# SENIOR ISSUES (B) TASK FORCE

Senior Issues (B) Task Force, Dec. 6, 2009, Minutes

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Senior Issues (B) Task Force
San Francisco, CA
December 6, 2009

The Senior Issues (B) Task Force met in San Francisco, CA, Dec. 6, 2009. The following Task Force members participated: Kevin M. McCarty, Chair, represented by Mary Beth Senkewicz (FL), Sean Dilweg, Vice Chair, represented by Guenther Ruch (WI); Jim L. Ridling represented by Steve Ostlund (AL); Jay Bradford represented by Dan Honey (AR); Steve Poizner represented by Denise Yuponce (CA); Thomas R. Sullivan represented by Richard Marcks (CT); Karen Weldin-Stewart represented by Tanya Sherman (DE); William W. Deal represented by Joan Krosch (ID); Michael T. McRaith represented by Bill McAndrew (IL); Carol Cutter represented by Doug Webber (IN); Sandy Praeger represented by Linda Sheppard (KS); James J. Donelon represented by Warren Byrd (LA); Ralph S. Tyler, III represented by Dudley Ewen (MD); Mila Kofman represented by Glenn Griswold (ME); Glenn Wilson represented by Tammy Lehman (MN); John M. Huff represented by Angela Nelson (MO); Mike Chaney represented by Aaron Sisk (MS); Adam Hamm represented by Michael Fix (ND); Ann Frohman represented by Martin Swanson and John Rink (NE); Scott J. Kipper represented by Van Mouradian (NV); Kim Holland represented by Russell Valleroy (OK); Teresa Miller represented by Mike Lydon (OR); Joel Ario represented by Shelley Bain (PA); Merle D. Scheiber represented by Randy Moses (SD); Mike Geeslin represented by Ana Smith-Daley (TX); Kent Michie represented by Tanji Northrup (UT); Alfred W. Gross represented by Brian Gaudiose and James Young (VA); Paulette Thabault represented by Christine Oliver (VT); Mike Kreidler represented by Beth Berendt (WA); and Jane L. Cline represented by Tim Murphy (WV).

1. Federal Issues Update

Josh Goldberg (NAIC) provided an update on issues being considered by Congress as part of the health reform debate. Both the House-passed bill (H.R. 3962, the Affordable Health Care for America Act) and the Senate legislation currently being debated (H.R. 3590, the Patient Protection and Affordable Care Act) contain a provision to direct the NAIC to update Medicare supplement plans C and F to increase beneficiary cost-sharing. This provision is a result of reports by the Medicare Payment Advisory Commission (MedPAC) regarding the impact of first dollar coverage on increased Medicare utilization. The requirement would likely be required for benefit packages effective January 2015.

The House-passed bill also contains the remnants of an amendment originally introduced by Rep. Kathy Castor (D-FL) and adopted in the Energy & Commerce Committee to create an NAIC process, similar to Medigap, for the oversight of Medicare Advantage plans. The final House-passed legislation does not contain the NAIC process, but does retain language granting states the ability to enforce federal guidelines.

Both the House-passed bill and the Senate package also include the Community Living Assistance Services and Support (CLASS) Act, which would create a new national long-term care insurance fund. Individuals choosing to participate in the fund would receive a cash benefit of up to $50 per day for community living supports. Premiums would be set by the Secretary of Health and Human Services, and large employers could auto-enroll employees. An amendment to strike the CLASS Act from the health reform package failed, so it will likely remain in the final Senate package.

Senators Herb Kohl (D-WI) and Ron Wyden (D-OR) are also likely to offer an amendment to add the Confidence in Long-Term Care Insurance Act of 2009 (S. 1177) to health reform legislation. The NAIC sent a letter of support for this legislation in September.

2. Long-Term Care Insurance Issues

a. Senate Long-Term Care Hearing

Ms. Senkewicz reported that she testified on behalf of the NAIC before a joint hearing of the Senate Special Committee on Aging and the Senate Committee on Homeland Security and Government Affairs—Subcommittee on Oversight of Government Management, the Federal Workforce, and the District of Columbia. The focus of the hearing was a pending 25% premium increase for participants in the federal employee long-term care insurance program who had selected the automatic compound inflation option on the basis of original marketing materials stating that there would be no premium increases.

As the federal employee program is regulated by the Office of Personnel Management (OPM), the focus of the hearing was not on state regulation; however, Ms. Senkewicz was asked to share the experience of the NAIC and Florida. Ms.

Senkewicz's testimony focused in particular on required consumer disclosures adopted by the NAIC in conjunction with rate stabilization provisions. Similar consumer disclosures did not appear to be required by the federal employee program.

b. Long-Term Care (EX) Task Force

Ms. Senkewicz informed the Task Force that a newly created Long-Term Care (EX) Task Force had met for the first time Dec. 6. That Task Force is charged, in part, to address legacy blocks of business formed prior to adoption of NAIC rate stabilization provisions. Both Florida and Wisconsin serve on the new Task Force. Ms. Senkewicz asked Senior Issues Task Force members and interested parties to contact Jane Sung (NAIC) if they were interested in being added to the Interested Regulators or Interested Parties e-mail lists for the new Long-Term Care (EX) Task Force.

c. Appendix E Revisions to the Long-Term Care Model Regulation

Ms. Senkewicz reviewed the status of revisions to the *Long-Term Care Insurance Model Regulation* (#641) that were adopted by the Task Force at the Fall National Meeting. These revisions amend Appendix E claim denial reporting so that companies specify whether they count and report claim denials "per claimant" or "per transaction." The revisions were exposed for a 30-day comment period in October and were adopted by the Health Insurance and Managed Care (B) Committee on a Nov. 9 conference call. The revisions are scheduled to be considered for adoption by the Joint Executive (EX) Committee/Plenary Dec. 7.

d. Long-Term Care Partnership Program

Ms. Senkewicz provided a brief update regarding the Long-Term Care Partnership program. There are now Partnership policies available for sale in 31 states. State plan amendments have also been approved in five additional states, with the most recent approvals being Louisiana and Maine. There are approximately 131,000 Partnership policies. According to the U.S. Department of Health and Human Services, the most recent reporting shows that there are now 100 insureds in claim.

3. Medicare Supplement Insurance Issues

a. Implementation of Modernization Revisions to the Medicare Supplement Model Regulation

The Task Force discussed implementation of revisions to the *Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act* (#651), as required by the federal Genetic Information Nondiscrimination Act of 2008 (GINA) and the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). Sept. 24 was the official deadline set by MIPPA for states to adopt the modernization revisions to the Medicare supplement model regulation. Ms. Senkewicz reported that it appears that all but one state that is required to adopt the revisions has completed adoption. Three states are waived from the federal requirements. The one remaining state is awaiting final action from its legislature.

b. Technical Corrections to Medicare Supplement Model Regulation

The Task Force reviewed draft technical corrections to the *Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act* (#651). Ms. Senkewicz reported that, as states worked to adopt the revisions to the model as required by MIPPA and GINA, certain technical errors in the outline of coverage charts and model language were identified. These errors include typos, formatting and punctuation errors, and missing or incorrect words and numbers. A draft of the necessary corrections is available on the Task Force Web page and has been distributed to the states for review and feedback. Some states have provided very technical and minor corrections, which will be incorporated into the model as technical corrections and sent out to the states when the model laws are published in January.

The Task Force discussed one specific draft correction to Section 9.1E(8)(c) of the model, which addresses Medicare Part A lifetime reserve days. It has been suggested that the phrase "150 Days" in the first sentence should be replaced with the phrase "Lifetime Reserve Days are Exhausted." Dotti Outland (United Healthcare) stated that the reference to "150 Days" was added mistakenly during the modernization revisions but should not have been added because it was an inaccurate description of the Medicare benefit, and no changes were made to Plan K benefits. She reported that some states were making this correction on their own when they discovered the error, and a change to the model was required for consistency and accuracy. The Task Force agreed to make this technical correction. Any other comments regarding the technical corrections should be submitted to Ms. Sung immediately.

c. Report from Accident and Health Working Group

Mr. Ostlund reported that the Accident and Health Working Group of the Life and Health Actuarial Task Force met Dec. 4 and discussed the possibility of modifying the Medicare Supplement Compliance Manual to state that Medicare supplement plans of the same letter for 1990 and 2010 plans should be pooled for rating purposes. The Working Group recommended that these changes be made and appointed a subgroup chaired by Florida to look at the language for the Compliance Manual.

Mr. Ostlund reported that the Working Group also agreed to request that the Society of Actuaries make recommendations regarding the development of a long-term care experience table. He reported that the Working Group has offered its services to support the new Long-Term Care (EX) Task Force because of the many actuarial issues before that group. The Working Group plans to coordinate with the Long-Term Care (EX) Task Force to conduct a pending state survey regarding closed blocks.

d. Update from CMS on Medicare Supplement Issues

1) Medicare supplement hospital network arrangement

Jim Mayhew (Centers for Medicare & Medicaid Services—CMS) reported that the CMS Acting Administrator had signed a letter responding to Ms. Senkewicz' letter on behalf of the Task Force regarding Medicare supplement hospital network provider arrangements. Mr. Mayhew did not have a copy of the letter, so he summarized its contents. He said CMS does not believe that this arrangement violates Medicare supplement standardization because CMS believes Section 1882 of the Social Security Act expresses standardization in terms of benefits, while this arrangement is not a benefit. As such, CMS believes there is no federal authority to stop these arrangements at the federal level. However, CMS believes that states do have discretion to reject these arrangements, and they have the authority to require permission for marketing in their jurisdictions.

Ms. Senkewicz expressed disappointment with CMS' opinion and urged states to look carefully at this arrangement. Mr. McAndrew suggested that the Task Force consider making a recommendation to states on how to address this issue. Mr. Rink agreed that there should be discussion about this issue and that states may want to address this in a uniform way because of the potential premium impact on rural beneficiaries.

Mr. Ruch suggested that the Task Force review the actual response letter before making a final judgment on the impact of CMS' response; however, he agreed that it would be a good idea to provide some guidance to states. Mr. Ruch expressed appreciation for CMS' recognition of state authority and noted that, in addition to state licensing authority, this arrangement may also implicate other sources of state authority such as Unfair Trade Practices Acts. Ms. Senkewicz agreed, and also suggested that state laws on unfair discrimination may be implicated.

Bonnie Burns (California Health Advocates) expressed disappointment with CMS' response and noted that she had also written to CMS and argued that this type of arrangement is the beginning of the destruction of the concept of standardization. She stated that she looked forward to the Task Force's guidance to states on this matter and expressed concern that this arrangement would not be the last discount scheme that will attempted. Bill Schiffbauer (Schiffbauer Law Office) urged CMS and state regulators to look at federal law beyond just Section 1882 and agreed that approval of this type of arrangement would unleash a storm of new arrangements.

Mr. Mayhew noted that CMS does not believe that this type of arrangement meets the definition of a Medicare Select plan. Mr. Rink expressed concern about the impact of these arrangements on rural citizens who are unlikely to receive a discount. He suggested that it may also be helpful for the Task Force to provide guidance to states, even if they choose not to stop the arrangement altogether in their states.

Evelyn Gay (NAIC Funded Consumer Representative) requested a copy of the response letter when it is available. Ms. Sung stated that, once received, the letter will be posted on the Task Force Web page.

2) Durable Medical Equipment coverage

Mr. Mayhew reported that CMS has been contacted by Durable Medical Equipment (DME) providers regarding clarification about the Medicare Part B Excess Charge benefit. Mr. Mayhew stated that it was CMS' view that Medicare rules require Medicare supplement carriers to be responsible for DME charges beyond the usual 15% for Medicare supplement plans that include a benefit for Medicare Part B Excess Charges.

Ms. Outland stated that industry has complained in the past that "usual and customary" language is necessary to limit the amount that carriers have to pay, or else carriers are simply subject to paying whatever DME providers choose to charge. Ms. Senkewicz noted that this is an area ripe for fraud, and that the Task Force would take CMS' opinion under advisement and discuss whether this issue needs to be addressed.

3) Choosing a Medigap Policy Guide for 2010

Mr. Mayhew reported that the 2010 *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare* guide was on track for spring publication. NAIC comments have been received and are being incorporated.

4. Medicare Private Plan Issues

a. Update on NAIC-CMS Policy Group

Mr. Ruch reported that the informal policy group formed with CMS to discuss policy matters and improve communication held a conference call Nov. 18 to discuss several issues. This was the second meeting of the group. On the call, CMS shared updates of issues of interest to state regulators, including an update on changes to CMS' contract with the Medicare Drug Integrity Contractor (MEDIC) and an update on CMS' agent/broker training and testing pilot program. The group also had a fruitful discussion on the agent/broker compensation structures for Medicare Advantage plans. While CMS implemented the new compensations structures in accordance with MIPPA and in an effort to discourage churning, Mr. Ruch suggested that differentiated compensation limits for first year and renewals may not be appropriate for Medicare Advantage plans, unlike Medicare supplement plans, because the plans change every year and there needs to be some incentive for agents to do appropriate suitability analysis. Both sides agreed that this was a worthwhile discussion and intend to continue this dialogue.

CMS updated the group on their efforts to eliminate low enrollment and duplicative Medicare Advantage plans in order to reduce beneficiary confusion. The state participants applauded these efforts, which resulted in 400 plan bids not being submitted to CMS for 2010 (12% of all plans). CMS intends to continue and expand these efforts for 2011 bids.

The group also discussed communications regarding nonrenewals of Medicare Advantage Private Fee-For-Service (PFFS) plans that are expected to occur in late 2010 (for the 2011 plan year) as a result of new network requirements. CMS officials agreed to work closely with state regulators to alert them to options and requirements facing beneficiaries in nonrenewing PFFS plans, such as CMS' decision that it is Congress' intent that these nonrenewing plans may not move enrollees into HMO or PPO plans.

Mr. Ruch stated that he, Ms. Senkewicz and Mr. McAndrew would continue to keep the Task Force apprised of the group's discussions and coordinate as appropriate. Mr. McAndrew noted that the group will continue to hold regular conference calls and may meet in person again in 2010, and that the group plays an important role in fostering good relations between states and CMS.

b. Update from CMS on Medicare Private Plan Issues

Deanna Greene (CMS) gave an update on Medicare Advantage and Medicare prescription drug plan issues. Ms. Greene reported that notices will be sent in December to 412,000 beneficiaries for Medicare Advantage and Medicare prescription drug plans who are not renewing their contracts for 2010. She stated that the total number of nonrenewals for 2010 is actually lower than CMS anticipated. Of the 412,000 beneficiaries, 400,000 are for Medicare Advantage plans, and 12,000 are for Medicare Part D prescription drug plans. CMS plans to mail these notices on Dec. 11 and will conduct outreach to State Health Insurance Assistance Programs (SHIPs) and to state departments of insurance at that time to notify them of the mailings. A state-by-state breakdown is available on the CMS Web site and is updated periodically.

Ms. Greene reported that CMS is in the 7th week of secret shopping of sales events for this year's open enrollment. Seventy-two Medicare Advantage and prescription drug plan organizations were secret shopped in October. CMS has observed that there seemed to be a dramatic decrease in the number of group sales events in October. In November, CMS initiated a pilot to use secret shoppers in one-on-one sales events. CMS also conducted secret shopping of call centers. CMS has reached out to state departments of insurance and provided secret shopping training; however, CMS requests that states hold off on conducting their own secret shopping until January.

Ms. Greene reported that CMS Regional Offices are still working on signing and distributing the joint letter between CMS and insurance commissioners to facility directors regarding dual-eligibles and marketing abuses. Six-thousand letters have been signed and mailed out so far.

Ms. Greene announced that new changes had been made regarding CMS' work with the MEDIC, which has opened up new opportunities for CMS' work with state departments of insurance. CMS has long worked with the MEDIC to address fraud, waste and abuse for Medicare Parts C and D. Recently, CMS announced that the MEDIC will be reorganized into two sections by issue. The section known as MEDIC South will continue to focus on fraud, waste and abuses cases, and criminal issues. The section known as MEDIC North will exclusively focus on compliance and enforcement issues such as agent/broker issues, marketing abuses, and other misconduct issues. This section intends to work closely with state departments of insurance, and also intends to perform audits. CMS would like to solicit ideas and suggestions from state regulators on how best to utilize the MEDIC, as this dedicated resource will be focusing on these priority areas. Ms. Senkewicz stated that she would like for the Task Force to discuss this by conference call and work with CMS to develop ideas for the MEDIC.

5. Any Other Matters

a. IIPRC and Long-Term Care Standards

Ms. Smith-Daley reported that the IIPRC will have a public conference call Dec. 17 regarding long-term care insurance standards and encouraged participation. Ms. Senkewicz inquired whether the draft standards were consistent with the NAIC model rating provisions. Ms. Smith-Daley responded that the draft standards were consistent, as the model provisions served as the guide for the draft standards and were referenced directly.

b. Wisconsin Medicare Supplement Guarantee Issue Expansions

Mr. Ruch said Wisconsin had recently amended its Medicare supplement insurance regulation by expanding its guarantee issue provisions by two conditions. First, guarantee issue protections were expanded for those retirees with Medicare supplement coverage with their former employer where their cost of the coverage increased by 25% or more. This expansion of guarantee issue protection was done as a result of testimony received during the adoption of Wisconsin's MIPPA/GINA changes where it was learned that some employers often did not terminate coverage, but instead substantially increased the retirees' cost for the coverage. The second condition for expanded guarantee issue protections is for those individuals enrolled in a Medicare Select plan and is triggered when their hospital or provider leaves the Medicare Select network, leaving them with no other network provider in a 30-minute or 30-mile radius.

Ms. Sheppard stated that Kansas had struggled to address a situation where a large employer with retiree benefits was pushing enrollees into a Medicare Advantage plan. Enrollees who were unsatisfied with the Medicare Advantage plan did not appear to have a guarantee issue right to a Medicare supplement plan.

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

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