Texas CHIP Coalition
Meeting Minutes

December 13, 2013

Present:	Anne Dunkelberg, CPPP Kit Abney Spelce, insure-a-kid Sr. JT Dwyer, Seton Joshua Houston, Texas Impact Greg Hansch, NAMI TX Becky Huerta, Central Health Clayton Travis, TCFC Ashlee Mooneyham, CommUnityCare Helen Kent Davis, TMA Kathleen Davis, TX IAF Network Megan Randall, CPPP Katrina Mendiola, Engage Texas
Conference Line:	Betsy Coats, Maximus Miryam Bujanda, MHM Jessica Boston, Office of Rep. Naishtat Ann-Marie Price, Central Health Robin Chandler, Disability Rights Texas Gracie Camarena, CDF Sendero Health Plans Carrie Alexander, BCBS TX Rose Marie Linan, HHSC Lee Johnson, Texas Council of Community Centers Juan, Molina Health Care Kamilah Hasan, County Health Department Luis Wilmot, HHS
Chairs:	Josh Houston, General Counsel, Texas Impact Miryam Bujanda, Governmental Relations, MHM
Minutes Scribe:	Megan Randall, CPPP
Next meeting:	January 17, 2013

I. Federal Update on the Health Insurance Marketplace, Luis Wilmot, HHS Dallas Regional Office

See attached press release and chart at end of document for more details.

LWilmot

- Enrollment numbers for October and November were low and this has to do with fact that the website was down for so long. As of this week, we have seen an uptick with the use of the website. The website is the fastest/most efficient way to enroll.
- It has been difficult for us to coordinate/organize and get people together to have events and educate them about how to enroll without a functional website. Paper applications are not very efficient. They take a long time and we have not had an opportunity to see if

that has worked well. A lot of this is not the fault of the organizers, the navigators, the assisters, etc. Their enthusiasm and efforts are there and are quite extraordinary, but they don't have the tools.

- One priority for HHS is to reach out to the Latino community with the ability to speak the language and communicate with those who might be potential enrollees.
- There are difficulties associated with people in this group who have never had insurance and having to explain it to them.
- We are trying to get community organizations on board who have the ability to speak both languages, and are trusted by the community. One major contributor is the Spanish language media. When you have a Spanish language media announcement that there will be events at particular sites, you get a turnout.
- There is some fear and caution to overcome amongst Latinos in the RGV and San Antonio. Success will be greater with word of mouth outreach in Latino community, and involvement of Spanish language press.

ADunkelberg:

- I will offer an optimistic counterpoint to the low enrollment numbers. As a CAC volunteer, there is no comparison between the functionality of healthcare.gov in November versus in December. It is day and night, it is so much better. Megan [Randall] has a blog post up that talks about her enrollment experience.
- While I in no way downplay the challenges, particularly with the Hispanic community, I do think we will see some very different numbers for December.

LWilmot

- I agree, Anne, and I have seen changes in the last week. People are going straight to navigators, and they are signing up. We might go through a 5 – 6 hour education process, and then send them to navigators. But we couldn't go very far when the website was down. It is hard because we brought them out one time, and they couldn't get what they needed. So, trying to get them out again is challenging. There were also problems with the Spanish language website. We are glad that that has been fixed. We will see a lot of changes and will hopefully see numbers approve.

II. Update on Navigator Rulemaking, Stacey Pogue, Center for Public Policy Priorities

Please see attached flow chart at the end of this document for more details.

SPogue

- TDI has proposed Navigator rules. Reference the flow chart to see whether you or your organization comes under regulation. Rules include organizations who are not technically ACA Navigators.
- CACs are out, HICAP is out (i.e., exempt from TDI rule), and CPP out. A lot of folks doing enrollment assistance are out due to some of the exceptions outlined in the rule.

KAbneySpelce

- And if you are doing enrollment but you are not a Community Partner, what then?

SPogue

- Then you move to step two in the flow chart to see if you fall under regulation. Who falls into this bucket? People who are doing enrollment assistance who are not regulated by another specific authority. This might include hospital eligibility workers.
- Also, the rule is so broad it doesn't just touch application assistance. It defines navigator services. People who fall under health education and outreach also fall under some regulations.

SrDwyer

- But even if that navigator service is not related to the ACA, you are saying they fall in the bucket?

SPogue

- That is what it looks like to me. I think there are a whole lot of people who fall into this bucket who have nothing to do with enrollment assistance at all.
- If you provide outreach or enrollment navigator services, you can't use the word navigator in your name. You also can't provide advice on substantive and comparative benefits of different health plans.

CTravis

- Many advocates have put together educational materials that look at which plans are best for mental health, etc. So, under this rule, is it possible that TCFC could not speak about these benefits?

SPogue

- Yes. I would be concerned about that.

KAbneySpelce

- We have several 1115 projects that are called "Navigator" projects.

JHouston

- If you even think you are implicated, it would be worth your time to engage.

KAbneySpelce

- Many of those navigators are disease-specific, but they talk about funding and health insurance, how to apply, etc.

KDavis

- I would check with your legal counsel, I don't know that TDI can appropriate that term and prohibit people from using it.

SPogue

- There is no appropriation of the term "navigator" in SB 1795.

KDavis

- Under education and outreach, I saw something in the rule/original comments that indicated if an organization that is doing education explains what a bronze, silver, gold plan, etc. is or explains health insurance terms, that all of that would throw people into the navigator category and require training, fees, etc. Is this right?

SPogue

- First part is correct. If you are doing education, you are providing navigator services, according to the proposed rule. But you don't have to register. I don't know how to define "substantive comparative benefits," but you are technically not able to talk about those things. It is difficult to understand what that stipulation means, though.

ADunkelberg

- One of many general things you may want to comment on is the language restricting the ability to explain the comparative benefits of plans.

SPogue

- We will certainly ask that that language is struck altogether. It is not in SB 1795. It is not clear what it means, but it certainly means that navigators would probably be hindered from helping people select a plan.

ADunkelberg

- Everyone who has access to actual counsel should comment on this. We have good practical comments but it is important for attorneys to respond, as well. There is no ambiguity in the federal training about the fact that a Navigator cannot recommend a specific plan to a consumer.

SrDwyer

- Rule says that navigator services are those performed "under SB 1795 or ACA." What about groups like insure-a-kid who, long before the ACA, did Medicaid/CHIP assistance? The way I read this, they are not falling in the bucket.

SPogue

- I talked to TDI staff, and raised the issue of whether the "under" phrase limits the universe, and TDI staff made a note of that, but their initial response was that they thought this was broad enough to regulate even me helping my neighbor with an application. We will be saying that you need to tighten the language of who provides navigator services.
- In the proposed rule, if you perform a navigator service, and you also provide enrollment assistance, then you must register with TDI. You have to do training, continuing education, finger printing and a background check, etc. It is expensive and time consuming and navigator organizations would have to buy liability insurance. Would have to come up with procedures and practices around privacy and security, etc.
- Most of the universe of application assistance has always happened outside of TDI's jurisdiction. It is not a commercial venture and TDI is a regulatory agency that regulates commercial entities, and there is a real disconnect between applying a regulatory model to a community-based group.
- These rules were drafted quickly, and that may have limited the depth of TDI's research. Anyone who has concerns should get comments in by the 6th.

KDavis

- One thing I raised with an attorney who is doing the MO case is, aren't there already ways in place to protect consumers on fraud issues? There are three: deceptive trade practices act, insurance code act, and a third one. In comments, other avenues of recourse normally used in every other situation, should be mentioned and put into record.

ADunkelberg

- And we do want TDI to be armed to crack down on fraud.

JHouston

- Being pro consumer-protection is a great message to take in your comments.
- Also can mention the inefficiency of the training process. It seems that a lot of the rule is very specific in the requirements for the training, and much of it is stuff that HHSC is already doing. Despite that, the rule is written in such a way that it looks like it would require a third-party vendor to provide services.

SPogue

- Additional state training would be 40 hours. Unfortunately would be provided at cost to trainees, unlike the HHSC and HICAP programs where training is free. Comments calling for fewer hours and free training more substantively based on existing training models would be helpful.
- Comments are due on 6th, hearing on 20th. Next week Tuesday, 10 am. Meeting at CPPP for those who want to coordinate testimony. There is value in getting lots of different comments, and not just one set of comments. Can send around comments on the outline, and then see if people could generate their own comments.
- Will compile tools, references, and prior comments all into one e-mail. We have a blog post coming up next week. Will put it all in one place with info on how and when you comment. If anyone has an attorney on staff who can add to and review comments, that would be helpful.

KAbneySpelce

- So gone are the days of the Fiesta enrollment events, recruiting volunteers to educate and distribute information. The easy way out for us is to go be a CAC. But it doesn't solve the bigger issue.

JHouston

- Before we leave this topic, it is important to remember that if you think the rule applies to you, it is important to file comments and remember that if you raise an issue in comments the agency MUST respond to that issue and explain in the final order adopting the rule a justification for why they are doing what they are doing in the rule. Important function of writing comments is to draw out justifications that can later be reviewed.

KAbneySpelce

- So, they will have to then justify why friends and family are included in this?

JHouston

- Have to provide reasoned justification for rule in final word.

ADunkelberg

- Also a note that under federal Medicaid law, there is the ability of anyone to designate an authorized representative to help them with their Medicaid application. I assume that just that general authority is protected, and it almost becomes an out for anyone assisting with Medicaid/CHIP application, and since this is also the Marketplace application I don't know how those interact.

SPogue

- We are clearly concerned about many of these provisions, but I think they have fixes and we will be offering up that message. There isn't an option to NOT have the rules at this point, so let's offer tweaks.

III. ACA Implementation Update, Anne Dunkelberg, Center for Public Policy Priorities

ADunkelberg

- The HHSC proposed rules comment period is closed. The proposed rules included 3 big issues (and a related 4th issue).
- Issue #1: The intention of the agency to continue asking asset questions even though they are no longer relevant to eligibility. HHSC has confirmed they did not intend to note in the draft application that these questions are optional. CMS said that they have sent letter to agency saying they won't approve it.
- Issue #2: The state's decision to not extend the new ACA-related Medicaid eligibility for former foster youth to kids who were from another state's foster system. Texans Care will take over this issue. Decision as it stands now, going forward, is that someone who aged out of foster care and Medicaid in Oklahoma (or another state) won't get coverage if residing in Texas. Handed lead on that issue over to Texans Care.

HKentDavis

- What has Senator Nelson said?

ADunkelberg

- Her staff has been briefed on it, and her staff said her office was not interested in taking action on it at this time.
- Issue #3: Since January of 2002, we have had a 6-month continuous eligibility segment for kids. This rule proposes to only give kids one six-month continuous eligibility segment each year. Rationale for that is that HHSC holds that because they cannot do a full redetermination (i.e., one requiring actions from parents) at the 6-month point (due to federal law), they cannot trigger another 6-months of continuous eligibility. They don't

think the electronic data they can get from third party sources is adequate to trigger another 6 months of continuous eligibility.

- For the second six months, eligibility would be subject to termination and parents would be subject to reporting requirements. State is thinking about this. Have had exchanges with Stephanie Muth, with Commissioner, etc. and they are aware of our concerns, as is CMS. I haven't given up hope that we can fix this.
- I don't think the policy they've proposed would be as rapidly devastating as the 2003 reduction of CHIP from 12 to 6 months of coverage which dropped 250,000 kids and 40% of enrollment. It won't be that quick or devastating, but continuous eligibility is a powerful lever. I am also concerned about the precedent established if HHSC ignores the state law requiring 6-month CE.
- I think that it will have a meaningful impact, particularly in depressing children's caseloads. I am hopeful that we will see some good progress that can satisfy the agency's concerns to have a strong basis for recertification, if we can make a good case that they need to get used to the idea that third party resources are supposed to be basis for income eligibility going forward.

KAbneySpelce

- I think our experience has told us that a lot of families aren't in third party databases.

ADunkelberg

- The standard under federal law and regulation now is that you can't put somebody out unless you have evidence that shows they are over-income. Lack of information cannot be basis for follow-up.

CTravis

- Is a family or individual considered to have committed fraud if a change comes up in the data search and it hasn't been reported by them?

ADunkelberg

- Don't know, but they are theoretically obligated to report those changes.

CTravis

- Would it be helpful for other orgs to send additional e-mails to the Commissioner, etc.?

ADunkelberg

- Why don't we continue to try to handle this on an administrative level for now and we will know in the next couple of weeks the direction that things are going in. One piece of info I left out is that I initially thought it was a violation of maintenance of effort requirements. It turns out there is a giant loophole in the maintenance of effort requirements, in that the requirements are strictly focused on the initial application. Because this is a renewal issue, maintenance of effort does not apply. It is something that CMS is concerned about. They may be helpful in encouraging the state to find another way to resolve.
- Issue #4: Kathy Eckstein pulled together a letter for HHSC about the stair-step problem. We thought we would get rid of the stair-step with the ACA. But the mechanics are looking at leaving us with ages 1 -5 at 144% and 6 – 18 at 133% of poverty which leaves some families with some of their children in Medicaid and some in CHIP. There is a time-limited opportunity for HHSC to make a change that would allow them to make them both at 144%. Kathy drafted a sign-on letter, and TMA sent a separate letter a few days later. Again, we will send an e-mail out to the listserv if we have an update on that before holidays.
- In other news, the feds recently put out guidance saying that despite the complaining by states of lack of readiness of the federal system, a lot of state systems are also not ready to receive transfer of files from the Marketplace to Medicaid/CHIP. Feds said they are

offering an option of new and improved data on Medicaid and CHIP-eligibles until we can do full electronic transfers.

- A letter went from the Commissioner to CMS which reads like it was written before this guidance came out. The letter was basically protesting the problems with the earlier iterations of data that had come from feds. The federal government is now offering new, better, different spreadsheets, not the earlier ones which were full of duplicates or missing information. The TX letter, however, makes it sound like this new federal guidance is asking them to certify the flawed duplicates with fields missing from data they had previously gotten. The takeaway is that the state is a little unhappy that it agreed to accept the determination of the Marketplace because they got these early files that looked so bad.
- The state has clarified (NOTE: this clarification was received later in December, after this CHIP Coalition Meeting) that they will still be ready to do MAGI processing starting Jan 1. Issue of transfers of cases between Medicaid and the Marketplace will continue to be problematic probably for a few more months. Best door policy: if you are pretty sure someone is eligible for Medicaid/CHIP, send them through that process and not the Marketplace

KAbneySpelce

- So, coming January 1st, if I submit an application to Medicaid, my eligibility should be assessed using MAGI and not current rules. Will this happen? In a regular HHSC application, when will they convert to MAGI? [NOTE: Clarification received later in December that HHSC HAS CONFIRMED MAGI PROCESSING EXPECTED TO BE IN PLACE 1/1/2014.]

ADunkelberg

- We will see if we can send this question to Stephanie today.

HKentDavis

- It also means presumably they are going to accept the transfer files from the feds, or we don't know that either?

ADunkelberg

- Don't know. Presumably they are talking to feds.
- Want to repeat what Stacey said regarding TDI. We have to understand that HHSC is under similar pressures that TDI is with the Governor so persistently oppositional to ACA implementation.

KAbneySpelce

- If 16,000 people have been identified CHIP/Medicaid eligible, are those people going to get coverage Jan 1? Are they getting a letter saying they haven't gotten the file? Are they going to hang out in no-man's land? Communication?

ADunkelberg

- I will make that a discrete question. Also a question about not being 100% certain that those 16,000 don't include coverage gap adults.

KAbneySpelce

- But for the people who are eligible, will they get a packet or something?

IV. Update on Medicaid Coverage Gap Activities, Katrina Mendiola, Engage Texas

ADunkelberg

- Katrina is Executive Director of Engage Texas
- Engage Texas is one of our partners in our grant with Atlantic Philanthropies. Katrina is our project coordinator for all of the organizing part of Texas Well and Healthy.

KMendiola

- Due to the fact that the lege did not do Medicaid expansion, we will have people falling into the coverage gap. TWAH and other orgs, including Progress Texas and TOP, have worked together on a campaign, Texas Left Me Out, to capture those folks who are falling into the gap, to help engage them in advocacy. We have been working together and planning how we will use this campaign, etc. Want to keep this issue front and center. Our plan currently is to roll out the website and do a soft launch of campaign in January. Also have an 800 number that folks can call to get involved, and a text number. Will be providing the website to folks in the field who are helping people enroll.
- Later in year, after March primaries, we will probably try to do a splashier launch trying to recruit some big orgs to be partners in this as well. Goal of grass roots activities next year is to work in targeted areas around state where we know we have legislators that we need to sway. Beating the drum on importance of addressing this in 2015. Planning a series of phone banks to do some issue ID and volunteer recruitment. One thing we would like to do is, in some of these target areas, identify and train up volunteers who will then go to any local town hall or community forum where candidates may be speaking or having conversations to make sure they are asking questions about this issue and that it is at forefront. Will try to focus targeted areas, but if we have volunteers who are interested in other areas, that is great.
- Late spring/early summer we will try to do a day of action, will probably find one location to do large healthcare town hall. Invite speakers to talk about Medicaid expansion issues. But will encourage community partners to do day of action and do something in their community: in-district lege visits, etc. We do want it to be focused on a single day to try to get some earned media around that.

KAbneySpelce

- Time frame/date?

KMendiola

- Early next year will probably have better idea. Maybe early mid-June. One day state-wide.
- Possibility of trying to do some issue mail which is kind of like issue education mail, early summer late fall. I think there will be opportunities to engage activists and volunteers and then hopefully come to legislative session in 2015.
- Partners in past have been in Houston, Dallas, Fort Worth, Corpus, San Antonio, and the Valley. This is not necessarily where we are focusing on our work. We have to go back and look at targeted districts, but we have partners in all of those cities.

ADunkelberg

- Courtney Watson at CDF is going to be doing a lot more aggressive community education and outreach and she is real excited about jumping more into that in the new year.
- Only other thing to mention is that we are framing this around the TX coverage gap language. Prepared to work within the Texas solution language as needed. But we want to be sure we are highlighting the real people who are left without any solution.
- I will always feel compelled to be part of the truth-telling on Medicaid and some partners, like THA and THOT, are very interested in doing reputation repair on Medicaid as well.
- CDF will be doing story collection, etc. Always something that we want to add to and keep fresh. If you want to get more directly involved and updated, we are doing most of that through Coverage Texas Now, let us know if you'd like to be on listserv, etc.

KMendiola

- Because Engage is a (c)(4), we have started to pull together a smaller subset of groups that want to do direct advocacy or work more directly related to elections. If anyone has a (c)(4) and is interested, please let me know.

V. Update on Miscellaneous Issues

ADunkelberg

- Just FYI: Congressional hearing in Dallas on Monday to bash Navigators.

HKentDavis

- Read that Senator Coburn said that the Marketplaces are going to work, and they have framework of healthcare reform and we need to move past bashing the exchanges.

SrDwyer

- Are other orgs doing application assistance experiencing uptick in lost CHIP perinate applications? May be more of an OTA question. Used to be you could escalate and get them settled in 4 – 5 days. We have some that have been at HHSC unsettled for weeks. Also seeing that babies born to CHIP perinate mom, family income make them Medicaid eligible, but those babies are being put in six months coverage?

KAbneySpelce

- Processing issue is that, separate from outstation eligibility workers' ability to handle this, in order to get TP 45 trigger, you have to process mom first. Only way you get TP 45 is if mom had Medicaid eligibility at birth. Giving birth under emergency Medicaid, counts. If you are a mom and if your birth wasn't covered under Medicaid, then the baby only gets six months. An error on mom causes an error for the baby. I think it is a training issue.

ADunkelberg

- Let's get this to them for Jan OTA.

HHS Press Release

U.S. Department of Health & Human Services
News Division

202-690-6343
media@hhs.gov
www.hhs.gov/news

FOR IMMEDIATE RELEASE
Wednesday, December 11, 2013

Nearly 365,000 Americans selected plans in the Health Insurance Marketplace in October and November

1.9 million customers made it through the process but have not yet selected a plan; an additional 803,077 assessed or determined eligible for Medicaid or CHIP

Health and Human Services (HHS) Secretary Kathleen Sebelius announced today that nearly 365,000 individuals have selected plans from the state and federal Marketplaces by the end of November. November alone added more than a quarter million enrollees in state and federal Marketplaces. Enrollment in the federal Marketplace in November was more than four times greater than October's reported federal enrollment number.

Since October 1, 1.9 million have made it through another critical step, the eligibility process, by applying and receiving an eligibility determination, but have not yet selected a plan. An additional 803,077 were determined or assessed eligible for Medicaid or the Children's Health Insurance Program (CHIP) in October and November by the Health Insurance Marketplace.

"Evidence of the technical improvements to HealthCare.gov can be seen in the enrollment numbers. More and more Americans are finding that quality, affordable coverage is within reach and that they'll no longer need to worry about barriers they may have faced in the past – like being denied coverage because of a pre-existing condition," Secretary Kathleen Sebelius said. "Now is the time to visit HealthCare.gov, to ensure you and your family have signed up in a private plan of your choice by December 23 for coverage starting January 1. It's important to remember that this open enrollment period is six months long and continues to March 31, 2014."

The HHS issue brief highlights the following key findings, which are among many newly available data reported today on national and state-level enrollment-related information:

- November's federal enrollment number outpaced the October number by more than four times.
- Nearly 1.2 million Americans, based only on the first two months of open enrollment, have selected a plan or had a Medicaid or CHIP eligibility determination;
    - Of those, 364,682 Americans selected plans from the state and federal Marketplaces; and
    - 803,077 Americans were determined or assessed eligible for Medicaid or CHIP by the Health Insurance Marketplace.
- 39.1 million visitors have visited the state and federal sites to date.
- There were an estimated 5.2 million calls to the state and federal call centers.

The report groups findings by state and federal marketplaces. In some cases only partial datasets were available for state marketplaces. The report features cumulative data for the two month period because some people apply, shop, and select a plan across monthly reporting periods. These counts avoid potential duplication associated with monthly reporting. For example, if a person submitted an application in October, and then selected a Marketplace plan in November, this person would only be counted once in the cumulative data.

To read today's report visit:
http://aspe.hhs.gov/health/reports/2013/MarketPlaceEnrollment/Dec2013/ib_2013dec_enrollment.pdf

To hear stories of Americans enrolling in the Marketplace visit:
http://www.hhs.gov/healthcare/facts/blog/2013/12/americans-enrolling-in-the-marketplace.html.

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Total Marketplace Applications, Eligibility Determinations, and Marketplace Plan Selections By Marketplace Type and State (1)
10-1-2013 to 11-30-2013

State Name	Total Number of Completed Applications (2)	Total Individuals Applying for Coverage in Completed Applications (3)	Number of Individuals Determined Eligible to Enroll in a Marketplace Plan		Determined or Assessed Eligible for Medicaid / CHIP by the Marketplace (6)	Pending/ Other (7)	Number of Individuals Who Have Selected a Marketplace Plan (8)
			Total Eligible to Enroll in a Marketplace Plan (4)	Eligible to Enroll in a Marketplace Plan with Financial Assistance (5)			
	Number	Number	Number	Number	Number	Number	Number
Iowa	12,755	25,007	12,613	4,946	7,382	5,012	757
Kansas	12,900	26,617	19,038	7,210	2,353	5,226	1,855
Louisiana	17,662	32,300	23,208	8,214	1,751	7,341	2,193
Maine	8,837	16,325	12,667	5,945	1,079	2,579	1,747
Michigan	52,780	98,235	74,693	29,222	7,363	16,179	6,847
Mississippi	9,992	18,809	13,050	3,974	1,214	4,545	802
Missouri	31,474	62,964	43,661	16,911	6,487	12,816	4,124
Montana	6,737	13,244	9,637	4,778	637	2,970	1,382
Nebraska	11,225	22,895	16,542	7,602	2,679	3,674	1,965
New Hampshire	8,763	17,234	12,768	4,927	1,204	3,262	1,569
New Jersey	51,019	95,800	50,458	19,582	25,286	20,056	3,259
North Carolina	63,568	124,352	89,335	35,589	9,948	25,069	8,970
North Dakota	2,253	4,350	2,637	1,145	1,001	712	265
Ohio	51,511	96,409	72,784	27,439	9,231	14,394	5,672
Oklahoma	14,875	30,786	21,261	5,524	2,747	6,778	1,673
Pennsylvania	74,185	136,606	100,535	39,923	6,792	29,279	11,788
South Carolina	24,768	46,494	33,596	12,242	4,099	8,799	2,761
South Dakota	3,114	6,505	4,636	1,863	540	1,329	372
Tennessee	39,231	73,746	52,987	19,552	5,768	14,991	4,507
Texas	118,577	244,695	177,472	62,321	16,767	50,456	14,038
Utah	13,663	33,015	20,078	9,534	8,062	4,875	1,865
Virginia	45,806	90,050	67,967	22,110	6,202	15,881	4,946
West Virginia	8,570	15,797	7,179	3,140	4,690	3,928	775
Wisconsin	47,173	85,863	50,733	24,140	18,768	16,362	5,303
Wyoming	2,871	5,612	4,228	1,918	357	1,027	521
FFM Subtotal	**1,152,075**	**2,225,244**	**1,525,408**	**580,558**	**268,974**	**430,862**	**137,204**
MARKETPLACE TOTAL, All States	**1,827,440**	**3,692,599**	**2,307,283**	**944,531**	**803,077**	**583,473**	**364,682**

Notes:
"N/A" means that the data for the respective metric is not yet available for a given state.

(1) Unless otherwise noted, the data in this table represent cumulative Marketplace enrollment-related activity for 10/1/13 to 11/30/13. For additional methodological information, please refer to Appendix B of this report.

(2) "Completed Applications" represents the total number of electronic and paper applications that were submitted to the Marketplace during the reference period with sufficient information to begin performing eligibility determinations for enrollment in a plan through the Marketplace and, if appropriate, sufficient information to begin performing eligibility determinations for advance payments of the premium tax credit and cost-sharing reductions, and eligibility assessments or determinations for Medicaid and CHIP.

(3) "Individuals Applying for Coverage in Completed Applications" represents the total number of individuals included in Completed Applications that were submitted to the Marketplace during the applicable reference period. This number does not include individuals

Are You Subject To Texas' Proposed Rules on "Navigators?"

The Texas Department of Insurance (TDI) has proposed to regulate more than just navigators receiving grants and assisting with enrollment under the Affordable Care Act (ACA). All organizations and individuals who perform application assistance, conduct public education on health coverage, or use the term "navigator" should evaluate whether they will be subject to TDI's proposed rules.

Step 1. Are you exempt?

TDI's rules do NOT apply to:

- Licensed health insurance agents and counselors
- Health insurance companies
- Individuals and organizations that provide consumers assistance under state authority or federal authority other than the ACA. (This should exclude the HHSC Community Partner Program, DSHS Community Health Workers, and HICAP Medicare counseling.)
- Certified Application Counselors

Step 2. Do you provide a "navigator service?"

"Navigator services" are those performed under Senate Bill 1795 or the ACA, including:

- Helping consumers apply for Medicaid, CHIP, or Marketplace subsidies,
- Explaining how Medicaid, CHIP, and Marketplace subsidies work,
- Explaining health insurance concepts, like premiums, deductibles, and networks,
- Providing culturally and linguistically appropriate information,
- Avoiding conflicts of interest, or
- Establishing standards for privacy and data security.

If you provide a "navigator service":

You CANNOT represent yourself as a navigator or use the term "navigator" in a person's title or an organization's name or website unless registered with TDI (see Step 3)

While providing navigator services, you CANNOT:

- Provide advice on the substantive or comparative benefits of different health plans,
- Recommend a specific health insurance plan,
- Charge consumers for providing information on health coverage,
- Sell, solicit, or negotiate health insurance, or
- Electioneer.

Step 3. Do you *also* provide "enrollment assistance?"

If an individual or organization provides "navigator services" (see Step 2) ***and also*** provides "enrollment assistance" by helping a consumer complete an application for Medicaid, CHIP, or Marketplace subsidies, then you must register with TDI by March 1, 2014.

Organizational registration* requires proof of financial responsibility and finger printing and background check for a designated responsible party.

Individual registration* requires:

- 40 hours of pre-registration training (on top of 20-30 hours of federal training), that could cost up to $800/person according to TDI
- 6 hours of annual continuing education (on top of federal requirements) at a cost up to $120
- Fingerprinting and a background check with registration, at a cost of around $100.

Analysis of TDI's proposed rules on navigators by CPPP, December 2013. **Only partial listing of registration requirements. See rule proposal for full list*.