Insurance Assistance Programs (SHIPs) be added as an option for beneficiaries to get additional help, and it must include the number of organizations/plans represented. He said there is a limit to the requirement to record calls between TPMOs and people with Medicare to marketing/sales enrollment calls that TPMOs must list all MA organizations and Part D sponsors they represent on marketing materials, and MA organizations must establish and implement an oversight plan that monitors agent and broker activities, identifies non-compliance with CMS requirements, and reports non-compliance to the CMS.

Nyetta Patton said additional oversight plans for 2024 include television ads, online videos, radio ads, provider office material, sales presentations, and enrollment forms. She said it is important that any reporting issues to the CMS be done quickly, and she encouraged state insurance regulators to use the 1-800-Medicare number and utilize their CMS-DOI Liaison office. She said the slide presentation the CMS provided for the meeting includes the contacts for all 12 regions of CMS-DOI offices.

Director Richardson asked if there is any other role for state insurance regulators other than looking at the information of CMS-DOI liaisons or if there is a regulatory role the CMS has any expectations for states to perform Nyetta Patton said as different states have different regulations and the CMS regulates from a federal level, the CMS's goal is to partner with each state to address that state's specific concerns.

Swanson asked about better interactions between the states and the CMS in obtaining the necessary evidence when states engage in prosecutions for mis-marketing by those entities states have jurisdiction over. He said the process of obtaining the evidence requires layers and layers of procedures, and he asked if there is a way to streamline or cut down the time it takes to obtain the necessary evidence. Nyetta Patton said she will take that question back to the CMS to get an answer about how to expedite that process.

Swanson said there has been a utilization of both Social Security and Medicare. Although the CMS is toughening up the regulations and it is tied to the Social Security Act of 1935, the Office of Inspector General (OIG) has been unwilling to prosecute in the past. He asked if these new regulations will mean the OIG will take prosecutions or have the same position. Nyetta Patton said she cannot speak for the OIG, but the CMS coordinates with the OIG on these matters.

Henderson said many states are dealing with beneficiaries in crisis who have been switched into a plan they did not ask for or does not fit them, and they cannot utilize it because their doctor is not part of that new plan they

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were switched into. He asked what the process is with dealing with third parties and the MA plans as far as educating them on what they are supposed and not supposed to do. He said he has a case in Louisiana where a beneficiary was switched on three different occasions in three months, and we scramble to help these folks with the CMS's help, but he asked how these issues can be addressed from the front end and not after the switch. Nyetta Patton said the most important advice is to keep working with the CMS regional offices and the CMS-DOI offices because we can then take care of the part of educating compliance.

McAnally asked about the narrowing of the scope on the requirement to record marketing calls and what kind of impact that has had as far as investigation and how useful that requirement is. Nyetta Patton said it is not really new but scaling back, for lack of a better term, and the CMS listens to those calls that it can help CMS staff better understand, as well as help the plans better understand what the beneficiary wanted.

3. Heard a Presentation Regarding Lead Generators

Charro Knight-Lilly (eHealth) and Gavin Galimi (eHealth) gave a presentation on lead generators. Galimi said eHealth is an online marketplace offering consumers a broad choice of insurance products from approximately 200 carriers that includes thousands of MA, Medicare Supplement (Medigap), and Medicare Part D plans, and it also offers individual and family health insurance, small business coverage, and ancillary health insurance products. He said eHealth cultivates long-term relationships with their customers, and that is the key to eHealth's success. He said retention is a constant focus, and if a customer cancels their plan or eHealth does not remain the broker of record, the commission revenue ceases. He said finding the right plan for each customer is essential.

Knight-Lilly discussed the marketing relationships with lead generators. She said the marketing relationships with lead generators may include affiliate organizations, online advertisers, content providers, and other marketing vendors. She said eHealth generally compensates lead generators for their referrals of potential customers. She said marketing partners, which include lead generation services, are a significant bridge for brokers and carriers to reach potential customers. She said partners are more effective in reaching potential customers who sign up to receive the partner's marketing materials and have invested in various ways of reaching customer segments, based on potential interests, such as suitability of product type and qualifying plan type.

Galimi said the success of the marketing partner relationship is dependent upon a series of factors, such as: 1) compliance of the marketing partner with applicable laws, regulations, and guidelines; 2) reputation and growth of the partner; 3) continued positive market presence; and 4) the ability to manage the partner. He said in recent years, the industry has experienced that some partners may be deceptive to consumers in their marketing message, and some partners may be deceptive to brokers and carriers about the sources of their referrals. He said when marketing partners fail to adhere to eHealth standards, they are subject to corrective action, up to and including termination of the relationship.

Knight-Lilly highlighted the characteristics of good marketing partners as the adherence with regulatory requirements, the referral of consumers interested in our products, and good long-term reputation and reliability. She said the indications of a concern with a marketing lead would be the failure to adhere to regulatory requirements, the referrals who are confused or not interested in our products, and a poor track record or short-term business focus. Galimi said insurance commissioners can help by distinguishing between high-quality, reputable referral sources and fly-by-night deceptive referral sources and continue to collaborate with eHealth on this topic.

Director Richardson asked whether a broker or agent referring a client or customer and choosing a different product or policy is considered a bad referral or something to learn from. She asked how one knows if it is a right plan. Galimi said CMS provides the PCL and the checklist that has a list of questions that need to be gone through

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and a need assessment. He said on eHealth's platform, people are asked to put in necessary information to determine the right plan and the right value of the plan.

T.J. Patton said he reads a large percentage of insurance-related complaints that come into the Minnesota Department of Commerce, and one thing that is frustrating is hearing how Minnesota's elderly residents have challenges in getting the accurate and complete information they need to make the best choice for themselves when they become Medicare eligible. One of the subcategories of those complaints received relates to the online domains they have visited. T.J. Patton asked what eHealth's position is on the domains it operates, specifically Medicare.com. Galimi said there is a lot of information as eHealth transforms, not just with a new logo, but also the transformation underway with its marketing team and creating a differentiated brand message, but Medicare.com is not being rebranded nor making significant use of it, and it is in static mode. T.J. Patton said while he appreciates the commitment, it may be in eHealth's best interest to pull down that domain.

Lombardo asked in eHealth's selection process and process of matching an individual to the right plan use any type of artificial intelligence (AI) or machine learning (ML); if not, he asked if that is something being contemplated for the future. Galimi said eHealth does not use any generative AI for any health or customer-facing work. He said it may be used for ideation and the creation of ideas to start, but the chat platform is a live licensed agent, not an AI robot. He said ML algorithms are used as part of call matching, but there are no plans to launch any sort of AI customer interface. Lombardo asked if any AI currently used is in-house or from vendors. Galimi responded that it is in-house.

Henderson asked if eHealth is contracted with the MA plans that it provides information on. Galimi said they are contracted with their licensed agents and appointed with those carriers. Knight-Lilly said eHealth is a licensed agency. She said eHealth is aware that there are bad actors in the industry, and it is difficult to lump together TPMO statements and difficult for people to understand who is licensed and who is not, as well as what services are being performed by each entity.

Director Richardson said that is an important statement, as every state insurance regulator has at some point called up one of these organizations and asked for their license number to then be hung up on. Henderson said he gets calls, and when he makes inquiries, he gets cut off. Knight-Lilly said many of those are off-shore, and eHealth does not contract with off-shore entities.

Cissne Carabell asked about the slide that discusses failure to adhere to eHealth standards and whether eHealth has taken action against a company that has failed to adhere to those standards; if so, she asked how often that happens. Galimi replied that eHealth has done this. Knight-Lilly said she does not have an exact number; it does occur, but it is infrequent.

4. Heard a Presentation Regarding Concerns Related to Adverse Risk Selection in MA Plans

Dr. Barbara McAneny (New Mexico Oncology Hematology Consultants Ltd.—NMOHC) gave a presentation on her opinions and experience with MA. She emphasized that these are her own anecdotal experiences and do not reflect views from her past American Medical Association (AMA) presidency or her current position as Chief Executive Officer (CEO) of the NMOHC.

Dr. McAneny said she is a cancer doctor and has seen a significant deterioration of benefits for cancer patients and others with serious illnesses. She believes the NAIC, outside of the CMS, is the only organization that has any ability to provide oversight of MA plans. She said her hope is for regulations to be promulgated that allow patients to select a plan that is honestly marketed and lives up to expectations.

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Dr. McAneny said her anecdotal experiences and opinions on MA plans related to cancer patients and others with serious illness are formed by: 1) discussions and interactions physicians have employed by managed care companies; 2) observations of delays in prior authorizations by MA companies; 3) attempts to participate in accountable care organizations (ACOs) or to be on the board; 4) discussions with other cancer practices; 5) discussions with physicians employed by hospitals that also have MA or other insurance plans; and 6) the report produced by the Governor of New Mexico’s Task Force on Drug Pricing on which she participated.

Dr. McAneny said she calls MA Medicare Dis-Advantage because of its poor treatment for those with serious illnesses. She said managers of the plans benefit from enrolling healthier seniors and finding hierarchical condition categories (HCCs) that increase the monthly payment from the CMS, such as gym memberships and dental care. She said primary care doctors she has tried to hire have told her that their job is more to find HCCs than to treat patients, and that step therapy is a deterrent to patients with serious illnesses. She said managers of the plans benefit from delaying care for enrolled seniors, especially near open enrollment when sicker patients can switch to fee-for-service (FFS) Medicare. She said managers of the plans benefit from higher drug prices as those increase the medical loss ratio (MLR), and they can get rebates from their pharmacy benefit managers (PBMs) utilizing copay accumulators and maximizers.

Dr. McAneny highlighted the chart from the Kaiser Family Foundation (KFF) in her presentation illustrating the massive margins MA makes per enrollee. She said the report’s findings are that in 2021, MA insurers reported gross margins averaging \$1,730 per enrollee, at least double the margins reported by insurers in the individual/non-group market (\$745), the fully insured group/employer market (\$689), and the Medicaid managed care market (\$768). She said the report found that for MA insurers, the gross margins per enrollee in 2021 were similar to the period before the COVID-19 pandemic, but the margins per enrollee for the individual and group markets in 2021 were below pre-pandemic levels, while the margins per enrollee for Medicaid managed care insurers are higher. She said these are the most profitable products the insurance companies market, and in her opinion, these companies are taking advantage of Medicare, taxpayers, and the people who are used to managed care when they are at work and they move to MA. She said it seems to her that these companies are trading free eyeglasses for the ability to treat cancer.

5. Heard an Update on Minnesota’s “Own Your Future” Initiative and Washington’s WA Cares Fund

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 LTC insurance for Minnesota’s Medicaid program and other funding sources, including Medicare LTSS and Older Americans Act (OAA) programs; and explore new and innovative models of 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 market consists of family incomes between \$25,000 and \$124,999. He said that population accounts for over 60% of the Minnesota population.

Schoonveld discussed the range of policy options: 1) “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

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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 option 1, this program will have a waiting period or dollar deductible; 3) 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 Long-Term Care Insurance Incentives, which would strengthen the appeal and encourage innovation within private long-term care insurance (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 leverages existing services, provides strong awareness and education, and supports 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, and a Care Navigation service will also 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, and participants receive care support and preventive services coordinated with their Medicare plans. He said the program will 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. He said the third option is catastrophic coverage, which is a mandatory state insurance program to help pay for long-lasting, long-term care (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.

Ben Veghte (WA Cares Fund) said the 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 it 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, there are 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.

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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; 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 a 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. He 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 donut hole.

6. Discussed Other Matters

Bonnie Burns (California Health Advocates—CHA) raised the issue of the conflict between Medicare and the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) rules that has led to some confusion about which system and set of rules govern eligibility for coverage, as well as how the responsibility for the payment of health care benefits for eligible individuals is determined. She once again encouraged the Task Force to reconsider editing the *Coordination of Benefits Model Regulation* (#120).

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

SITF 2023 Summer National Minutes