15.0165.02000

FISCAL NOTE
Requested by Legislative Council
01/09/2015

Bill/Resolution No.: SB 2163

1 A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2013-2015 Biennium		2015-2017 Biennium		2017-2019 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues		$0		$4,500		$4,500
Expenditures		$0		$167,088		$173,358
Appropriations		$0		$167,088		$173,358

1 B. **County, city, school district and township fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

	2013-2015 Biennium	2015-2017 Biennium	2017-2019 Biennium
Counties			
Cities			
School Districts			
Townships			

2 A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

The bill would require the Insurance Department to develop a program to certify and monitor assisters as defined in the bill as well as collect a fee.

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

The bill would generate an undetermined amount of revenue through a fee. There are currently an estimated 45 people and entities that would fall under the definition. The Department would have to request and fund all of the resources for one FTE similar to an agent licensing position. There would be higher start-up costs the first 2-4 years.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*

A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

Based on two other states that register assisters, the state could charge $25 every year for individuals and $50 every year for business entities. There are 45 current assisters listed on the federal website. Approximately 15 are entities so $100 x 15 = $1,500; $25 x 30 = $750 for a total of $2,250 each year or $4,500 for the biennium.

B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

For 2015-2017, salaries and fringe of $124,587; operating of $37,205; and IT of $5,296. All funding would come out of Fund 239-Insurance Regulatory Trust Fund. One FTE would be requested.

C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation or a part of the appropriation is included in the executive budget or relates to a continuing appropriation.*

For 2015-2017, one FTE and $167,087 would be needed.
For 2017-2019, $173,358 would be requested.

Name: Rebecca L. Ternes

Agency: Insurance Department

Telephone: 328-2440

Date Prepared: 01/15/2015

2015 SENATE HUMAN SERVICES

SB 2163

2015 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

SB 2163
1/21/2015
22285

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature Donald Mueller

Explanation or reason for introduction of bill/resolution:

A bill relating to regulation of health benefit exchange assisters; and to provide a penalty.

Minutes:

Attach #1: Testimony by Norbert Mayer
Attach #2: Testimony by Dana Schaar Jahner
Attach #3: Testimony by Jerilyn Church
Attach #4: CMS FAQ on Exchanges, Market Reforms, and Medicaid
Attach #5: Testimony written by Patrick Gulbranson
Attach #6: Testimony written by Mara M. Jiran
Attach #7: Testimony written by Kristi Halvarson
Attach #8: Testimony by Neil Scharpe

V. Chairman Oley Larsen introduced SB 2163 to the committee. This bill comes from insurance agents that deal with Affordable Care Act (ACA) and enrolling of individuals in that program. V. Chairman Oley Larsen is a licensed agent in Blue Cross Blue Sheild, Sanford, Medica, and certified to enroll people in the exchange. The intent of the bill is to make it that the navigators, assisters, and those who assist people get insurance are licensed agents. A lot of these processes to help people come onto the marketplace or to pick a policy is an intensive process, takes a lot of time, and a lot of information is passed between client and agent that gets quite in-depth for best policy for individuals.

Chairman Judy Lee asked if there are any limitations that the feds have on states for navigators or assisters.

V. Chairman Oley Larsen indicated yes, feds can supersede our wishes to having these folks licensed in the state. Currently, they are not licensed or fingerprinted. State sovereignty and our laws should hold them accountable in some way.

Senator Axness can you explain the licensing process.

V. Chairman Oley Larsen answered in becoming a health insurance agent, you must complete many hours of training to understand policies and health insurance industry, take a test, and that's just to sell insurance. Then after you a North Dakota licensed insurance agent, you have to be appointed by an entity, such as Blue Cross Blue Shield, Medica, Sanford, Assurant, Prudential, Mutual of Omaha, the list goes on. Each one of those

carriers then require that you not only take continuing education from the to learn about the products and pieces that are in the policies. Blue Cross Blue Shield may have 31 policies that are available. Agent needs to know each one of those policies. On the exchange, when an individual enrolls or a navigator or assister helps them enroll, there will be 21 to 31 different policies, not only from Blue Cross Blue Shield but Medica and Sanford as well. As an agent to sell on the exchange, they need to be certified in each one of those carriers and policies with continuing education credits and understanding of the policies that might be a fit for the individual. V. Chairman Oley Larsen provided an example of a person buying insurance, and if you are an individual assisting them into getting a policy and you provided them a Medica policy, which is health insurance, they may be out of network and not serviced in that location - that person may buy that policy. If something happened to that person, they wouldn't have any coverage, being out-of-network. This is a big issue of doing the right thing for the person being enrolled. If something does happen, where the policy may not be the best fit for them, they have no one to turn to because the navigator is not carrying Errors of Omissions insurance to protect that coverage. We feel as agents that if people are selling something, they need to understand what they are doing. The navigators are supposed to just ask minimal information (name, date,income), but in talking with some navigators, they are talking to people 2+ hours and doing more than gathering information. We feel they are going above and beyond that scope of practice.

Senator Warner how navigators are compensated? Are they paid commissions by the insurance companies they recommend?

V. Chairman Oley Larsen answered navigators when Obamacare started, the entity was able to provide a grant to the state. The Feds granted them $600,000. Additionally, there was a grant for the native population, and they were granted as well. The navigator is paid from the grant, as well as assisters and however he coordinates it.

Senator Warner reconfirmed the question that they are not compensated by insurance company.

V. Chairman Oley Larsen answered that is correct. Agents are compensated.

Senator Warner indicated that agents may have conflicts of interest in recommending one company over another.

V. Chairman Oley Larsen stated it is not so much of an issue because the compensation rates between the companies are pretty much the same. When you have someone who comes into the exchange to enroll and their location put them "out of network" as compared to "in network" or if they are seeking more or less medical treatment, if they are a young person who doesn't want to pay a lot and get catastrophic insurance policy, at the end of the day, the compensation between carriers is minimal.

Senator Warner indicated there is still a finite number of companies that you represent as opposed to a larger universe of companies that offers insurance. You are only representing a segment of the total. You aren't licensed for absolutely every company?

V. Chairman Oley Larsen indicated there are only three companies on the exchange. He is appointed with many companies. You would not want to have someone sell an Assurant medical plan when places don't take that plan.

Senator Warner indicated that it should be easy to sort by geographical area that would identify what companies would cover specific areas. Is that a problem for an agent, or does website steer towards companies that cover zip code?

V. Chairman Oley Larsen indicated it does not. It shows the 28 plans, and you pick the plan, but it does not say that it is not available through that carrier. As an agent being educated in each policy and provider, we know that information.

Chairman Judy Lee stated that when we started this, navigators were authorized by the feds and paid by the state.

V. Chairman Oley Larsen no, they are paid by the feds. The concept of these navigators and assisters, agents will embrace that the navigator is the team player that gets everyone together. Ft. Berthold reservation, navigator would call school and indicate education and enrollment at teacher's conference, and navigator would coordinate this along with assisters that would explain the information of how it is, and here is a list of agents. That's not the case that happens at all. Very seldom are the agents involved in the process.

Senator Axness stated that the fiscal note, it is based on 2 other states, and asked what are those states.

V. Chairman Oley Larsen doesn't know. V. Chairman Oley Larsen doesn't understand the fiscal note. The agents just want to make the navigators licensed, so right now we don't have to pay to have an agent licensed.

Chairman Judy Lee read the fiscal note, revenue from a fee; there are currently estimated 45 people and entities who fall under the definition. The department would have to request and fund all of the resources for one FTE. There would be higher startup costs for the first two years.

V. Chairman Oley Larsen stated that it is not our intent to take over the federal grant, so they would still get the money from the feds, but they just have to be licensed agent.

Chairman Judy Lee read the fiscal note.

Norbert Mayer, North Dakota Association of Insurance and Financial Advisors, testified IN FAVOR of SB 2163 (15:55-24:00) (attach #1)

Senator Dever indicated that Mr. Mayer provided a good review going through the process as an agent. What about navigator role in same process; where do they stop and what are they permitted to do. Are there federal limits on what they do?

Mr. Mayer indicated the navigator can walk through the website. But when client asks what plan to enroll in, they are supposed to stop. Navigators are not permitted to recommend the most appropriate plan.

Senator Dever indicated that it may be easy to blur that line, and Mr. Mayer confirmed that it is.

Chairman Judy Lee asks do you find that the co pay and deductibles under the exchange are a tough nut to crack for some of the folks who have been insured, but now may even benefit from the subsidy, but may have higher co pays or deductibles.

Mr. Mayer first stated that he does a limited amount of insurance with people under the age of 65. If they have retired, many have come off a company plan, and have no clue what the deductibles are, what they have to meet them because they took the company plan and had no decision making or need to understand.

Chairman Judy Lee stated that occasionally that there may have been a cafeteria plan, but more often, the employer would be providing a fixed plan.

Mr. Mayer indicated yes. One client he worked with had a health savings through employer, where they could carry those savings with them. So to them, a health savings plan wasn't important because they had money set aside.

No more testimony in FAVOR

Opposition to SB 2163

Dana Schaar Jahner, representing the Community HealthCare Association of the Dakotas (CHAD), spoke IN OPPOSITION to SB 2163 (attach #2) (27:00-31:10). Ms. Jahner provided further written testimony from the following individuals:

- **Patrick Gulbranson**, Chief Executive Officer of Family HealthCare in Fargo (attach #5)
- **Mara M. Jiran**, Interim CEO of Valley Community Health Centers (attach #6)
- **Kristi Halvarson**, representing Community Health Service Inc. (attach #7)

Chairman Judy Lee how many folks have you been able to assist?

Ms. Jahner indicated she didn't know but could get the information and provide it to the committee. Chairman Judy Lee indicated that she didn't need to do that. Ms. Jahner indicated that she doesn't work directly with this program so doesn't know.

V. Chairman Oley Larsen asked if assisters are fingerprinted, are is there a full background check.

Ms. Jahner stated those who are employed by the community health centers, they are employees of the health centers and follow all those regulations.

Josh Asvig, AARP, spoke IN OPPOSITION to SB 2163. They have one point - page 2, line 31, we now understand that if anyone who is providing any assistance would be required to be a licensed insurance agent or broker. They have to stop if someone asks

them to pick a plan. So we are not quite sure about the limitation to broker. The additional training we are not certain it is needed but they don't have issues with the training. But we don't think it should be limited to only insurance brokers.

V. Chairman Oley Larsen asked if AARP are only working with people 65 years and older, or do you work with people before medicare age.

Ms Asvig indicated that they don't do any assistance. They have worked with other organizations, partnered with organizations with navigators, but don't do any themselves. They do tax assistance, it is open to anyone, but primary who is 50 and over.

Jerilyn Church, Enrolled Member of the Cheyenne River Sioux Tribe, Testified OPPOSED to SB 2163 (attach #3), (34:46-40:00)

V. Chairman Oley Larsen how many enrolled tribal members are there in North Dakota?

Ms. Church indicated that she doesn't know the number.

V. Chairman Oley Larsen estimated that there are about 14,000 in Ft. Berthold that are enrolled member, and this doesn't include other reservations. You enrolled 561 people and 1,000 on CHIP. There seems to be a disconnect there about enrolling all of these folks. You talked about how they are getting this training. How does the enrolled member can get the advice that they need to pick a policy if they can't get that advice from the person enrolling them. Where do they seek out that advice?

Ms. Church indicated navigators are not allowed to give recommendations on specific plans to ensure no conflict of interest. If tribal members have additional questions, they can be referred to additional insurance agents.

V. Chairman Oley Larsen continued, as you stated, V. Chairman Oley Larsen vice-chaired the tribal and governmental affairs, and he asked another individual about this. Do you have a list of the 265 agents in North Dakota, and do you provide that list to those individuals as you are enrolling them? The barrier is that you won't allow agents to come down there.

Ms. Church indicated no, what we do as a grantee, we uphold the tenant that we will not advocate for any one particular plan. It wouldn't be feasible to have all 265 agents for what that represents those plans to be at any of the education and outreach activities that we do. That is a requirement of our grant.

Chairman Judy Lee stated navigators can't advocate for a particular plan. They are not a competitor. What the concern is for those who support the bill is that customers aren't getting all the information that a licensed agent has available to assist them in making that choice. Do navigators and assisters who are on the reservations follow exactly the same criteria as those who are working off the reservation.

Ms. Church answered yes.

Chairman Judy Lee indicated we have 3 companies who work on the exchange North Dakota, so having access to a list of those agents who are geographically located to that tribe may allow those tribal members for someone else to contact so if they want more information, they could get this.

Ms. Church indicated that would be acceptable.

Chairman Judy Lee indicated that if we could enable the list for the tribe by geographical areas, this may answer some of the concern.

Ms. Church restated that the criteria are that navigators cannot make recommendations on any plan, but should provide information to consumers.

Chairman Judy Lee talked about the navigator program in Minot. There is a cliff there, now that they get that part, the navigator has to state they can't tell you the next information. There needs to be a smooth transition to the agents. There are only 3 companies, and in some areas, there aren't that many agents.

End of Ms. Church testimony.

No other opposition

NEUTRAL FOR SB 2163

Rebecca Ternes, deputy insurance commissioner 48:03. Indicated they have been worried about this issue, and the conversation is continuous. In fact, at one time, a requirement in the prior exchange bill required navigators to be licensed, but it was struck because of the federal prohibition to do this. Ms. Ternes provided a copy of the CMS Frequently Asked Questions on Exchanges, Market Reforms and Medicaid document (See attach #4). On page 8, question 18, can states require navigators to hold license (she read from this document). The federal government states on page 9, you cannot require navigators to hold a producer license or a licensed as an agent or broker for the purpose of carrying out any of the duties required in this section, and Ms. Ternes continued to read from this document. The State of Missouri passed a law at one point stating navigators and assisters had to be licensed and the state was sued and lost in court. The department wasn't sure what the intent was of the bill. When we create a program in our department to where someone has to apply for something, it means we have to have a system for them to apply, to track the applications for approval or denial, and appeals. This represents the cost of the FTE for their department if this bill is adopted. Ms. Ternes indicated the department is also very concerned who are not trained that they do not sell insurance. When navigators got their first grant, the department wrote a letter that this is the list of the insurance producer licensing laws that cannot be broken. The department has not had a complaint since that time against navigators or assisters. There were some pieces of the bill that surprised the department, such as where they could set a fee at any rate they wanted to, take away a license or suspend any time they want to - this flexibility is rarely provided to the department. These assisters, outside of navigators, that with the Medicaid and CHIP population, not all business is going to commercial insurance. That's not the role of the agents, but it is a part of what these folks are supposed to be doing.

Chairman Judy Lee stated the goal is always the protection of the consumer

Senator Axess sited the Missouri case, are you implying if we pass this bill that we are setting ourselves up for lawsuit.

Ms. Ternes indicated potential is yes, as it is constructed.

Senator Dever stated on occasions when sitting down with insurance, I understand until I walk out the door. If I go to navigator, I could work through process, but I'd be looking for advice. That's the line that is difficult to maintain.

Ms. Ternes agrees. We said from the beginning that there are agents who do this already, there are state health insurance counseling programs where folks can call their office to get an understanding of their insurance. If they come to us, we are going to say here are the agents by city who can help you with your issues. You can still go to an agent or broker to buy insurance on or off the exchange, so discount them, and there is no cost difference. The best person you can go to is an agent. Some will go to Medicaid, CHIP; some are not comfortable with an agent and prefer the informal setting with the navigator. Again, any hint that they are selling insurance without producer license, we will follow up.

Senator Howard Anderson, Jr. help understand some of the terms in the bill. Page 2, subsection 5, what the certification centers around, line 31, insurance producer. What's the difference between an insurance producer and agent, navigator, assistor.

Ms. Ternes stated that an insurance agent is also an insurance producer is licensed by state of North Dakota to sell, solicit, negotiate insurance and they must follow regulations to keep their license, including continued education, an examination at the beginning, subject to commissioner walking in to look at books and records, all to protect the consumer. A navigator and assistor are functions that were created by the federal government and each has a different role. The assisters are funded by a HRSAA grant versus the navigators that are funded from the navigator grant through the exchange program. They are more community-like counseling centers or one-on-ones. For example, Minot state group has partnered with 7 or 8 non-profits that would access populations that may need this type of assistance.

Senator Howard Anderson, Jr. on page 2, line 23, "is an individual who." That could be a natural person or company?

Ms. Ternes indicated there are 2 sections here: individuals are section "a", and business entities are section "b". In producer licensing laws in our office, we also have different requirements for business entity licenses and individual licenses.

Chairman Judy Lee stated that person applies to both corporation or business and could be either, but individual is a breathing person.

Ms. Ternes indicated that is correct.

End of Ms. Ternes testimony.

Closed Public Hearing.

Additional written testimony supplied:

- **Neil Scharpe** (attach #8)

2015 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

SB 2163
1/21/2015
22318

☐ Subcommittee
☐ Conference Committee

Donald Mueller Donald Mueller

Explanation or reason for introduction of bill/resolution:

A bill relating to regulation of health benefit exchange assisters; and to provide a penalty.

Minutes: "Click to enter attachment information."

These minutes are from committee work on January 21, 2015.

Chairman Judy Lee provided a review of the bill.

Chairman Judy Lee indicated that the people understand the bill, but there are so many prohibitions from the federal government that it is pretty hard to make this work.

V. Chairman Oley Larsen indicated that the intention of the bill is to just have the navigators licensed, and those people that are doing what licensed agents are doing now. When reviewing the bill, on page 2, line 10, it says an exemption for an attorney licensed to practice in the state, he doesn't understand why that is in the bill. It was not expressed to have. Throughout the whole bill, there are issues. V. Chairman Oley Larsen doesn't understand where, with the fiscal note, we have to start a whole new thing. We aren't taking over the navigator's role that the federal government is responsible for. All we are doing is having a requirement that they are licensed. He does understand that the feds supersede what can be done. We are doing above and beyond what the feds want, but perhaps wrong in that aspect. If we make a rule to have them report to someone, who's going to do that? If they are not licensed agents, like myself, I answer to the insurance department. If they are not licensed insurance agents, then why would we have them report to them what they are doing? Perhaps they could report to legislative council on who they are seeing and what they are doing.

Chairman Judy Lee asked are you talking about having them licensed as an agent or a new category of licensure.

V. Chairman Oley Larsen answered not new. For example, if I am already a licensed agent, there is already a licensed agent and they would go to work as a federal navigator.

Chairman Judy Lee indicated when setting up state exchange, we wanted to have insurance agents be the navigators, but we were told unequivocally we could not do that. She stated that she doesn't disagree with the logic of having qualified people do the work, but doesn't see where this is different for the feds. Feds have been straightforward about keeping navigators and agents separate.

V. Chairman Oley Larsen stated on the two entities having a federal exchange or having a state exchange, Representative Keiser was in support of the state exchange because then we could have our rules, and we would have to incur those costs. But as a federal exchange, the feds are incurring those costs and regulations.

Chairman Judy Lee indicated we will have to watch the next supreme court ruling about state and federal exchanges as that could make a difference in everything we are talking about. If they can't provide subsidies to the people who have signed up on the federal exchange, that's a big deal. So the, will North Dakota come back and look again at the proposed state exchange we had before with some changes now that we have seen some differences in what's going on? The idea of the state exchange was so we had some control over the situation where we could serve our citizens better, but that's not the way the vote went in the last session.

There was also indication from this morning's testimony that the State may be in a lawsuit, based on the Missouri lawsuit.

Senator Warner moved that the Senate Human Services Committee recommend a DO NOT PASS for SB 2163. The motion was seconded by **Senator Axness**.

No further discussion.

Roll Call Vote
4 Yes, 2 No, 0 Absent

Chairman Judy Lee will carry the bill.

Date: 1/21 2015
Roll Call Vote #: 1

2015 SENATE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. SB2163

Senate Human Services Committee

☐ Subcommittee

Amendment LC# or Description: _____

Recommendation: ☐ Adopt Amendment
☐ Do Pass ☒ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Warner Seconded By Axness

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee (Chairman)	✓		Senator Tyler Axness	✓	
Senator Oley Larson (V-Chair)		✓	Senator John M. Warner	✓	
Senator Howard C. Anderson, Jr.		✓			
Senator Dick Dever	✓				

Total (Yes) 4 No 2

Absent 0

Floor Assignment Lee

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2163: Human Services Committee (Sen. J. Lee, Chairman) recommends **DO NOT PASS** (4 YEAS, 2 NAYS, 0 ABSENT AND NOT VOTING). SB 2163 was placed on the Eleventh order on the calendar.

2015 TESTIMONY

SB 2163

J# 22285 Attach #1
SB 2163 01/21/15

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TESTIMONY SUPPORTING SB 2163
January 21, 2015
10:45 am

SENATE HUMAN SERVICES COMMITTEE
JUDY LEE, CHAIR

Senator Lee and members of the Senate Human Services Committee:

My name is Norbert Mayer and I represent the ND Association of Insurance and Financial Advisors. We support this bill because selecting the appropriate health insurance plan is difficult. The decision is based upon much more than the lowest premium. I will briefly describe the many decisions that have to be made to select that most appropriate plan.

With the Affordable Care Act the interview begins with determining whether the client may qualify for a premium subsidy. For this we utilize the "healthcare.gov" web site. Fortunately this web site worked much better this year than last. You enter the age of each family member and their smoker status. Next you enter their estimated income for the year, explaining carefully what happens if at the end of the year they find that their estimate was not accurate. What income is counted? The final determination is made when the client files their income tax return. 2014 is the first year tax returns are being used to verify their income. Consumers will be expected to pay back subsidy payments if their income estimate was too low or get a refund if their estimate was too high.

Next you go to the plan comparisons. Does the plan permit you to go to the Doctor you choose or is there a limited network. If the network is limited is there a reduced reimbursement and higher co-pay or is there no reimbursement if you go out of network. Does the plan qualify for a Health Savings Account permitting you to set aside before tax dollars to pay for unreimbursed medical expenses.

Deductibles are expressed as a dollar amount, such as $3,500. This deductible can be an individual or family deductible. If it is individual does each family member have to meet it before the plan starts reimbursement for each individual's expenses or is there a family maximum amount.

Then you have to consider co-payments. Are they expressed as a flat dollar amount or a percentage? Does the deductible have to be met before the co-pay starts paying or are there co-pays made on certain expenditures before the deductible is met?

Now the real work begins. I was surprised by the subsidy. The client I worked with (husband and wife) projected a $51,000 income which gave them an estimated $701.00 monthly premium subsidy. Now was time for some counseling. If they should have an additional $1,000 of monthly income they would lose all of their subsidy ($8,412). I urged them to talk this over with their financial planner and they did before making their final decision.

There were 31 plans available. The premiums with subsidy varied from $133 per month to $679. The deductibles varied from $2,700 to $10,000 and the out of pocket maximum was pretty consistent around $13,000. We narrowed down to four plans for comparison. They selected the one with a $7,800 deductible and slightly higher premium over one with a $3,900 deductible because there were co-pays for primary care and specialist visits before the deductible was met.

This job requires an extensive background in health insurance and financial planning to do it correctly. Many clients don't understand what a network is, what's a HSA account and how does it benefit me and the list goes on. We find that before the decision can be made a lot of education has to take place. With all of this information dissemination, is it possible to make an error or omit vital information which could result in a plan not reimbursing for expenses as expected. Absolutely. If a licensed insurance agent makes an error or omits information, the client is protected with errors and omissions insurance. Navigators and Assisters do not have a similar requirement. We do not know if this bill can affect how the Federal Government regulates those who work with clients seeking a health insurance plan but feel it is necessary to send the message that their current requirements are totally inadequate.

We urge a yes vote in support of this bill and I will stand for any questions.

SB 2163
Attach #2
01/21/15
J# 22285

CHAD
Community HealthCare
Association of the Dakotas

Testimony of Dana Schaar Jahner, Community HealthCare Association of the Dakotas
To Senate Human Services Committee in Opposition to SB 2163
Wednesday, January 21, 2015

I am Dana Schaar Jahner, representing the Community HealthCare Association of the Dakotas (CHAD), and I would like to speak on behalf of community health centers in opposition to Senate Bill 2163.

CHAD works with its community health center (CHC) members and other community leaders to find solutions for improving health care options in areas of the Dakotas that are underserved. Community health centers offer a unique model with proven results for high-quality, cost-effective care customized to benefit the patient and communities being served.

There are four community health centers with 13 clinic sites providing primary medical care services in North Dakota: Coal Country Community Health Centers based in Beulah, Family HealthCare Center based in Fargo, Northland Community Health Center based in Turtle Lake, and Valley Community Health Centers based in Northwood. In addition, Community Health Service Inc. provides primary health care services for migrant workers and their families at multiple sites, including Grafton and Moorhead, Minnesota.

Starting in 2013, community health centers received funding from the Health Resources and Services Administration (HRSA) to hire and train federally Certified Application Counselors (CACs). Assisters are responsible for conducting consumer outreach and education about and enrollment in qualified health plans (QHPs), Medicaid, and the Children's Health Insurance Program (CHIP). North Dakota's community health centers offer consumer assistance at all 13 clinic sites.

In order to provide this assistance, each of the community health centers had to apply to the federal Centers for Medicare and Medicaid Services to become a Certified Application Counselor (CAC) organization and ensure that all health center assisters successfully complete all required federal CAC training. Federal regulations require assisters to be recertified and trained on at least an annual basis, and all of North Dakota's community health centers are in full compliance with this requirement, which includes completion of the updated 2015 plan year training curriculum for assisters.

A certified organization is responsible for making sure that all of the staff and volunteers it certifies as individual CACs take and pass the training; comply with the requirements to be a CAC,

including privacy and security regulations; and sign an agreement that he or she will comply with the CAC requirements. Further, CACs receiving certification must display their certificate when completing CAC duties, much as a hair stylist must display theirs.

Community health centers must educate consumers about affordable insurance options, including the benefits of insurance that extend beyond the services provided by the health center (e.g., access to specialty care and hospitalization), and provide assistance with enrollment for eligible individuals. CACs receive no additional compensation for this assistance.

Community health center CACs are not selling insurance, nor are they allowed to advise a consumer about choosing a specific insurance policy. Further, health center assisters are not allowed to refer consumers to any specific insurance agent or broker. However, assisters may inform consumers about the general availability of licensed, Marketplace-trained health insurance agents and brokers as an additional resource that may be able to provide recommendations to the consumer or answer complex health insurance issues.

Given the significant federal regulations established for both CAC organizations and CACs, an additional layer of state regulation seems unnecessary at this time. Rather, it appears that this would be a duplicative effort at the state level that would expend unnecessary financial and staff resources that could instead be focused on other issues.

Collaboration has been and continues to be a major component of the success of the Certified Application Counselor program at the state's community health centers. Specifically, CHAD's facilitation has unified the application counselors into one team to share best practices and challenges. Further, CHAD's involvement has streamlined the process to create more consistency and continuity in how consumers are provided assistance.

North Dakota community health centers and their certified application counselors are committed to maintaining expertise in eligibility, enrollment, and the health care marketplace, as well as to providing free and impartial assistance to consumers so the consumer may choose the best health insurance option to meet their needs. We ask that you not require an additional layer of unnecessary regulation that increases the expenditure of financial and time resources to a system that is currently working.

CHAD requests the committee's recommendation for a do not pass on SB 2163.

Attach #3
SB 2163
01/21/15
J# 22285

Testimony for Sixty-fourth
Legislative Assembly of North Dakota
The Senate Human Services Committee
January 21, 2015

Jerilyn Church, CEO
Great Plains Tribal Chairmen's Health Board
1770 Rand Road
Rapid City, SD 57702

SENATE BILL NO. 2163 - In-person assisters bill requiring licensing and fees for Navigators and Certified Application Counselors

Good Morning Honorable Chair Lee, and other distinguished committee members, I want to thank you for this opportunity to address SB-2163.

My name is Jerilyn Church, I am an enrolled member of the Cheyenne River Sioux Tribe and I serve as the Chief Executive Officer for the Great Plains Tribal Chairmen's Health Board (GPTCHB). The Great Plains Tribal Chairmen's Health Board is a representative organization of the 18 tribes in the Great Plains region that includes the states of South Dakota, North Dakota, Nebraska and Iowa. The Great Plains Tribal Chairmen's Health Board is one of five tribal organizations nationally that was awarded funding in fiscal year 2014 and 2015 through CMS to provide navigator services specifically for the tribes in North Dakota and South Dakota. As a navigator grantee last year, GPTCHB trained 17 navigators in the state of North Dakota. Twenty-one navigators are completing certification and/or recertification this year. Some of these navigators are direct employees of the Great Plains Tribal Chairmen's Health Board; the majority however are employees of the Indian Health Service or of tribally owned and operated health centers and clinics. These dedicated Navigators as well as Certified Application Counselors that serve tribal communities in the state of North Dakota have been instrumental in assisting approximately 561 consumers' complete applications for health coverage including QHPs, and insurance affordability programs like Premium Tax Credits (PTCs) and Cost-Sharing Reductions (CSRs). They have also assisted approximately 1,493 consumers select Medicaid/CHIP as their coverage option.

I am here to express my opposition to the proposed Senate Bill 2163, which would enact additional and unnecessary regulation on services provided by navigators and certified application counselors who provide unbiased, informed resources for consumers seeking federal or state marketplace information.

As a navigator grantee, GPTCHB trained Navigators already adhere to the strict and comprehensive eligibility standards and guidelines required by CMS for individuals who seek to become Certified Navigators. Navigators receive extensive training on privacy and security and are required to follow the standards issued by the Exchange pursuant to 45 C.F.R. §155.260, which includes comprehensive background checks, conflict of interest and ethics training, and guidelines for proper handling of tax data and personal information. Additionally, Navigators of Federally facilitated Marketplaces and State

Partnership Marketplaces are required to obtain continuing education and be certified and/or recertified on an annual basis.

SENATE BILL NO. 2163 would add an additional layer of bureaucracy to a new and already complicated system and it would duplicate federal measures already enforced to protect the rights of North Dakota citizens. The duplicative requirements outlined in SENATE BILL NO. 2163 would not be prudent use of taxpayer resources and would serve as a barrier rather than enhance access to affordable health insurance for North Dakota consumers.

Lastly, Senator Oley Larsen and Representative Jim Kasper who serve as members on the North Dakota Tribal and State Relations Committee also understand the necessity for consultation with tribes of North Dakota and the importance of upholding the primary of tenets of tribal sovereignty in its government-to-government relations in all matters including health and human services.

Of the 12 tribes served by the GPTCHB Navigator program in North Dakota and South Dakota, 11 have passed proclamations, which endorse and support the efforts of the GPTCHB Navigator program to provide information and assistance to all tribal members in reviewing their options and selecting their own health insurance choices. The 12th proclamation is pending council approval.

Again, I respectfully urge this committee to reconsider the necessity and value that SENATE BILL NO. 2163 would have for the citizens of North Dakota. Thank you for your time and consideration.

Respectfully,

Jerilyn Church, MSW
Chief Executive Officer
Great Plains Tribal Chairmen's Health Board

Attach #4
SB 2163 01/21/15
Jt 22285

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop 00-00-00
Baltimore, Maryland 21244-1850

Date: December 10, 2012

Subject: Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid

EXCHANGES & MARKET REFORMS

State-Based Exchanges and State Partnership Exchanges

1. ***Does HHS plan to further extend deadlines for states to decide on their level of involvement in implementing Exchanges?***

   A. No. As mentioned in the two letters that Secretary Sebelius sent to governors in November 2012, states have been and will continue to be partners in implementing the health care law and we are committed to providing states with the flexibility, resources and time they need to deliver the benefits of the health care law to the American people.

   In response to various governors' requests for additional time, we extended the deadline for a Blueprint Application to operate a State-Based Exchange from November 16, 2012 to December 14, 2012. If a state is pursuing a State Partnership Exchange, we will accept Declaration Letters and Blueprint Applications and make approval determinations for State Partnership Exchanges on a rolling basis. A state that plans to operate the Exchange in its state in partnership with the federal government starting in 2014 will need to submit its Declaration Letter and Blueprint Application declaring what partnership role they would like to have by February 15, 2013.

   A state may apply at any time to run an Exchange in future years.

2. ***What federal funding is available to assist a state in creating and maintaining a State-Based Exchange? Will a state have to return federal funding if it decides not to implement a State-Based Exchange?***

   A. By law, states operating Exchanges in 2014 must ensure that their Exchanges are financially self-sustaining by January 1, 2015. The costs to states for establishing a State-Based Exchange and testing Exchange operations during 2014 may be funded by grants under section 1311(a). Additionally, grants under section 1311 may be awarded until December 31, 2014, for approved establishment activities that fund first year start-up activities (i.e., activities in 2014). It is also permissible that under a State Partnership Exchange, a state may receive grants for activities to establish and test functions that the state performs in support of a Federally-Facilitated Exchange. This applies whether or not a state is a State Partnership Exchange. Generally, states will not be required to repay funds, provided funds are used for activities approved in the grant and cooperative agreement awards.

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3. ***Will HHS charge fees to a state that utilizes federal data in connection with its State-Based Exchange?***

   A. No. HHS is establishing a federally-managed data services hub to support information exchanges between states (Exchanges, Medicaid and CHIP agencies) and relevant federal agencies. In many cases, federal agencies other than HHS will be providing information through the hub. As stated in previous guidance, no charge will be imposed on states for use of the hub, nor for the required data accessed there.

4. ***What is the approval process for a state that would like to participate in a State Partnership Exchange?***

   A. To operate a State Partnership Exchange in 2014, a state must submit a declaration letter, complete the relevant portions of the Exchange Blueprint and be approved or conditionally approved by HHS for participation in a State Partnership Exchange. State Partnership Exchange approval standards mirror State-Based Exchange approval standards for plan management and the relevant consumer activities, where applicable, and include standards related to sharing data and coordinating processes between the state and a Federally-Facilitated Exchange. States have until February 15, 2013 to submit a declaration and Blueprint Application for approval as a State Partnership Exchange.

Federally-Facilitated Exchange

5. ***How will HHS work with state policymakers to make sure that the Federally-Facilitated Exchange accounts for the needs of a particular state? How will the Federally-Facilitated Exchange for each state ensure that it accurately incorporates state-specific laws and procedures into its business processes?***

   A. To the greatest extent possible, HHS intends to work with states to preserve the traditional responsibilities of state insurance departments when establishing a Federally-Facilitated Exchange for a particular state. Additionally, HHS will seek to harmonize Exchange policy with existing state programs and laws wherever possible.

   For example, qualified health plans that will be offered in a Federally-Facilitated Exchange must be offered by issuers that meet state licensure and solvency requirements and are in good standing in the state (section 1301(a)(1)(C) of the Affordable Care Act; 45 C.F.R. section 156.200(b)(4)). In addition, qualified health plans will be subject to requirements that apply to all individual and small group market products such as the proposed market rules. Accordingly, states continue to maintain an important responsibility with respect to qualified health plans licensed and offered in their states, regardless of whether the Exchange is Federally-Facilitated or State-Based.

   HHS is currently working to determine the extent to which activities conducted by state insurance departments such as the review of rates and policy forms could be recognized as part of the certification of qualified health plans by a Federally-Facilitated Exchange. For example, most states currently have an effective rate review program in place and HHS will rely on such processes in connection with qualified health plan certification decisions and oversight by a Federally-Facilitated Exchange. HHS will work with regulators in each state with a Federally-Facilitated Exchange to identity these efficiencies.

HHS is working with the National Association of Insurance Commissioners to enable states to use the System for Electronic Rate and Form Filing as part of the qualified health plan submission and certification process in a State Partnership Exchange. This will help ensure that state and federal regulators are using the same data for their reviews and simplify issuer compliance responsibilities.

HHS also will collect state-specific Medicaid and CHIP policy data so that the Federally-Facilitated Exchange is able to evaluate Medicaid and CHIP eligibility.

6. ***Will Federally-Facilitated Exchange customer support personnel be familiar with state rules so that they can advise consumers adequately?***

   A. Yes. HHS will operate the Federally-Facilitated and State Partnership Exchange call center and website, and personnel will be trained on relevant state insurance laws and Medicaid and CHIP eligibility standards so that they can advise consumers. In a state operating in a State Partnership Exchange, a state will be responsible for the day-to-day management of the Exchange Navigators and the development and management of another separate in-person assistance program, and may elect to conduct additional outreach and educational activities. The Affordable Care Act directs Navigators to conduct public education to target Exchange-eligible populations, assist qualified consumers in a fair and impartial manner with the selection of qualified health plans and distribute information on tax credits and cost-sharing reductions, and refer consumers to any consumer assistance or ombudsman programs that may exist in the state. Navigators must provide this information in a manner that is culturally and linguistically appropriate and accessible by persons with disabilities.

7. ***What restrictions will there be on a state regulator's authority to enforce state laws when consumers purchase coverage through a Federally-Facilitated Exchange? Will states retain their ability to protect consumers?***

   A. States have significant experience and the lead role in insurance regulation, oversight, and enforcement. We will seek to capitalize on existing state policies, capabilities, and infrastructure that can also assist in implementing some of the components of a Federally-Facilitated Exchange. We also encourage states interested in improving this alignment to apply to conduct plan management through a State Partnership Exchange.

   A Federally-Facilitated Exchange's role and authority are limited to the certification and management of participating qualified health plans. Its role and authority do not extend beyond the Exchange or affect otherwise applicable state law governing which health insurance products may be sold in the individual and small group markets. Several qualified health plans certification standards rely on reviews that some state departments of insurance may not currently conduct. Therefore, HHS will evaluate each potential qualified health plan against applicable certification standards either by deferring to the outcome of a state's review (e.g., in the case of licensure) or by performing a review necessary to verify compliance with qualified health plan certification standards. Federally-Facilitated Exchanges will consider completed state work to support this evaluation to the extent possible.

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8. ***How will the Federally-Facilitated Exchange be funded?***

   A. To fund the operation of the Federally-Facilitated Exchange, we proposed for comment in the draft Payment Notice that participating issuers pay a monthly user fee to support the operation of the Federally-Facilitated Exchange. For the 2014 benefit year, we proposed a monthly user fee rate that is aligned with rates charged by State-Based Exchanges. While we proposed that this rate be 3.5 percent of premium, it may be adjusted in the final Payment Notice to take into account State-Based Exchange rates. Exchange user fees will support activities such as the consumer outreach, information and assistance activities that health plans currently pay themselves. This policy does not affect the ability of a state to use grants described in section 1311 of the Affordable Care Act to develop functions that a state elects to operate under a State Partnership Exchange and to support state activities to build interfaces with a Federally-Facilitated Exchange.

9. ***If a state chooses to provide some services to a Federally-Facilitated Exchange, will the state be reimbursed for its costs?***

   A. Yes in certain circumstances. HHS expects that states supporting the development of a Federally-Facilitated Exchange may choose to seek section 1311(a) Exchange Establishment cooperative agreement funding for activities including, but not limited to:

   - Developing data system interfaces with the Federally-Facilitated Exchange;
   - Coordinating the transfer of plan information (e.g., licensure and solvency) from the state insurance department to the Federally-Facilitated Exchange; and
   - Other activities necessary to support (and related to the establishment of) the effective operations of a Federally-Facilitated Exchange.

   After section 1311(a) funds are no longer available, HHS anticipates continued funding, under a different funding vehicle, for state activities performed on behalf of the Federally-Facilitated Exchange. To the extent permissible under applicable law, HHS intends to make tools and other resources used by the Federally-Facilitated Exchange available to state partners in State Partnership Exchanges, as well as to State-Based Exchanges.

Market Issues

10. ***How are Exchanges going to increase insurance market competition based on quality and cost? Some markets may be starting off from a position of having few local issuers.***

    A. The introduction of Exchanges and the insurance market rules in 2014 will help promote competition based on quality and cost since consumers will have an unprecedented ability to compare similar products from different issuers and will be assured the right to purchase these products, regardless of their health condition. Further, consumers in many states will have new options such as the ability to purchase coverage from the Consumer Operated and Oriented Plans and Multi-State Plans created under the Affordable Care Act. Additionally, Exchanges can leverage market forces to drive further transformation in health care delivery.

We anticipate that the number of individuals who will be eligible for advance payments of premium tax credits and cost-sharing reductions – which are only available in connection with qualified health plan coverage purchased through an Exchange – will attract issuers to Exchanges where the certification process will encourage and reward high quality affordable insurance offerings. In addition, HHS is developing a Star Ratings system for qualified health plans purchased in an Exchange pursuant to section 1311(c)(3) of the Affordable Care Act.

11. When will we have final rules on essential health benefits, actuarial value, and rating?

A. The proposed rules on essential health benefits and actuarial value and the market reforms, including rating, were published on November 20, 2012. Public comments are due by December 26, 2012. On November 20, 2012, we also issued a state Medicaid directors letter on how we will propose essential health benefits be implemented in Medicaid. HHS will analyze the comments, adjust any policies accordingly, and publish final rules early next year.

12. What level of benefit is required in a specific benchmark to satisfy the ten essential health benefit categories? What process will be undertaken by HHS to select backfilling benefit options if a state defaults to the largest small group product?

A. In section 156.100 of the proposed rule on Essential Health Benefits/Actuarial Value/Accreditation, we propose criteria for the selection process for a state that chooses to select a benchmark plan. The essential health benefits benchmark plan would serve as a reference plan, reflecting both the scope of services and limits offered by a typical employer plan in that state. This approach and benchmark selection, which would apply for at least the 2014 and 2015 benefit years, would allow states to build on coverage that is already widely available, minimize market disruption, and provide consumers with familiar products. Since some base-benchmark plan options may not cover all ten of the statutorily required essential health benefits categories, we propose standards for supplementing a base-benchmark plan that does not provide coverage of one or more of the categories.

We also propose that if a base-benchmark plan option does not cover any items and services within an essential health benefits category, the base-benchmark plan must be supplemented by adding that particular category in its entirety from another base-benchmark plan option. The resulting plan, which would reflect a base-benchmark that covers all ten essential health benefits categories, must meet standards for non-discrimination and balance. After meeting these standards, it would be considered the essential health benefits-benchmark plan.

The proposed rule also outlines the process by which HHS would supplement a default base-benchmark plan, if necessary. We clarify that to the extent that the default base-benchmark plan option does not cover any items and services within an essential health benefits category, the category must be added by supplementing the base-benchmark plan with that particular category in its entirety from another base-benchmark plan option. Specifically, we propose that HHS would supplement the category of benefits in the default base benchmark plan with the first of the following options that offer benefits in that particular essential health benefits category: (1) the largest plan by enrollment in the second largest product in the state's small group market; (2) the largest plan by enrollment in the third largest product in the state's small group market; (3) the largest national

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Federal Employees Health Benefit Program plan by enrollment across states that is offered to federal employees; (4) the largest dental plan under the Federal Employees Dental and Vision Insurance Program, for pediatric oral care benefits; (5) the largest vision plan under the Federal Employees Dental and Vision Insurance Program, for pediatric vision care benefits; and (6) habilitative services as described in section 156.110(f) or 156.115(a)(4).

Multi-State Plans

13. The Office of Personnel Management is required to certify Multi-State Plans that must be included in every Exchange. How will you ensure that Multi-State Plans compete on a level playing field and are compliant with state laws?

A. The U.S. Office of Personnel Management released a proposed rule implementing the Multi-State Plan Program on November 30, 2012. To ensure that the Multi-State Plans are competing on a level playing field with other plans in the marketplace, the proposed regulation largely defers to state insurance law and the standards promulgated by HHS and states related to qualified health plans. Under the proposal, Multi-State Plans will be evaluated based largely on the same criteria as other qualified health plans operating in Exchanges. The few areas in which the Office of Personnel Management proposes different regulatory standards from those applicable to qualified health plans are areas where the Office of Personnel Management has extensive experience through its administration of the Federal Employees Health Benefits Program. However, in order to ensure that these few differences will not create any unfair advantages, the Office of Personnel Management seeks comment from states and other stakeholders on these proposals. The regulation appeared in the Federal Register on December 5, 2012, and the comment period runs through January 4, 2013.

Bridge Plan

14. Can a state-based Exchange certify a Medicaid bridge plan as a qualified health plan?

A. Yes. HHS has received questions about whether a state could allow an issuer that contracts with a state Medicaid agency as a Medicaid managed care organization to offer qualified health plans in the Exchange on a limited-enrollment basis to certain populations. This type of limited offering would permit the qualified health plan to serve as a "bridge" plan between Medicaid/CHIP coverage and private insurance. This would allow individuals transitioning from Medicaid or CHIP coverage to the Exchange to stay with the same issuer and provider network, and for family members to be covered by a single issuer with the same provider network. This approach is intended to promote continuity of coverage between Medicaid or CHIP and the Exchange.

In general, an Exchange may allow an issuer with a state Medicaid managed care organization contract to offer a qualified health plan as a Medicaid bridge plan under the following terms:

- *The state must ensure that the health insurance issuer complies with applicable laws, and in particular with section 2702 of the Public Health Service Act.* Consistent with section 2702(c) of the Public Health Service Act, a health plan whose provider network reaches capacity may deny new enrollment generally while continuing to permit limited enrollment of certain individuals in order to fulfill obligations to existing group contract

holders and enrollees. Therefore, if the issuer demonstrates that the provider network serving the Medicaid managed care organization and bridge plan has sufficient capacity only to provide adequate services to bridge plan eligible individuals and existing Medicaid and/or CHIP eligible enrollees, the bridge plan could generally be closed to other new enrollment. However, in order to permit additional enrollment to be limited to bridge plan eligible individuals, the state must ensure there is a legally binding contractual obligation in place requiring the Medicaid managed care organization issuer to provide such coverage to these individuals. We note that any such contract would need to have provisions to prevent cost-shifting from the non-Medicaid/CHIP population to the Medicaid/CHIP population. We also note that the guaranteed availability provision of section 2702 of the Public Health Service Act is an important protection that provides consumer access to the individual and small group markets. Accordingly, we plan to construe narrowly the network capacity exception to the general guaranteed issue requirement.

- *The Exchange must ensure that a bridge plan offered by a Medicaid managed care organization meets the qualified health plan certification requirements, and that having the Medicaid managed care organization offer the bridge plan is in the interest of consumers.*

- *As part of considering whether to certify a bridge plan as a qualified health plan, the Exchange must ensure that bridge plan eligible individuals are not disadvantaged in terms of the buying power of their advance payments of premium tax credits.*

- *The Exchange must accurately identify bridge plan eligible consumers, and convey to the consumer his or her qualified health plan coverage options.*

- *The Exchange must provide information on bridge plan eligible individuals to the federal government, as it will for any other individuals who are eligible for qualified health plans on the Exchange, to support the administration of advance payments of premium tax credits.* This will be done using the same mechanism that will be in place for the larger Exchange population.

Successful implementation of a Medicaid bridge plan will involve a high degree of coordination between the state Medicaid agency, department of insurance and the Exchange. States operating State-Based Exchanges will be best positioned to achieve the level of coordination needed to implement and support the offering of a Medicaid bridge plan on an Exchange. Additional guidance will be issued soon.

Pre-Existing Condition Insurance Plan and Other High-Risk Pools

15. Does the federal government intend to maintain the Pre-Existing Condition Insurance Plan program beyond 2014? How will state high risk pools be affected by the affordability and insurance market reforms in 2014?

A. Under the Affordable Care Act, coverage for persons under the Pre-Existing Condition Insurance Plan program (whether federally-run or state-run in a state) will generally not extend beyond January 1, 2014, which is when all individuals will be able to access coverage without any pre-existing condition exclusions in the individual market. The transitional

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reinsurance program is expected to help stabilize premiums in the individual market by reimbursing issuers who enroll high cost individuals, such as those currently enrolled in the Pre-Existing Condition Insurance Plan, as they enter that market.

In the notice of proposed rulemaking on the health insurance market rules (77 Fed. Reg. 70584; November 26, 2012), we noted that we are exploring ways in which states could continue to run their existing high risk pools (i.e., separate from the Pre-Existing Condition Insurance Pool program) beyond 2014.

Basic Health Plan

16. Will HHS issue federal guidance and regulation regarding implementation of the Basic Health Plan?

A. Yes. HHS plans to issue guidance on the Basic Health Plan in the future. States interested in this option should continue to talk to HHS about their specific questions related to the implementation of the Basic Health Plan.

CONSUMERS

Consumer Outreach

17. How does HHS plan to conduct outreach about the Exchanges and new coverage options? Will outreach materials be tailored to each state? Will states be able to provide HHS with input in developing materials?

A. Education and outreach are high priorities for implementing the changes coming in 2014. HHS plans to conduct outreach to consumers in a variety of ways, including the Navigator program, in-person assistance, the internet, and call centers. States and other stakeholders definitely will be able to provide input in developing its outreach approach to consumers.

18. How does HHS plan to operate the Navigator program for the Federally-Facilitated Exchanges? How many and what types of Navigators will there be in a particular state? What will their roles be? Can states require Navigators to hold a producer license? If not, what type of training or certification will they receive?

A. Section 1311(i) of the Affordable Care Act directs an Exchange – whether a State-Based Exchange or a Federally-Facilitated Exchange – to establish a program under which it awards grants to Navigators. Section 1311(i) and 45 C.F.R. section 155.210 articulate the required duties of a Navigator. In addition, section 155.210(c)(2) directs that the Exchange select two different types of entities as Navigators, one of which must be a community and consumer-focused non-profit group. This program is further described in the "General Guidance on Federally-facilitated Exchanges."

The number of Navigators per state served by a Federally-Facilitated Exchange will be contingent upon the total amount of funding available as well as the number of applications that we receive in each state in response to the forthcoming Navigator Grant Funding Opportunity Announcement that we plan to issue early next year to support the Federally-Facilitated Exchanges.

Additionally, a state or Exchange cannot require Navigators to hold a producer license (i.e., a license as an agent or broker) for the purpose of carrying out any of the duties required of Navigators in section 1311(i)(3) of the Affordable Care Act and 45 C.F.R. section 155.210(e). Because the law directs Navigators to carry out all required duties, linking a producer license to any one of those specific duties would have the effect of requiring all Navigator entities, their employees, and their sub-grantees to hold a producer license. As described above, this would prevent the application of the standard set forth in 45 C.F.R. section 155.210(c)(2) that at least two different types of entities must serve as Navigators. As such, and as provided by section 1321(d) of the Affordable Care Act, any state laws which would require all Navigators to hold a producer license would be preempted by 45 C.F.R. section 155.210(c)(2).

In Federally-Facilitated Exchanges and State Partnership Exchanges, individuals selected to receive Navigator grants or working for entities selected to receive Navigator grants must successfully participate in an HHS-developed and administered training program, which will include a certification examination pursuant to 45 C.F.R. section 155.210(b). In addition, under state law, states may impose Navigator-specific licensing or certification requirements upon individuals and entities seeking to operate as Navigators, so long as such licenses or certifications are not preempted by the requirement to award to different types of entities identified in 45 C.F.R. section 155.210(c)(2), such as producer licenses.

19. What does HHS expect that states in a State Partnership Exchange must do to fulfill their obligations regarding in-person consumer assistance? How will the state-specific in-person consumer assistance programs be integrated with the Navigator program?

A. In-person assistance programs are an additional mechanism through which Exchanges may meet the consumer assistance responsibilities of the Exchange under 45 C.F.R. section 155.205(d) and (e). As described in the Federally-facilitated Exchange Guidance, states operating under a State Partnership Exchange will build and operate an in-person assistance program, for which grant funding is available under section 1311 of the Affordable Care Act, distinct from the Navigator program for that Exchange. State-Based Exchanges may do so as well. The purpose of providing multiple tools for in-person assistance is to ensure that all consumers can receive help when accessing health insurance coverage through an Exchange.

Consumer Eligibility and Enrollment

20. What information will consumers provide in the single streamlined application? What is the process/timeline for the approval of a state-specific single streamlined application?

A. Section 1413 of the Affordable Care Act directs HHS to develop a single, streamlined application that will be used to apply for coverage through qualified health plans, Medicaid and CHIP. In addition, it can be used by persons seeking the advance payment of premium tax credits and cost sharing reductions available for qualified health plans through the Exchange. In consultation with states and other stakeholders, and with the benefit of extensive consumer testing, HHS has been developing an on-line and paper version of the single, streamlined application. We are releasing information on a rolling basis both to seek public comment and to support states in their eligibility system builds.

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In July 2012, HHS published a notice in the Federal Register outlining the initial data elements that will be included in the streamlined application for public comment. HHS received over 60 comments from states and other stakeholders that have helped inform our ongoing development work. These comments, coupled with ongoing consumer testing, have helped us refine and improve the application.

Consumer testing and extensive consultation with states and consumer groups continues. HHS expects to provide the final version of the online and paper application in early 2013 and will also work with states that seek Secretarial approval for their own application.

21. What will consumers be told if it appears they are not eligible for Medicaid, CHIP, or advance payments of premium tax credits?

A. A qualified individual still will have the option to purchase a qualified health plan through the Exchange if he or she is not eligible for Medicaid. CHIP or an advance payment of a premium tax credit. As outlined in 45 C.F.R. section 155.310(g), Exchanges will provide timely written notice to an applicant of any eligibility determination made by the Exchange. 45 C.F.R. section 155.230(a) provides further detail on the content of notices, including that notices contain contact information for available customer service resources and an explanation of appeal rights, if applicable.

22. How will HHS help Exchanges with the eligibility process for exemptions from the shared responsibility payment for individuals?

A. Section 1311(d)(4)(H) of the Affordable Care Act specifies that the Exchange will issue certificates of exemption from the shared responsibility payment described in section 5000A of the Internal Revenue Code, which otherwise applies to individuals who do not maintain minimum essential coverage. In the "State Exchange Implementation Questions and Answers" released on November 29, 2011, we indicated that a State-Based Exchange could either conduct this assessment itself or use a federally-managed service for exemptions from the shared responsibility payment. We included this option in the Exchange Blueprint. State-Based Exchanges can also choose to conduct this function independently.

With this service, the Exchange will accept an application for an exemption, and then transfer the information contained on the application to HHS through a secure, electronic transaction. HHS will conduct relevant verifications and return an eligibility determination to the Exchange, which will then notify the individual who submitted the application. The Exchange and HHS will share responsibility for customer service. To the extent that an individual's situation changes during the year, he or she would be required to submit an update to the Exchange, which will then transfer it to HHS to process. This configuration limits the level of effort required on the part of the Exchange, while ensuring that the Exchange complies with the statutory direction to issue certificates of exemption.

HHS will provide additional information regarding exemptions shortly, including technical specifications for the application and for the application transfer service.

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Consumer Experience

23. How will the Federally-Facilitated Exchange display qualified health plan options to consumers? Will consumers see all of their options or just those that are "best" for them? Will the Federally-Facilitated Exchange allow individuals who are eligible for Medicaid or CHIP to purchase qualified health plans instead?

A. Consumers will see all qualified health plans, including stand-alone dental plans, certified to be offered through the Federally-Facilitated Exchange, offered in their service area. HHS is developing ways for consumers to sort qualified health plan options based on their preferences.

Qualified individuals who are Medicaid or CHIP eligible are allowed to purchase qualified health plans instead of receiving coverage through the Medicaid or CHIP programs. However, they are not eligible to receive advance payments of premium tax credits or cost-sharing reductions to help with the cost of purchasing qualified health plans through an Exchange.

MEDICAID

Expansion

24. Is there a deadline for letting the federal government know if a state will be proceeding with the Medicaid expansion? How does that relate to the Exchange declaration deadline? Is HHS intending to provide guidance to states as to the process by which state plan amendments are used to adopt Medicaid expansion under the Affordable Care Act?

A. No, there is no deadline by which a state must let the federal government know its intention regarding the Medicaid expansion. Nor is there any particular reason for a state to link its decision on the Exchange with its decision on the Medicaid expansion. States have a number of decision points in designing their Medicaid programs within the broad federal framework set forth in the federal statute and regulations, and the decision regarding the coverage expansion for low-income adults is one of those decisions.

As with all changes to the Medicaid state plan, a state would indicate its intention to adopt the new coverage group by submitting a Medicaid state plan amendment. If a state later chooses to discontinue coverage for the adult group, it would submit another state plan amendment to CMS. The state plan amendment process is itself undergoing modernization. As part of an overall effort to streamline business processes between CMS and states, in early 2013 CMS will begin implementing an online state plan amendment system to assist states in filing state plan amendments. We will be discussing the submission process for Affordable Care Act-related state plan amendments on our monthly State Operations and Technical Assistance calls with states and will be available to answer questions through that process.

While states have flexibility to start or stop the expansion, the applicable federal match rates for medical assistance provided to "newly eligible individuals" are tied by law to

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specific calendar years outlined in the statute: states will receive 100 percent support for the newly eligible adults in 2014, 2015, and 2016; 95 percent in 2017, 94 percent in 2018, 93 percent in 2019; and 90 percent by 2020, remaining at that level thereafter.

25. If a state accepts the expansion, can a state later drop out of the expansion program?

A. Yes. A state may choose whether and when to expand, and, if a state covers the expansion group, it may decide later to drop the coverage.

26. Can a state expand to less than 133% of FPL and still receive 100% federal matching funds?

A. No. Congress directed that the enhanced matching rate be used to expand coverage to 133% of FPL. The law does not provide for a phased-in or partial expansion. As such, we will not consider partial expansions for populations eligible for the 100 percent matching rate in 2014 through 2016. If a state that declines to expand coverage to 133% of FPL would like to propose a demonstration that includes a partial expansion, we would consider such a proposal to the extent that it furthers the purposes of the program, subject to the regular federal matching rate. For the newly eligible adults, states will have flexibility under the statute to provide benefits benchmarked to commercial plans and they can design different benefit packages for different populations. We also intend to propose further changes related to cost sharing.

In 2017, when the 100% federal funding is slightly reduced, further demonstration opportunities will become available to states under State Innovation Waivers with respect to the Exchanges, and the law contemplates that such demonstrations may be coupled with section 1115 Medicaid demonstrations. This demonstration authority offers states significant flexibility while ensuring the same level of coverage, affordability, and comprehensive coverage at no additional costs for the federal government. We will consider section 1115 Medicaid demonstrations, with the enhanced federal matching rates, in the context of these overall system demonstrations.

27. Do you still support the Medicaid blended FMAP (matching rate) proposal in your budget?

A. No. We continue to seek efficiencies and identify opportunities to reduce waste, fraud and abuse in Medicaid, and we want to work with Congress, states, and stakeholders to achieve those goals while expanding access to affordable health care. The Supreme Court decision has made the higher matching rates available in the Affordable Care Act for the new groups covered even more important to incentivize states to expand Medicaid coverage. The Administration is focused on implementing the Affordable Care Act and providing assistance to states in their efforts to expand Medicaid coverage to these new groups.

28. How does the Supreme Court ruling affect the interaction between the Exchanges and Medicaid? Will a state's decision whether or not to proceed with the Medicaid expansion have implications for the Exchange's ability to make Medicaid eligibility determinations?

A. As the letter from Secretary Sebelius to Governors sent on July 10, 2012 and the letter from the CMS Acting Administrator Marilyn Tavenner sent on July 13, 2012 stated, the Supreme Court's decision affects the financial penalty that applies to a state that does not expand Medicaid coverage to 133% of the federal poverty level under the Affordable Care Act. No

other provisions of the law were affected. Thus regardless of whether a state adopts the Medicaid expansion, the provisions related to coordination with the Exchange, including the use of standard income eligibility methods, apply. An Exchange in each state will make either a Medicaid eligibility determination or a Medicaid eligibility assessment (at the state's option) based on the Medicaid rules in the state, including the income levels at which the state's Medicaid program provides coverage.

29. What help will be available to states to accommodate the added administrative burdens and costs they will have to bear if they expand coverage in Medicaid?

A. We have provided 90 percent federal matching funds for the new or improved eligibility systems that states are developing to accommodate the new modified adjusted gross income rules and to coordinate coverage with the Exchange. To further reduce system costs, we have promoted ways for states to share elements of their system builds with each other, and we will be sharing the business rules for adopting modified adjusted gross income in the new eligibility systems. In addition we are designing, with extensive state and stakeholder consultation, a new combined and streamlined application that states can adopt (or modify subject to Secretarial approval). And, we will continue exploring opportunities to provide States additional support for the administrative costs of eligibility changes. These and other initiatives relating to state systems development will lower administrative costs.

Implementation of the on-line application system, the new data-based eligibility rules, verification and renewal procedures and states' access to the federally-managed data services hub ("the hub") will collectively help defray states' ongoing costs and result in greater efficiency in the long term. For example, states will be able to electronically verify eligibility factors through the hub, where previously they had to verify through multiple federal venues. This is expected to lower the per-person administrative costs of enrollment and renewal for both newly and currently eligible individuals. As stated in previous guidance, no charge will be imposed on states for use of the hub, nor for the required data accessed there. In addition, it is anticipated that many individuals—both those who are eligible under current state eligibility rules as well as those who are eligible under the adult expansion—will apply for coverage via the Exchange. Our rules provide states the option to have the Exchange determine eligibility for Medicaid or to assess eligibility for Medicaid, in both cases using the state's eligibility rules and subject to certain standards. No charge will be imposed on states for the Medicaid determinations or assessments conducted by the Exchanges.

30. CMS has released 90/10 funding in order for states to improve their eligibility systems for Medicaid. Will that funding continue?

A. Yes. "90/10" funding remains available through December 31, 2015 for Medicaid eligibility system design and development, and the enhanced 75 percent matching rate will be available indefinitely for maintenance and operations of such systems as long as the systems meet applicable program requirements.

In previous guidance, we have assured states that the 90/10 and 75/25 percent funding for eligibility systems will be available without regard to whether a state decides to expand its program to cover newly eligible low-income adults. We reiterate that system modernization will be supported and the enhanced matching funds will be available

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regardless of a state's decision on expansion. Additionally, we will continue exploring opportunities to provide States additional support for the administrative costs of eligibility changes.

31. Will low-income residents in states that do not expand Medicaid to 133 percent of the FPL be eligible for cost sharing subsidies and tax credits to purchase coverage through an Exchange?

A. Yes, in part. Individuals with incomes above 100 percent of the federal poverty level who are not eligible for Medicaid, the Children's Health Insurance Program (CHIP) or other minimum essential coverage will be eligible for premium tax credits and cost sharing reductions, assuming they also meet other requirements to purchase coverage in the Exchanges.

32. Can states that are "expansion states" under the law receive newly eligible matching rate for some populations in their state?

A. Yes. The expansion state Federal Medical Assistance Percentage, or matching rate, described in section 1905(z)(2) of the Social Security Act is available to some states that expanded Medicaid coverage prior to enactment of the Affordable Care Act, but does not exclude those states from receiving the increased newly eligible match for expenditures for beneficiaries who meet the statutory qualifications. If a population covered by a state that qualifies as an expansion state meets the criteria for the newly eligible matching rate, the state will receive the newly eligible matching rate for that population. States will receive the highest matching rate possible for a given population; being an expansion state will never disadvantage the state in terms of matching rates for that population.

The following are several examples of circumstances in which an expansion state will receive the newly eligible matching rate for some beneficiaries:

- States are considered expansion states if, as of March 23, 2010, they provided coverage that meets the standards specified in section 1905(z)(3) of the Act to both childless adults and parents up to at least 100 percent of the federal poverty level. If a state provided Medicaid coverage up to 100 percent of the federal poverty level but not above, expenditures for individuals between 100 and 133 percent of the federal poverty level would qualify for the newly eligible matching rate.
- States that qualify as expansion states may have offered less than full benefits, benchmark benefits, or benchmark-equivalent benefits. Individuals who received limited benefits under a Medicaid expansion will qualify as "newly eligible" individuals and the newly eligible matching rate will apply.
- States that qualify as expansion states based on the provision of state-funded coverage will receive the newly eligible matching rate for people previously covered by the state-only program, since they will be newly eligible for Medicaid coverage.

The expansion state matching rate is only available for expenditures for non-pregnant, childless adult populations described in the new low-income adult group. CMS will work with states to ensure that the correct matching rate is applied to expenditures for populations in expansion states that qualify as newly eligible.

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Flexibility for States

33. What specific plans and timeline do you have for enacting the reforms and flexibility options for Medicaid that you spoke of in 2009? When can states give further input on the needed reforms?

A. CMS continues to work closely with states to provide options and tools that make it easier for states to make changes in their Medicaid programs to improve care and lower costs. In the last six months, we have released guidance giving states flexibility in structuring payments to better incentivize higher-quality and lower-cost care, provided enhanced matching funds for health home care coordination services for those with chronic illnesses, designed new templates to make it easier to submit section 1115 demonstrations and to make it easier for a state to adopt selective contracting in the program, and developed a detailed tool to help support states interested in extending managed care arrangements to long term services and supports. We have also established six learning collaboratives with states to consider together improvements in data analytics, value-based purchasing and other topics of key concern to states and stakeholders, and the Center for Medicare and Medicaid Innovation has released several new initiatives to test new models of care relating to Medicaid populations. Information about these and many other initiatives are available on Medicaid.gov. We welcome continued input and ideas from states and others.
States can implement delivery system and payment reforms in their programs whether or not they adopt the low-income adult expansion. With respect to the expansion group in particular, states have considerable flexibility regarding coverage for these individuals. For example, states can choose a benefit package benchmarked to a commercial package or design an equivalent package. States also have significant cost-sharing flexibility for individuals above 100% of the federal poverty level, and we intend to propose other cost-sharing changes that will modernize and update our rules.

34. Will the federal government support options for the Medicaid expansion population that encourage personal responsibility?

A. Yes, depending on its design. We are interested in working with states to promote better health and health care at lower costs and have been supporting, under a demonstration established by the Affordable Care Act, state initiatives that are specifically aimed at promoting healthy behaviors. Promoting better health and healthier behaviors is a matter of importance to the health care system generally, and state Medicaid programs, like other payers, can shape their benefit design to encourage such behaviors while ensuring that the lowest income Americans have access to affordable quality care. We invite states to continue to come to us with their ideas, including those that promote value and individual ownership in health care decisions as well as accountability tied to improvement in health outcomes. We note in particular that states have considerable flexibility under the law to design benefits for the new adult group and to impose cost-sharing, particularly for those individuals above 100% of the federal poverty level, to accomplish these objectives, including Secretary-approved benchmark coverage

35. Will CMS approve global waivers with an aggregate allotment, state flexibility, and accountability if states are willing to initiate a portion of the expansion?

A. Consistent with the guidance provided above with respect to demonstrations available under the regular and the enhanced matching rates, CMS will work with states on their

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proposals and review them consistent with the statutory standard of furthering the interests of the program.

MAGI

36. Will states still be required to convert their income counting methodology to Modified Adjusted Gross Income (MAGI) for purposes of determining eligibility regardless of whether they expand to the adult group? If so, how do states link the categorical eligibility criteria to the MAGI?

A. Yes, as required by law. Conversion to modified adjusted gross income eligibility rules will apply to the nonelderly, nondisabled eligibility groups covered in each state, effective January 2014, without regard to whether a state expands coverage to the low-income adult group. The new modified adjusted gross income rules are aligned with the income rules that will be applied for determination of eligibility for premium tax credits and cost-sharing reductions through Exchanges; the application of modified adjusted gross income to Medicaid and CHIP will promote a simplified, accurate, fair, and coordinated approach to enrollment for consumers. CMS has been working with states to move forward with implementation of the modified adjusted gross income rules, and consolidation and simplification of Medicaid eligibility categories.

DSH

37. The Disproportionate Share Hospital allotments will be reduced starting in 2014 using a methodology based on the reduction in the number of uninsured. One, when will HHS issue the regulations and methodology for this reduction? Two, for a state that does not see a decrease in its uninsured population, will the remaining states absorb the full reduction? Is HHS planning any modification to the manner in which it will reduce DSH allotments as it relates to states that do not expand?

A. The law directs HHS to develop a methodology to reduce Disproportionate Share Hospital (DSH) funding over time in a way that is linked to reductions in the number of uninsured or how states target their funds. We have heard from states and health care providers about their concerns related to this change and are exploring all options. The Department will propose this methodology for public comment early next year.

COORDINATION BETWEEN EXCHANGES AND OTHER PROGRAMS

38. How can states use premium assistance to help families that are split among the Exchange, Medicaid, and the Children's Health Insurance Program (CHIP) enroll in the same plans?

A. In 2014, some low-income children will be covered by Medicaid or CHIP while their parents obtain coverage on the Exchange with advance payments of the premium tax credit. Premium assistance, an option under current law, provides an opportunity for state Medicaid and CHIP programs to offer coverage to such families through the same coverage source, even if supported by different payers. Under Medicaid and CHIP statutory options, states can use federal and state Medicaid and CHIP funds to deliver Medicaid and CHIP coverage through the purchase of private health insurance. Most commonly, states have used premium assistance to help Medicaid/CHIP eligible families pay for available

employer-based coverage that the state determines is cost effective. There are cost sharing assistance and benefit wrap-around coverage requirements, to the extent that the insurance purchased with Medicaid and/or CHIP funds does not meet Medicaid or CHIP standards. In both Medicaid and CHIP, premium assistance is authorized for group health coverage and, under some authorities, for health plans in the individual market, which, in 2014 would include qualified health plans available through the Exchange. Please note that advance payments of the premium tax credit and cost-sharing reductions are not available for an individual who is eligible for Medicaid or CHIP. The statutory authorities that permit use of title XIX or title XXI funds to be used for premium assistance for health plans in the individual market, including qualified health plans in the Exchange, are sections 1905(a) and 2105(c)(3) of the Social Security Act.

For example, beginning in 2014, when a child is eligible for Medicaid/CIIIP and the parent is enrolled in a qualified health plan through the Exchange, a state Medicaid or CHIP program could use existing premium assistance authority to purchase coverage for a Medicaid or CHIP-eligible child through that qualified health plan. The premium tax credit would not be available to help cover the cost of coverage for these children. As noted above, with respect to the children, the state would adhere to federal standards for premium assistance, including providing wrap-around benefits, cost sharing assistance, and demonstrating cost-effectiveness, as appropriate. A State-Based Exchange may be able to support such an option, and in states where a Federally-Facilitated Exchange is operating, a State Medicaid or CHIP agency may be able to take this approach by making arrangements with qualified health plans to pay premiums for individuals. We will be working with states interested in this option to consider how the state Medicaid and CHIP agency can coordinate with the Exchange to establish and simplify premium assistance arrangements.

39. How can states use premium assistance to promote continuity of care when individuals move between Exchange, CHIP, and Medicaid coverage?

A. The Affordable Care Act envisions and directs that there be a coordinated system for making eligibility determinations between Medicaid, CHIP and the Exchange to avoid gaps in coverage as individuals' income fluctuates. Smooth eligibility transitions will not necessarily prevent people from having to select a new plan and/or provider when they lose eligibility for one insurance affordability program and gain eligibility for another. The extent to which such changes in plans and providers occur will depend on whether and to what degree plans participate in both the Exchange and in Medicaid and CHIP, and the networks in such plans.

Premium assistance can help address this issue, while encouraging robust plan participation in Medicaid, CHIP, and the Exchange. As discussed above, this option permits state Medicaid or CHIP programs to use premium assistance to enroll a Medicaid or CHIP eligible individual or family in a qualified health plan through the Exchange. States may be most interested in this option for families close to the top of the Medicaid income limit. Under this arrangement, if a family's income changes such that some or all members of the family become ineligible for Medicaid or CHIP and eligible for a premium tax credit to help cover the cost of a qualified health plan through the Exchange, it would be less likely that members moving into Exchange coverage would need to change plans or providers. Similarly, premium assistance could help increase the likelihood that individuals moving from Exchange coverage into Medicaid or CHIP may remain in the same qualified health plan in which they had been enrolled through the Exchange.

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As discussed above, premium assistance options in Medicaid and CHIP are subject to federal standards related to wrap around benefits, cost sharing and cost effectiveness. There may also be an opportunity for states to promote continuity of coverage through "bridge plans" as described earlier.

Attach #5
SB2163
01/21/15
Jt # 22285

FAMILY
HealthCare

Testimony of Patrick Gulbranson, Family HealthCare, Fargo
To Senate Human Services Committee in Opposition of SB 2163

Wednesday, January 21, 2015

I am Patrick Gulbranson, Chief Executive Officer of Family HealthCare in Fargo, and I would like to speak on behalf of Family HealthCare (FHC) and offer this testimony in opposition to Senate Bill 2163.

Family HealthCare is the largest federally qualified community health center in North Dakota. FHC is a primary care, safety net clinic that serves diverse and vulnerable populations; including homeless, low income, uninsured, and under insured patients. FHC is committed to finding solutions for improving health care options to patients that are underserved. We, as do all community health centers in North Dakota, offer a unique model with proven results for high-quality, cost-effective care customized to benefit the patient and communities being served.

Starting in 2013, FHC received funding from the Health Resources and Services Administration (HRSA) to hire and train federally Certified Application Counselors (CACs). CACs are responsible for conducting consumer outreach and education about and enrollment in qualified health plans (QHPs), Medicaid, and the Children's Health Insurance Program (CHIP).

In order to provide this assistance, we applied to the federal Centers for Medicare and Medicaid Services (CMS) to become a Certified Application Counselor (CAC) organization and ensure that all our CACs successfully complete all required federal CAC training. Federal regulations require CACs to be recertified and trained on at least an annual basis, and FHC is in full compliance with this requirement, which includes completion of the updated 2015 plan year training curriculum for CACs.

A CAC organization is responsible for making sure that all of the staff and volunteers it certifies as individual CACs take and pass the training; comply with the requirements to be a CAC, including privacy and security regulations; and sign an agreement that he or she will comply with the CAC requirements. Further, CACs receiving certification must display their certificate when completing CAC duties.

FHC, as a community health center must educate consumers about affordable insurance options, including the benefits of insurance that extend beyond the services provided by the health

5.2

FAMILY
HealthCare

center (e.g., access to specialty care and hospitalization), and provide assistance with enrollment for eligible individuals. CACs receive no additional compensation for this assistance.

Our CACs are not selling insurance, nor are they allowed to advise a consumer about choosing a specific insurance policy. Further, our CACs are not allowed to refer consumers to any specific insurance agent or broker. However, CACs may inform consumers about the general availability of licensed, Marketplace-trained health insurance agents and brokers as an additional resource that may be able to provide recommendations to the consumer.

As a private non-profit organization, with limited resources, implementation of government mandates or regulatory compliance initiatives is often challenging. Additionally, given the significant federal regulations established for both CAC organizations and CACs, an additional layer of state regulation seems unnecessary at this time. Rather, it appears that this would be a duplicative effort at the state level that would expend unnecessary financial and staff resources that could instead be focused more effectively elsewhere.

Collaboration has been and continues to be a major component of the success of the Certified Application Counselor program at the state's community health centers. As a member of the Community HealthCare Association of the Dakotas (CHAD), our fellow organizations have collaborated and unified the CACs into one team to share best practices. Further, CHAD's involvement has streamlined the process to create more consistency and continuity in how consumers are provided assistance.

North Dakota community health centers and their CACs are committed to maintaining expertise in eligibility, enrollment, and the health care marketplace, as well as to providing free and impartial assistance to consumers so the consumer may choose the best health insurance option to meet their needs. We ask that you not require an additional layer of unnecessary regulation that increases the expenditure of financial and time resources to a system that is currently working.

Family HealthCare respectfully requests the committee's recommendation for a "do not pass" on SB 2163.

Attach #6
SB 2163
01/21/15
J# 22285

Valley Community Health Centers

Written Testimony of Mara M. Jiran
Valley Community Health Centers
To Senate Human Services Committee in Opposition to SB 2163
01 / 20 / 2015

I am Mara M. Jiran, Interim CEO, of Valley Community Health Centers and I would like to provide written testimony in opposition to Senate Bill 2163.

Valley Community Health Centers (VCHC) is a Federally Qualified Health Center (FQHC) that receives federal funding which allows us to provide discounted health care services to income eligible patients in Northwood, Larimore, Grand Forks and the surrounding communities. VCHC provide community-based primary and preventive care offering broad-based access in a caring environment. We promote excellent, affordable healthcare, meeting the needs of all.

As a member of the Community HealthCare Association of the Dakotas (CHAD), we oppose the additional state regulation of certified application counselors outlined in SB 2163.

Certified Application Counselors (CACs) are certified through the federal government, accountable to the VCHC Quality and Care Manager, complete annual training and recertification, and attend weekly Outreach and Enrollment conference calls with the primary care association CHAD. CACs are also required to submit quarterly reports to the federal government and are held to strict privacy laws as dictated through the Health Information Portability and Accountability Act (HIPAA). CACs do not sell insurance, nor do they refer to any specific insurance broker.

The primary role of CACs is to provide education about affordable insurance options and provide assistance with enrollment for eligible individuals. Increased paperwork and regulations diverts time away from meeting with clients and creates another tier of bureaucracy and

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Valley Community Health Centers

redundancy. Valley Community Health Centers prides itself on client-centered care. Additional regulations when not needed takes time away from our clients.

I request the committee's recommendation for a do not pass on SB 2163.

Sincerely,

Mara M. Jiran
Interim Chief Executive Officer
Valley Community Health Centers

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701-587-6000

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Grand Forks Clinic
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Grand Forks, ND 58201
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Attach #7
SB2163
01/21/15
J# 22285

Community Health Service Inc.

Testimony of Kristi Halvarson, Community Health Service Inc.
To Senate Human Services Committee in Opposition to SB 2163
Wednesday, January 21, 2015

I am Kristi Halvarson, representing Community Health Service Inc. (CHSI) (formerly known as Migrant Health Service, Inc. prior to July 2014) and I would like to speak on behalf of our health center in opposition to Senate Bill 2163.

Community Health Service Inc. is a migrant health center that provides primary care services to migrant and seasonal farmworkers and their families. We operate a total of four year-round and three seasonal clinic locations throughout Minnesota and North Dakota. Two of our year-round clinics are in Grafton, ND and Moorhead, MN. Our reach into North Dakota is expanded with the use of our seasonal mobile unit, which regularly sees patients in areas such as Wahpeton, Oakes, Tappen, and Hillsboro during the summer and early fall.

Starting in 2013, CHSI received funding from the Health Resources and Services Administration (HRSA) to hire and train federally Certified Application Counselors (CACs). Assisters are responsible for conducting consumer outreach and education about and enrollment in qualified health plans (QHPs), Medicaid, and the Children's Health Insurance Program (CHIP).

In order to provide this assistance, we had to apply to the federal Centers for Medicare and Medicaid Services to become a Certified Application Counselor (CAC) organization and ensure that all health center assisters successfully complete all required federal CAC training. Federal regulations require assisters to be recertified and trained on at least an annual basis, and we are in full compliance with this requirement, which includes completion of the updated 2015 plan year training curriculum for assisters. Additionally, we meet the training requirements as navigators in the MNSure health exchange in Minnesota.

We pride ourselves on providing the most accurate information we can to our patients, whether it is sound medical advice or appropriate education on affordable insurance options. It

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is an obligation that we take very seriously not only to maintain patient safety, but also to earn and strengthen the trust that is imperative to a successful clinic-consumer relationship. Our patient population is over 90% uninsured, 85% Hispanic, and nearly half are best served in a language other than English. Those patients look to us to provide guidance and assistance and are grateful for the ability to be insured, often for the first time in their lives. CHSI would not knowingly do anything to jeopardize that valued relationship. Our interest is never in a specific insurance plan; rather, it is making sure that our patients are empowered with the knowledge necessary to make an insurance plan selection that best meets their needs.

CHSI takes great care to ensure that our CACs are properly trained and adequately prepared to answer questions of our patients and community members. As a healthcare facility we are already subject to a number of regulatory requirements that require a significant amount of resources to maintain compliance, such as HIPAA, OSHA, and the like. Adding yet another certification is burdensome and unnecessary.

CHSI, along with the Community Healthcare Association of the Dakotas, requests the committee's recommendation for a do not pass on SB 2163.

Kristi Halvarson, MHA
Executive Director, Community Health Service Inc.
Resident, ND District 45

Attach #8
JH 22285
SB 2163
01/21/15

Testimony for Sixty-fourth
Legislative Assembly of North Dakota
The Senate Human Services Committee
January 21, 2015

Neil Scharpe, Navigator Project Director

North Dakota Center for Persons with Disabilities

Minot State University

Senate Bill No. 2163-Written testimony on bill requiring licensing and fees for Navigators and Certified Application Counselors

Honorable Chair Lee and members of the committee.

My name is Neil Scharpe, I work for the North Dakota Center for Persons with Disabilities (NDCPD) as the Project Director of the Navigator project. It is a cooperative agreement with the Centers for Medicare and Medicaid Services (CMS). We were awarded the initial agreement in 2013-14 to assist people in North Dakota accessing the federal Marketplace. CMS open the competition a second year and through the competitive process NDCPD was again awarded the cooperative agreement.

Currently, we have 18 certified Navigators spread out across the state. We have partnered with Family Voices, the Federation of Families for Children's Mental Health, and DLN Consulting, Inc. to provide these Navigators. As a requirement of the agreement Navigators must be certified by CMS by competing required on line training. This training covers accessing the Marketplace, privacy regulations, conflict of interest, health insurance basics, Marketplace eligibility and affordability, exemptions, cultural competence, vulnerable populations, and fraud prevention. CMS estimates it will take approximately 20 hours to complete the training.

I have presented to the Interim Committee on Healthcare Reform several times during the first year of open enrollment. During those testimonies I have been asked how we assist consumers in choosing a specific plan. I explained choosing a health plan is the most complicated and time consuming part of assisting a person to enroll. Navigators never chose a plan for a consumer, we may assist them in narrowing their choices by cost, health needs, and access to services, but if the consumer cannot make a decision they are referred to an agent. Personally I have conferenced agents in on calls to have them assist with plan selection.

All Navigators have undergone criminal background checks although they are not required by the agreement or state statute, we do this so Navigators are not called into question. Navigators have assisted many of the 11,000 plus North Dakotans who accessed health insurance through the Marketplace last year and many of the thousands who accessed Medicaid Expansion. There has not been one complaint filed with me as the project director about the conduct of any of the Navigators. It may be beneficial to check with the Insurance Commissioner's Office to see if any have been lodged there, but I am sure they would have contacted me if one had been filed.

The ACA is new, there are many cases last year and again this year that require someone trained to navigate the nuances of the law. Navigators will be the first to say they do not know the law or insurance, but they can assist consumers in finding the answers to their questions.

SB 2163 says it will require the Insurance Commissioner to develop guidelines for certification, but it does not delineated what those would be or how long it would take a Navigator to accomplish these requirements or the cost. CMS clearly defines Navigator duties, requirements and limitations it would seem that any legislation proposed should do at least that.

Respectfully submitted,

Neil Scharpe, NDCPD Navigator Project Director