2023 SENATE INDUSTRY AND BUSINESS

SB 2349

2023 SENATE STANDING COMMITTEE MINUTES

Industry and Business Committee
Fort Union Room, State Capitol

SB 2349
2/1/2023

A bill relating to exemption from insurance regulations for nonprofit agriculture membership organizations.

9:48 AM Chairman D. Larsen called the meeting to order. Members present: Chairman D. Larsen, Vice Chairman Kessel, Senator Barta, Senator Klein, Senator Boehm.

Discussion Topics:
- Rural health care coverage
- Family healthcare plans and benefits
- South Dakota health care bill
- Regulations
- Effects on healthcare insurance
- Fair policies

9:49 AM Senator Klein, District 14, introduced SB 2349, and testified in favor. (verbal)
9:50 AM Pete Hannibut, North Dakota Farm Bureau, testified in favor. (verbal)

9:51 AM Jeff Messling, Executive Vice President and CEO, North Dakota Farm Bureau testified in favor. #19616

10:04 AM Benjamin Sanders, Tennessee Farm Bureau Health Plans, testified in favor. #18360

10:14 AM Krystil Smit, Executive Director, South Dakota Farm Bureau, testified in favor. #18416

10:28 AM Matt Purdue, Farmers Union Service Association, testified in opposition. #18413

10:29 AM Lance Boyer, Insurance Broker, Farmers Union Insurance, testified in opposition. (verbal)

10:43 AM Megan Houn, Vice President, Government Affairs and Public Policy, Blue Cross/Blue Shield, testified in opposition. (verbal)

10:49 AM Steve Bicher, Executive Director, Professional Insurance Agents, testified in opposition. #17779
10:52 AM John Godfred, North Dakota Insurance Commissioner, testified neutral. (verbal)

11:01 AM Chairman D. Larsen closed the hearing on SB 2349.

Brenda Cook, Committee Clerk

2023 SENATE STANDING COMMITTEE MINUTES

Industry and Business Committee
Fort Union Room, State Capitol

SB 2349
2/1/2023

A bill relating to exemption from insurance regulations for nonprofit agriculture membership organizations.

3:12 PM Chairman D. Larsen called the committee meeting to order. Members present: Chairman D. Larsen, Vice Chairman Kessel, Senator Barta, Senator Klein, Senator Boehm.

Discussion Topics:
- Committee action

3:12 PM Senator Kessel moved to DO PASS SB 2349.
3:12 PM Senator Boehm seconded the motion to DO PASS SB 2349.

3:13 PM Chairman D. Larsen called for the vote.

Roll call vote:

Senators	Vote
Senator Doug Larsen	Y
Senator Greg Kessel	Y
Senator Jeff Barta	Y
Senator Keith Boehm	Y
Senator Jerry Klein	Y

Vote: 5-0-0 DO PASS SB 2349

3:13 PM Senator Barta will carry the bill.

3:29 PM Chairman D. Larsen adjourned the meeting.

Brenda Cook, Committee Clerk

REPORT OF STANDING COMMITTEE

SB 2349: Industry and Business Committee (Sen. Larsen, Chairman) recommends **DO PASS** (5 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). SB 2349 was placed on the Eleventh order on the calendar. This bill does not affect workforce development.

2023 HOUSE AGRICULTURE

SB 2349

2023 HOUSE STANDING COMMITTEE MINUTES

Agriculture Committee
Room JW327C, State Capitol

SB 2349
3/2/2023

Relating to exemption from insurance regulations for nonprofit agricultural membership organization.

Chairman Thomas call the meeting to order 9:17 AM

Members present: Chairman Thomas, Vice Chairman Beltz, Representatives Finley-DeVille, Fisher, Headland, Kiefert, Olson, Prichard, Schreiber-Beck, Tveit, VanWinkle.

Members absent: Representatives Christy, Henderson

Discussion Topics:

- Products offered
- Established network
- Health share programs
- Preexisting conditions
- ACA regulated plans
- Forced coverage options
- Consumer protection
- Self-regulated protections

In Favor:
Senator Jerry Klein District 14, Fessenden ND (no written testimony)
Pete Hanebutt, ND Farm Bureau, #25603
Krystil Smit, Executive Director, SD Farm Bureau, #21696
Jeffery Missling, Executive Vice President, and CEO of ND Farm Bureau, #21673
Ryan Brown, Tennessee Farm Bureau (no written testimony)

Opposed:
Megan Houn, Vice President, Government Affairs and Public Policy, Blue Cross Blue Shield of North Dakota, #21799, #21800
Representative Jorin Johnson, District 41 Fargo, representing Steve Becher, Executive Director of the Professional Insurance Agents of ND (PIA of ND) testimony and proposed amendments, #21276, #21798
Kristy Schlosser Carlson, ND Farmers Union, and Farmers Union Insurance, #21658

Neutral:
Jon Godfread, Commissioner, ND Insurance Department (no written testimony)

Chairman Thomas adjourned the meeting at 10:58 AM

Diane Lillis, Committee Clerk

2023 HOUSE STANDING COMMITTEE MINUTES

Agriculture Committee
Room JW327C, State Capitol

SB 2349
3/17/2023

Relating to exemption from insurance regulations for nonprofit agricultural membership organization.

Chairman Thomas call the meeting to order 9:11 AM

Members present: Chairman Thomas, Vice Chairman Beltz, Representatives Christy, Finley-DeVille, Fisher, Headland, Henderson, Kiefert, Olson, Prichard, Schreiber-Beck, Tveit, VanWinkle.

Discussion Topics:
- Costs
- Mandates
- Comparable insurance
- Disputes

Chairman Thomas presented amendment, #25717
Pete Hanebutt, ND Farm Bureau (no written testimony)
Ben Sanders, Executive Director Government Affairs, Tennessee Farm Bureau Health Plans (no written testimony)
Jeffery Missling, Executive Vice President, and CEO of ND Farm Bureau (no written testimony)
Steve Becher, Executive Director of the Professional Insurance Agents of ND (no written testimony)
Megan Houn, Vice President, Government Affairs and Public Policy, Blue Cross Blue Shield of North Dakota (no written testimony)
Dylan Wheeler, Director of Government Affairs, Sanford Health Plan (no written testimony)
Chrystal Bartuska, Life and Health Director, ND Insurance Department (no written testimony)

Representative Tveit moved to adopt the amendment LC #23.1070.01001.
Representative Olson seconded.

Roll call votes:

Representatives	Vote
Representative Paul J. Thomas	Y
Representative Mike Beltz	Y
Representative Josh Christy	Y
Representative Lisa Finley-DeVille	Y
Representative Jay Fisher	Y
Representative Craig Headland	Y
Representative Donna Henderson	Y

Representative Dwight Kiefert	Y
Representative SuAnn Olson	Y
Representative Brandon Prichard	AB
Representative Cynthia Schreiber-Beck	Y
Representative Bill Tveit	Y
Representative Lori VanWinkle	N

Motion passed 11-1-1

Representative VanWinkle moved a do pass as amended.
Representative Tveit seconded.

Roll call vote:

Representatives	Vote
Representative Paul J. Thomas	Y
Representative Mike Beltz	AB
Representative Josh Christy	N
Representative Lisa Finley-DeVille	Y
Representative Jay Fisher	Y
Representative Craig Headland	N
Representative Donna Henderson	Y
Representative Dwight Kiefert	Y
Representative SuAnn Olson	Y
Representative Brandon Prichard	AB
Representative Cynthia Schreiber-Beck	Y
Representative Bill Tveit	Y
Representative Lori VanWinkle	Y

Motion passed 9-2-2

Representative Thomas will carry the bill.

Chairman Thomas adjourned the meeting at 10:33 AM

Diane Lillis, Committee Clerk

23.1070.01001
Title.02000

Prepared by the Legislative Council staff for
Representative Thomas
March 6, 2023

AGT
3-17-23
(1-1)

PROPOSED AMENDMENTS TO SENATE BILL NO. 2349

Page 1, line 8, replace "A" with "Except as provided under this section, a"

Page 1, line 13, replace "may" with "must"

Page 1, line 15, after "3." insert "A nonprofit agricultural membership organization may not provide health care coverage under this section unless the organization has filed with the commissioner verification the organization meets the requirements of this section.

4. Health care coverage under this section may be sold only by an insurance producer who is both appointed by the nonprofit agricultural membership organization and licensed as an insurance producer to sell or solicit health insurance in this state.

5. Health care coverage under this section must provide benefits under a self-funded arrangement administered by an entity that holds a certificate of authority under section 26.1-27-03.

6. A health care coverage application for coverage under this section and any related contract provided to the member prominently must state the health care coverage is not insurance, is not provided by an insurance company, is not subject to the laws and rules governing insurance, and is not subject to the jurisdiction of the commissioner.

7."

Page 1, line 18, after "health" insert "care"

Renumber accordingly

REPORT OF STANDING COMMITTEE

SB 2349: Agriculture Committee (Rep. Thomas, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (9 YEAS, 2 NAYS, 2 ABSENT AND NOT VOTING). SB 2349 was placed on the Sixth order on the calendar.

Page 1, line 8, replace "A" with "Except as provided under this section, a"

Page 1, line 13, replace "may" with "must"

Page 1, line 15, after "3." insert "A nonprofit agricultural membership organization may not provide health care coverage under this section unless the organization has filed with the commissioner verification the organization meets the requirements of this section.

4. Health care coverage under this section may be sold only by an insurance producer who is both appointed by the nonprofit agricultural membership organization and licensed as an insurance producer to sell or solicit health insurance in this state.

5. Health care coverage under this section must provide benefits under a self-funded arrangement administered by an entity that holds a certificate of authority under section 26.1-27-03.

6. A health care coverage application for coverage under this section and any related contract provided to the member prominently must state the health care coverage is not insurance, is not provided by an insurance company, is not subject to the laws and rules governing insurance, and is not subject to the jurisdiction of the commissioner.

7."

Page 1, line 18, after "health" insert "care"

Renumber accordingly

TESTIMONY

SB 2349

Testimony for SB 2349– ND Senate IBL Committee

Chairman Larsen and members of the Senate Industry and Business Committee for the record my name is Steve Becher and I am the Executive Director of the Professional Insurance Agents of ND. PIA of ND represents approximately 300 main street insurance agencies with well over 1000 independent agents across the state of North Dakota. I am providing testimony today and asking you for a Do Not Pass recommendation on Senate Bill **2349.**

Insurance is a complex product that can be the only protection that stands between a secure financial future and bankruptcy for many consumers. Without the proper insurance coverage many consumers would have no way to pay for the unexpected things that can happen that damage their health, income earning ability, or the assets that they have obtained such as housing, vehicles, equipment, and businesses. A complex product like insurance requires diligent regulation so that the consumer knows that the product they are buying has been fully vetted by a governmental entity with the ultimate goal of consumer protection. This regulation needs to verify that consumers are being protected, companies are formulating the policies that are fair to the consumer and covering the areas that need to be covered, and to regulate the conduct of those that are selling the product to make sure that consumers are being advised property to make the right decisions.

Senate bill 2349 basically carves out one type of organization, a nonprofit ag membership organization and one type of insurance coverage, health care coverage and makes them exempt from any regulation by the ND Insurance

Department. In other words, this bill allows them to formulate and sell health insurance without being subject to the same regulation and consumer protection requirements that all other insurance companies and insurance agents are required to abide by. This is wrong on so many levels and a dangerous precedent to set in the insurance industry. With no regulation who is going protect the consumer? Who is going to verify that the health care coverage is appropriately formulated and that the money being collected is adequate to pay everyone should disastrous claims occur? Who is going to make sure that those selling this coverage to the consumer are advising the client properly and giving the client the correct information? With this legislation – NO ONE if your belong to a nonprofit ag membership organization and buy your health care coverage through them! The ag membership group will tell you that they will look out for their members as they want to do what's best for them and they are being honest. However, good intentions can sometime lead to unintended bad consequences. If the ag membership group doesn't set up the policies correctly or collect enough money to pay out claims there will be no money there to take care of their members all of their good intentions mean nothing and the consumer will have no place to turn. It is one thing to operate a nonprofit ag membership organization and whole other thing to run an actuarially sound insurance company. If an organization wants to operate as an insurance company and sell insurance policies they should be subject to the same regulation and insurance consumer protection requirements that everyone else in the industry is required to follow.

In the interest of consumer protection and fairness to everyone else in the insurance industry, I would strongly ask for a “Do Not Pass” recommendation on Senate Bill **2349**.

Testimony for SB 2349
February 1, 2023
Benjamin Sanders
Tennessee Farm Bureau Health Plans

Available for q/a in support of SB2349.

SB 2349
Testimony before the Senate Industry and Business Committee
February 1, 2023
Oppose

I am Lance Boyer, and I am the Sales Director of Financial Products for Farmers Union Service Association, a general insurance agency contracted with over 300 agents in over 20 states. We provide insurance products and services to rural America, including members of the North Dakota Farmers Union and other state Farmers Union organizations.

We have a number of concerns about SB 2349.

First, this bill completely exempts these health care coverage plans from protection under the insurance code. Under the insurance code, the insurance commissioner regulates insurance companies, health plans, and insurance producers (agents) so they are transparent and accountable. It sets standards for fair practices in marketing, sales, underwriting, benefits, and claims. But this bill exempts certain organizations from those requirements - there is no accountability to members or the insurance department and there are no standards.

Second, there is no requirement in this bill that the health care coverage is actuarially sound, which means there is no assurance that the organization will be able to meet its financial obligations to those who buy coverage.

Third, as you know, health insurance plans under the Affordable Care Act cannot medically underwrite applicants. However, because this bill says these plans are not “insurance,” they will not have restrictions on the medical underwriting, which means they are allowed to cherry pick the healthiest applicants while keeping out those with pre-existing conditions. We are concerned that healthy people will leave the insurance market, making the remaining pool more expensive.

Finally, we do not believe this bill will solve affordability concerns. Our team has invested a lot of time and energy exploring alternative options for our members. The simple reality is the marketplace provides the best coverage options for our farmer and rancher members and others. Premium tax credits and cost sharing reductions significantly reduce the cost of marketplace plans, helping our clients access high quality, affordable coverage.

We respectfully request a “Do Not Pass” on SB 2349. I will stand for any questions.

Good morning Chair and Committee Members,

I am Krystil Smit, executive director of South Dakota Farm Bureau. I am joining you today to share our experience with passing legislation two years ago which has allowed South Dakota Farm Bureau to offer health care plans to our members.

The South Dakota legislature passed our health care bill in February of 2021 and we started offering health plans 7 months later on October 1. After just over a year of operating, I am pleased to share that we have over 700 covered lives in the South Dakota Farm Bureau Health plans and our members have reported saving from $500 up to $1600 per month on their health coverage. Those savings are life changing for the families in our health care plans.

Because of our health care program, one young mom was able to give up her job in town and the employer health insurance for which was the reason she was working, to stay home with their three young sons and help out on the family ranch. Not only did she experience a health event which landed her in the hospital for a few days, they are also soon welcoming a fourth child. They could not be more pleased with the reliable coverage they have experienced with SDFB Health Plans.

Testimonials like this are what we were hoping for that would make a difference for our members who had been reaching out to Farm Bureau for many years asking for help with high health care costs for independent business operators like our farmers and ranchers. Partnering with Farm Bureau Health Plans of Tennessee, which has been offering health care plans for 70 years, has provided an option to current and new Farm Bureau members looking for affordable, quality health care coverage. Having a financially stable partner who provides the financial assurance to cover claims is critical for the success of the South Dakota Farm Bureau Health Plans.

The Farm Bureau Health Plans are patterned after the ACA plans on the marketplace today and offer a robust nationwide network of providers through the United Health Care Network. The out-of-pocket maximums and co-pays are comparable to what most are used to on ACA plans as well. But Farm Bureau Health Plans are not individually rated which means families pay one rate whether they have one or multiple children and there are several coverage options available.

Once a member is offered a plan of coverage and they continue their SDFB membership and pay their premiums, they will never be denied coverage or be cancelled. While pre-existing conditions are considered, South Dakota Farm Bureau Health Plans have accepted about 90 percent of applicants into the program.

And you do not have to be a farmer or rancher to be a Farm Bureau member; anyone can join and apply for health care coverage. Our program has offered solutions not only to rural families, but we have teachers, small business owners and community members in our plan. What’s more is our state’s Governor recently announced during her State of the State address that she plans to partner with South Dakota Farm Bureau Health Plans to offer solutions and options to our state’s daycare providers.

Just like South Dakota Farm Bureau, North Dakota Farm Bureau is uniquely positioned to offer health care coverage options to North Dakotans, filling a gap of uninsured or underinsured individuals and families. They are a trusted organization with over a century long track record of serving farm, ranch, rural and community families.

I encourage you to support SB 2349 and North Dakota Farm Bureau's effort to join other Farm Bureaus including Tennessee, South Dakota, Kansas, Indiana, Texas, Michigan and others in offering a solution to burdensome costs and provide options for quality, affordable and benefits-rich health care coverage to North Dakotans.

I welcome any questions you may have. Thank you for your consideration.

ndfb.org

Written testimony presented to the Senate Industry and Business Committee – February 1, 2023

Good morning, Chairman Larsen, and members of the Senate Industry and Business Committee.

My name is Jeffrey Missling. I serve as Executive Vice President and CEO of North Dakota Farm Bureau. I rise this morning to ask for your support of Senate Bill 2349.

As some of you know, NDFB has a long history of offering property and casualty insurance to members through Nodak Insurance Company and its team of career agents, customer service representatives and sales associates.

Since 1942, NDFB has been working to strengthen agriculture and the lives of North Dakotans through advocacy, education and service. Today, NDFB member-families live and work in each of our state's 53 counties. Many of these families produce food, fuel and fiber to support local economies and work to add value to agricultural products that are exported around the world.

For many years, our members have asked us what we can do to help them temper the tremendous burden of healthcare coverage. We know that access to quality, affordable healthcare coverage is a source of anxiety and stress for many rural North Dakota families.

According to a U.S. Department of Agriculture-funded study conducted approximately five years ago, "lack of access to affordable health insurance is one of the most significant concerns facing American farmers and overlooked risk factor that affects their ability to run a successful enterprise. The study found that health-related costs are a cross-sector risk for agriculture, tied to farm risk management, productivity, health, retirement, the need for off-farm income and land access for young and beginning farmers."

Even more concerning was the fact that two out of three farmers and ranchers reported having a pre-existing health condition. With the average age of a farmer/rancher of 58 years, farmers and ranchers are also vulnerable to higher insurance premiums due to age-rating bands.

I continue to hear our member-families talk about the need for off-farm/off-ranch employment in order to receive health insurance benefits. I also routinely hear from members who are paying premiums of $1,500 to more than $2,000 per month to access health insurance coverage for those who have no access to off farm/ranch employee health benefits.

There is a segment of North Dakotans who are not eligible to access health insurance through a spouse or employer, fall above the income cap for government assistance through the Affordable Care Act (ACA) exchanges, and/or struggle to find affordable coverage in meeting their needs. We understand that over 7% (over 50,000) of North Dakotans remain uninsured.

What we are asking for in Senate Bill 2349, is the opportunity to address a critical need for our member-families that have fallen through the cracks – to offer them an affordable option that will provide coverage, and ultimately, peace of mind, for their families.

Passage of Senate Bill 2349 would allow NDFB to offer a healthcare coverage product to our members without being subject to regulation as insurance. Having said that, NDFB is committed to working with the North Dakota Insurance Department to provide whatever information is required to ensure we are complying with the law while offering a quality product to our members. Additionally, NDFB is also committed to partnering with a third-party administrator that is licensed in our state and has experience offering healthcare coverage and resources to ensure claims are properly handled and success is achieved.

North Dakota Farm Bureau is not the first state Farm Bureau to offer this type of product to its members. Tennessee Farm Bureau has offered this type of product to its members for more than 70 years, while other Midwest states including Iowa, Indiana, Kansas (and most recently South Dakota) have also passed similar legislation that has allowed them to offer these products to their members, as has Texas Farm Bureau.

These aforementioned state Farm Bureaus have shared some of their experiences with us, and we now know that: (1) on average, plans utilized by other participating state Farm Bureaus provide coverage to 90% of members who apply for coverage, (2) all major illnesses and conditions are covered, just like every other health insurance plan, and (3) these plans are comparable if not better than most ACA plans from a benefits and coverage perspective.

Market data from these participating state Farm Bureaus demonstrates their Farm Bureau health plans have little to no impact on the ACA individual market. In most situations, the types of member-families that would participate in our plan are either: (1) over the ACA premium threshold and are uninsured, or (2) in an employee plan and are leaving that to become self-insured or because they don't need the health coverage anymore.

The way this bill is written, similar organizations who meet the criteria in this legislation could offer similar products to their members.

In closing, access to reliable, affordable, quality healthcare coverage should not be something our farm and ranch families should be worried about. We believe this bill, if passed, will help us provide more options for our member-families. The status quo is not working for some of our farmers and ranchers, and we hope to, in some small way, help North Dakota farm and ranch families remain viable in this industry and in our great state.

We ask you to help us create this opportunity for NDFB member-families who are struggling with healthcare costs and options. Please recommend a "do pass" on Senate Bill 2349.

Testimony for SB 2349– ND House Ag Committee

Chairman Thomas and members of the House Agriculture Committee for the record my name is Steve Becher and I am the Executive Director of the Professional Insurance Agents of ND. PIA of ND represents approximately 300 main street insurance agencies with well over 1000 independent agents across the state of North Dakota. I am providing testimony today and asking you for a Do Not Pass recommendation on Senate Bill **2349.**

Insurance is a complex product that can be the only protection that stands between a secure financial future and bankruptcy for many consumers. Without the proper insurance coverage many consumers would have no way to pay for the unexpected things that can happen that damage their health, income earning ability, or the assets that they have obtained such as housing, vehicles, equipment, and businesses. A complex product like insurance requires diligent regulation so that the consumer knows that the product they are buying has been fully vetted by a governmental entity with the ultimate goal of consumer protection. This regulation needs to verify that consumers are being protected, companies are formulating the policies that are fair to the consumer and charging premiums that will allow them to remain financially viable, and to regulate the conduct of those that are selling the product to make sure that consumers are being advised property to make the right decisions.

Senate bill 2349 basically carves out one type of organization, a nonprofit ag membership organization and one type of insurance coverage, health care coverage and makes them exempt from any regulation by the ND Insurance

Department. In other words, this bill allows them to formulate and sell health insurance without being subject to the same regulation and consumer protection requirements that all other insurance companies and insurance agents are required to abide by. This is wrong on so many levels and a dangerous precedent to set in the insurance industry. With no regulation who is going protect the consumer? Who is going to verify that the health care coverage is appropriately formulated and that the money being collected is adequate to pay everyone should disastrous claims occur? Who is going to make sure that those selling this coverage to the consumer are advising the client properly and giving the client the correct information? With this legislation – NO ONE if your belong to a nonprofit ag membership organization and buy your health care coverage through them! The ag membership group will tell you that they will look out for their members as they want to do what's best for them and they are being honest. However, good intentions can sometime lead to unintended bad consequences.

For example, when an insurance agent works with the customer and for some reason a mistake is made the consumer can go to the Insurance Dept for help and/or they can sue the agent under their Errors and Omissions insurance. If this bill passes, the consumer would have nowhere to go for help as it will not be considered insurance so the Insurance Dept can't get involved and the agent's Errors and Omissions policy would not response since it is not insurance. Also, if the ag membership group doesn't set up the policies correctly or collect enough money to pay out claims there will be no money there to take care of their members and the consumer will have no place to turn. It is one thing to operate a nonprofit ag membership organization and whole other thing to run an

actuarially sound insurance company. If an organization wants to operate as an insurance company and sell insurance policies they should be subject to the same regulation and insurance consumer protection requirements that everyone else in the industry is required to follow.

In the interest of consumer protection and fairness to everyone else in the insurance industry, I would strongly ask for a “Do Not Pass” recommendation on Senate Bill **2349**.

SB 2349
Testimony before the House Agriculture Committee
March 2, 2023
Oppose

I am Kristi Schlosser Carlson, and represent Farmers Union Service Association, a general insurance agency providing insurance products and services to rural America, including members of the North Dakota Farmers Union and other state Farmers Union organizations.

While we applaud any effort to find creative ways to address affordability and access to health insurance by farmers and ranchers – and we have searched for those options as well – we have a number of concerns about SB 2349 as it is written.

First, this bill completely exempts these health care coverage plans from the insurance code. Under the insurance code, the insurance commissioner regulates insurance companies, health plans, and insurance producers (agents) so they are transparent and accountable. It requires that health insurance plans are actuarially sound, which means there is assurance that the insurer will be able to pay claims. It sets standards for fair practices in marketing, sales, underwriting, benefits, and claims. But under this bill, there is no accountability to members or the insurance department and there are no standards.

This bill has been compared to laws other states. However, it is not the same. For example, South Dakota's statute includes a number of protections that have been described today, but none of those protections are actually in this bill. South Dakota requires that the plan is regulated like a self-funded plan, requires a contract with a third party administer, requires that the product be sold by a licensed insurance producer, requires it to be reinsured by a carrier (and the carrier has to file actuarial statement with commissioner), and requires it to file with the insurance department. The North Dakota bill has none of that. You have heard this is similar to association health plans, but those plans are also regulated with standards in place.

Second, as you know, health insurance plans cannot medically underwrite applicants. However, because this bill says these plans are not "insurance," they will not have restrictions on the medical underwriting, which means they are allowed to cherry pick the healthiest applicants while keeping out those with pre-existing conditions. One outcome will be that healthy people will leave the insurance market, making the remaining pool more expensive for the rest of us.

As we have researched opportunities to provide affordable and accessible health insurance to farmers and ranchers, we have come to realize that limiting the number of people in a pool actually means the risk of the pool is more concentrated. In that way, this bill does not solve affordability concerns. However, we know that the Affordable Care Act premium tax credits and cost sharing reductions, which have been enhanced recently, have significantly helped our farmer and rancher members and others find affordable coverage that also promises the protections we want to assure our members.

For these reasons, we cannot support this bill as written.

I'd be happy to answer any questions.

Kristi Schlosser Carlson
kristi.carlson@fumic.com
(701) 951-1109
Lobbyist #202

Written testimony presented to the House Agriculture Committee – March 2, 2023

Good morning, Chairman Thomas, and members of the House Agriculture Committee.

My name is Jeffrey Missling. I serve as Executive Vice President and CEO of North Dakota Farm Bureau. I rise this morning to ask for your support of Senate Bill 2349.

As some of you know, NDFB has a long history of offering property and casualty insurance to members through Nodak Insurance Company and its team of career agents, customer service representatives and sales associates.

Since 1942, NDFB has been working to strengthen agriculture and the lives of North Dakotans through advocacy, education and service. Today, NDFB member-families live and work in each of our state's 53 counties. Many of these families produce food, fuel and fiber to support local economies and work to add value to agricultural products that are exported around the world.

For many years, our members have asked us what we can do to help them temper the tremendous burden of healthcare coverage. We know that access to quality, affordable healthcare coverage is a source of anxiety and stress for many rural North Dakota families.

According to a U.S. Department of Agriculture-funded study conducted approximately five years ago, "lack of access to affordable health insurance is one of the most significant concerns facing American farmers and overlooked risk factor that affects their ability to run a successful enterprise. The study found that health-related costs are a cross-sector risk for agriculture, tied to farm risk management, productivity, health, retirement, the need for off-farm income and land access for young and beginning farmers."

Even more concerning was the fact that two out of three farmers and ranchers reported having a pre-existing health condition. With the average age of a farmer/rancher of 58 years, farmers and ranchers are also vulnerable to higher insurance premiums due to age-rating bands.

I continue to hear our member-families talk about the need for off-farm/off-ranch employment in order to receive health insurance benefits. I also routinely hear from members who are paying premiums of $1,500 to more than $2,000 per month to access health insurance coverage for those who have no access to off farm/ranch employee health benefits.

There is a segment of North Dakotans who are not eligible to access health insurance through a spouse or employer, fall above the income cap for government assistance through the Affordable Care Act (ACA) exchanges, and/or struggle to find affordable coverage in meeting their needs. We understand that over 7% (over 50,000) of North Dakotans remain uninsured.

What we are asking for in Senate Bill 2349, is the opportunity to address a critical need for our member-families that have fallen through the cracks – to offer them an affordable option that will provide coverage, and ultimately, peace of mind, for their families.

Passage of Senate Bill 2349 would allow NDFB to offer a healthcare coverage product to our members without being subject to regulation as insurance. Having said that, NDFB is committed to working with the North Dakota Insurance Department to provide whatever information is required to ensure we are complying with the law while offering a quality product to our members. Additionally, NDFB is also committed to partnering with a third-party administrator that is licensed in our state and has experience offering healthcare coverage and resources to ensure claims are properly handled and success is achieved.

North Dakota Farm Bureau is not the first state Farm Bureau to offer this type of product to its members. Tennessee Farm Bureau has offered this type of product to its members for more than 70 years, while other Midwest states including Iowa, Indiana, Kansas (and most recently South Dakota) have also passed similar legislation that has allowed them to offer these products to their members, as has Texas Farm Bureau.

These aforementioned state Farm Bureaus have shared some of their experiences with us, and we now know that: (1) on average, plans utilized by other participating state Farm Bureaus provide coverage to 90% of members who apply for coverage, (2) all major illnesses and conditions are covered, just like every other health insurance plan, and (3) these plans are comparable if not better than most ACA plans from a benefits and coverage perspective.

Market data from these participating state Farm Bureaus demonstrates their Farm Bureau health plans have little to no impact on the ACA individual market. In most situations, the types of member-families that would participate in our plan are either: (1) over the ACA premium threshold and are uninsured, or (2) in an employee plan and are leaving that to become self-insured or because they don't need the health coverage anymore.

The way this bill is written, similar organizations who meet the criteria in this legislation could offer similar products to their members.

In closing, access to reliable, affordable, quality healthcare coverage should not be something our farm and ranch families should be worried about. We believe this bill, if passed, will help us provide more options for our member-families. The status quo is not working for some of our farmers and ranchers, and we hope to, in some small way, help North Dakota farm and ranch families remain viable in this industry and in our great state.

We ask you to help us create this opportunity for NDFB member-families who are struggling with healthcare costs and options. Please recommend a "do pass" on Senate Bill 2349.

Good morning Chair and Committee Members,

I am Krystil Smit, executive director of South Dakota Farm Bureau. I am joining you today to share our experience with passing legislation two years ago which has allowed South Dakota Farm Bureau to offer health care plans to our members.

The South Dakota legislature passed our health care bill in February of 2021 and we started offering health plans 7 months later on October 1. After just over a year of operating, I am pleased to share that we have over 900 covered lives in the South Dakota Farm Bureau Health plans and our members have reported saving from $500 up to $1400 per month on their health coverage. Those savings are life changing for the families in our health care plans.

Because of our health care program, one young mom was able to give up her job in town and the employer health insurance for which was the reason she was working, to stay home with their three young sons and help out on the family ranch. Not only did she experience a health event which landed her in the hospital for a few days, they are also soon welcoming a fourth child. They could not be more pleased with the robust coverage they have experienced with SDFB Health Plans.

Testimonials like this are what we were hoping for that would make a difference for our members who had been reaching out to Farm Bureau for many years asking for help with high health care costs for independent business operators like our farmers and ranchers. Partnering with Farm Bureau Health Plans of Tennessee, which has been offering health care plans for 70 years, has provided an option to current and new Farm Bureau members looking for affordable, quality health care coverage. Having a financially stable partner who provides the financial assurance to cover claims is critical for the success of the South Dakota Farm Bureau Health Plans.

The Farm Bureau Health Plans are patterned after the ACA plans on the marketplace today and offer a extensive nationwide network of providers through the United Health Care Network. The out-of-pocket maximums and co-pays are comparable to what most are used to on ACA plans as well. But Farm Bureau Health Plans are not individually rated which means families pay one rate whether they have one or multiple children and there are several coverage options available.

Once a member is offered a plan of coverage and they continue their SDFB membership and pay their premiums, they will never be denied coverage or be cancelled. While pre-existing conditions are considered, South Dakota Farm Bureau Health Plans have accepted about 90 percent of applicants into the program. Farm Bureau Health Plans is an option for those looking for more affordable health care coverage that provides quality coverage.

Also you do not have to be a farmer or rancher to be a Farm Bureau member; anyone can join and apply for health care coverage. Our program has offered solutions not only to rural families, but we have teachers, small business owners and community members in our plan. What’s more is our state’s Governor recently announced during her State of the State address that she plans to partner with South Dakota Farm Bureau Health Plans to offer solutions and options to our state’s daycare providers.

Just like South Dakota Farm Bureau, North Dakota Farm Bureau is uniquely positioned to offer health care coverage options to North Dakotans, filling a gap of uninsured or underinsured individuals and families. They are a trusted organization with over a century long track record of serving farm, ranch, rural and community families.

I encourage you to support SB 2349 and North Dakota Farm Bureau's effort to join other Farm Bureaus including Tennessee, South Dakota, Kansas, Indiana, Texas, Michigan and others in offering a solution to burdensome costs and provide options for quality, affordable and benefits-rich health care coverage to North Dakotans.

I welcome any questions you may have. Thank you for your consideration.

#21798

Proposed amendments to SB 2349

Line 13	Strike the word "~~may~~" and replace with the word "must"
Starting at Line 21	Add "4. Before providing health care coverage described by this section, the organization shall file with the Insurance Commissioner verifying that the organization meets the requirements of this section."
	Add "5. Health care coverage described in this section may be sold only by an insurance producer who is both appointed by the organization meeting the requirements of this section and licensed as an insurance producer to sell or solicit health insurance in this state."
	Add "6. The health care coverage described in the section must provide benefits under a self-funded arrangement administered by an entity that holds a certificate of authority under Section 26.1-27-03"
	Add "7. Under this section, any health care coverage application for coverage and any contract provided to the member must prominently state that the health care coverage is not insurance, that the coverage is not provided by an insurance company, that the coverage is not subject to the laws and rules governing insurance, and that the coverage is not subject to the jurisdiction of the Insurance Commissioner"

TESTIMONY

Chairman Thomas and Members of the House Agricultural Committee,

Blue Cross Blue Shield of North Dakota (BCBSND) respectfully requests a Do Not Pass for Senate Bill 2349.

The proposed legislation in SB 2349 creates an unfair market within the health insurance industry. SB 2349 will exempt a single entity from state requirements that all other health insurance providers in North Dakota must follow, creating an uneven playing field where one organization will have a regulatory and competitive advantage. This legislation will allow this organization to design a unique product that, due to current regulations surrounding it, no other carrier will be able to match.

BCBSND has always worked closely with our farming members to support them and provide affordable products that best suit their needs, as we do with all our members. However, unlike the organizations that would qualify under SB 2349, we have to do so within the guidelines of the existing regulations. As such, SB 2349 should be amended to deregulate us as well. This will provide not only the option for these lower-cost alternatives but also create competition within the space beyond that of just one organization. Competition would foster an environment where insurance providers will strive to lower prices and improve the quality of their products and services. We would love the opportunity to exist in a similar unregulated space and believe BCBSND has the creativity and innovation to do even more: same sandbox, same rules.

Secondly, current law requires insurers to offer policies to people with pre-existing conditions. Absent that legal requirement, the SB 2349 exempt organizations can “cherry pick” healthy applicants and reject others. That leaves the other carriers which are by law not permitted to deny an individual based on these pre-existing conditions to pick up the cost. As a result those on the ACA marketplace, with already high deductibles and premiums, will now face even higher costs as the healthiest leave to join the “non-insurance” plan. Further, since these coverage options supposedly geared toward farmers could turn out to have a far broader reach, allowing those outside the membership of the Farm Bureau to enroll, there could be a significant adverse impact on the insurance market. The likely result is that this plan with lower premiums will lure healthier people out of the regular insurance risk pools for individuals and small businesses. The market will become fragmented, driving up premiums for those who remain.

Under this “cherry picking” method, many of those in need will not be effectively served within our state. In a survey funded by the U.S. Department of Agriculture, 2 out of 3 farmers and ranchers reported having a pre-existing health condition. In the previous testimony provided, this plan stated they disapprove approximately 10% of the applicants based on their current health needs, which will leave a portion of the population unable to access this lower-cost coverage while simultaneously facing the new reality of higher premiums across the board due to loss of member participation. Further, even in the case that individuals who have pre-existing conditions are permitted into the policy, it is unlikely the plan will be able to meet the needs of this group, as people with health conditions who manage to buy such a plan will likely find features such as benefit gaps, higher out-of-pocket costs, and pre-existing condition exclusions.

The state protections and regulations are lost for those lucky enough to qualify for an SB 2349 exempt policy. Provider mandates are important to both healthcare consumers and providers. Some of these provider mandates this legislature has put into place over the years include chiropractic care, treatments for alcoholism and substance abuse, mental health disorders, cancer screenings and treatments, breast reconstruction, pregnancy, and post-delivery services, among others. Absent a legal obligation, what guarantee do lawmakers have that chiropractors, psychologists, or other providers will be covered under these new “non-insurance” policies? None.

North Dakota law also requires that insurers have adequate reserves to pay claims. Again, this bill removes that requirement for certain organizations. Who gets stuck with the bill if this exempt organization can’t pay? The patient? The provider? North Dakota has a Health Insurance Guaranty Association that normally covers such obligations; however, these policies would not qualify for this protective mechanism, so the providers and policyholders may likely be exposed to risk.

The product described under SB 2349 is reminiscent of health care sharing ministries, where coverage is provided based on the ministry’s beliefs. Although these organizations may not have the same aspect of belief-based reasoning, the same principle applies. Without being subject to the state’s regulatory arm, they could choose what they want to cover and possibly for how long. Example being how will they address special enrollment periods? Can someone enroll after a broken arm that requires surgery or not? Could they drop someone once already enrolled if they end up with a chronic or catastrophic condition?

Currently, when a North Dakotan is denied approval for a procedure based on medical necessity, they have the right to appeal that decision both internally as well as a right to an external review conducted through the Insurance Department. This protection will no longer exist for the policies issued under SB 2349. Who will approve the policy, prevent discrimination, or manage complaints under this bill? Because it is not an insurance product, it will not be regulated by the ND DOI or Commissioner Godfread. Would these N.D. complaints go to the Tennessee regulator? Will we be outsourcing our citizens to an out-of-state regulator to manage their healthcare coverage when we already have a system that is in place locally?

Cherry picking will also impact the Reinsurance Association of North Dakota or RAND, created to reduce premiums. RAND functions from carriers paying into the reserve funds in exchange for a tax break. RAND then pays 75% of the claim amounts, for individual policies, between $100,000 and $1 million, after which the carrier resumes payment. SB 2349 could be improved by requiring the Farm Bureau to be one of the parties assessed to help cover the costs of RAND.

Lastly, the affordability of these plans is not worth the risk. One example is in South Dakota, where our sister Blue plan administers the Farm Bureau product, where the cost between this product and the other plans they administer is very close. However, the Blue Plan provides the security of the insurance regulations supported in South Dakota and a competitive coverage product, while the Farm Bureau product does not. The risk, coupled with the fact that similar Short Term Limited Duration Plans already exist on the marketplace, which are regulated through the Department of Insurance is the basis for BCBSND asking for a Do Not Pass recommendation for SB 2349.

Thank you.

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#21800

Expanding Skimpy Health Plans Is the Wrong Solution for Uninsured Farmers and Farm Workers

JULY 17, 2018 | BY SARAH LUECK AND MATT BROADDUS

The Trump Administration and some states have either implemented or are considering policy changes that would expand enrollment in skimpier health plans that skirt the usual insurance market standards and consumer protections. The proposals' supporters at times invoke middle-income farmers as a key constituency for these more limited coverage options. But this group does not represent the vast majority of farmers and farm workers experiencing health insurance challenges. Most farmers and farm workers who lack health insurance have low incomes, and for them, skimpy plans would be inadequate and unaffordable. And even for those farmers with higher incomes, expanding limited plans subject to weaker rules would do more harm than good.

The vast majority of farmers and farm workers who lack health coverage have incomes below 400 percent of the federal poverty level, the income cut-off for federal subsidies that help pay for premiums in the individual health insurance market. Most uninsured farmers and farm workers have family incomes less than 200 percent of the federal poverty level (or about $48,000 for a family of four) and a large majority have incomes less than 400 percent of poverty (or about $98,000 for a family of four).[1] (See Figure 1.) Separate data show that farm workers, when distinguished from farm owners, have even lower incomes (30 percent are below the poverty level) and more often lack health insurance (65 percent are uninsured).[2]

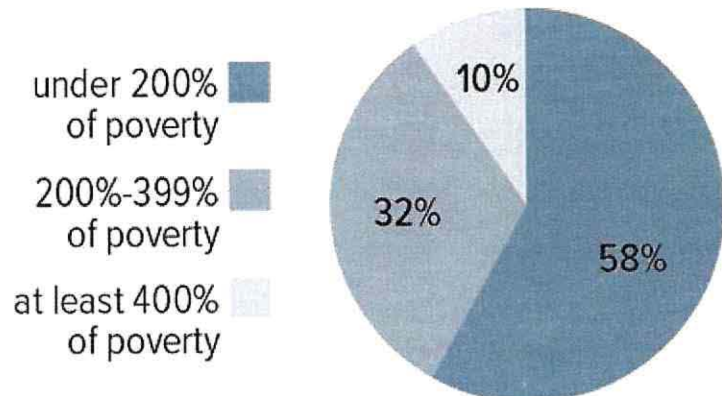
For people at all income levels, expanding skimpy health plans is an inadequate solution. But for people with low incomes, such plans are an especially bad fit. Some in this group are likely eligible for more affordable and comprehensive health coverage through their state's Medicaid program or Affordable Care Act (ACA) marketplace. And for those who aren't eligible for help (for example, those who are stuck in the "coverage gap" because their state has not expanded Medicaid), skimpy plans with premiums they could afford are likely to offer extremely limited coverage, leaving anyone who buys them exposed to high costs if they experience an illness or injury.

Even among farmers with incomes that exceed 400 percent of the poverty level, expanding skimpy plans subject to weaker rules would do more harm than good. People who are healthy may decide to enroll in more limited plans that offer them lower premiums because they can vary premiums

based on health status, exclude key benefits, and impose various limits on coverage. Some of these individuals will be lucky enough to remain healthy while they are covered by a skimpy plan. But for everyone who gains, other people will be harmed. People enrolled in standard, comprehensive individual-market plans will see their premiums rise as healthier people flock to the less generous plans subject to weaker standards and leave a costlier risk pool behind. And people who switch to the more limited plans to save on premiums but then experience health problems may be unable to afford needed care or find themselves facing catastrophic medical bills.

FIGURE 1

9 of 10 Uninsured Farmers and Farm Workers Have Family Income Below 400 Percent of Poverty Line



Source: CBPP analysis using 2016 American Community Survey data

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Proposals to Expand Skimpier Plans Undermine Crucial ACA Protections

Policymakers at the state and federal levels have proposed, and in some cases enacted or finalized, several different ideas for expanding health plans exempt from some or all the standards that apply to health insurance sold in the individual market or to small businesses. They have at times framed these ideas as especially helpful to farmers.

For example, a law recently enacted in Iowa allows the state's Farm Bureau to offer health plans that are exempt from all state and federal health insurance standards. The plans could deny coverage to people with pre-existing conditions, provide coverage to such people but decline to cover their pre-existing conditions, charge far higher premiums based on a person's health status, age, and other characteristics, and leave out benefits such as maternity care and prescription drugs.[3]

Similar legislation, backed by North Carolina's Farm Bureau, passed the North Carolina Senate but failed in that state's House last month. As with the Iowa Farm Bureau plans, the North Carolina plans would have been exempt from all ACA benefit standards and consumer protections, as well as state and federal insurance rules.

In Idaho, state officials say they are continuing to work on a proposal for "state-based plans" that are exempt from certain ACA rules, in order to provide lower-premium options to people who are not eligible for ACA subsidies. An initial version of the proposal (which diverged from ACA requirements, including by allowing pre-existing condition exclusions, higher premiums for older people, and gaps in essential health benefit coverage) didn't pass muster with the federal government because it would have violated federal law.[4] Idaho officials say they are working on modifications with the federal Department of Health and Human Services.[5]

At the federal level, the Department of Labor recently finalized rule changes for association health plans (AHPs), offered by trade and professional organizations to their members. AHPs will be able to expand, starting late this year, to cover more small businesses and self-employed people, form more easily, and avoid standards and protections that would otherwise apply to health insurance plans that cover individuals and small groups. Because an AHP will be considered a large employer plan — even if it enrolls small groups and self-employed individuals — such a plan will not be required to cover the ACA's essential health benefits, can charge higher premiums due to gender and occupation (which is not permitted in ACA plans), and can charge far more to older people than the ACA allows.

A number of agricultural organizations supported the federal AHP rule changes and may be among the groups offering the new types of AHPs to farmers and farm workers. For example, the Nebraska Farm Bureau has said it is planning to set up an AHP.[6] The same group worked on a provision in the U.S. House version of the farm bill, first proposed by a Nebraska congressman, that would provide up to $65 million over four years in federal grants and loans to agricultural organizations that want to form AHPs.[7]

The Trump Administration has also proposed expanding another type of skimpy health coverage: short-term plans. The plans, which under current rules can cover someone for less than three months, could last for up to one year under proposed federal changes. This would allow the plans — which do not have to cover the essential health benefits, can deny coverage or charge people higher premiums based on health status and other factors, and typically exclude coverage of pre-existing conditions — to operate as an alternative to more comprehensive ACA plans, one likely to attract healthier people and drive up premiums in the individual-market risk pool.

Often, supporters of offering more limited plans to farmers highlight the need for people with incomes higher than the ACA subsidy cut-off to have health insurance options with more affordable premiums.[8] Indeed, people ineligible for subsidies have borne the brunt of recent large increases in health insurance premiums in the individual insurance market. And farmers are more likely than the general population to buy their own insurance, perhaps because they are more likely to be self-employed and without access to an employer plan. However, if AHPs or Farm Bureau plans offer lower premiums to farmers or any other population, they will do so mainly by providing reduced coverage, covering a healthier group of people, or a combination of both. That won't meet the needs of most farmers and will harm many.

Skimpier Plans Distract from the True Needs of Uninsured Farmers and Farm Workers

Skimpier health plan options that fail to provide comprehensive coverage won't solve health care affordability problems for most people working in agriculture, especially if they face illness or injury.

In a survey funded by the U.S. Department of Agriculture, 2 out of 3 farmers and ranchers reported having a pre-existing health condition. Skimpier plans are unlikely to meet the needs of this group. In some cases, people with pre-existing conditions could be denied coverage under these plans or offered coverage with only very high premiums. People with health conditions who manage to buy such a plan will likely find it does not meet their needs because of features such as benefit gaps, higher out-of-pocket costs, and pre-existing condition exclusions. In the same survey, 3 out of 4 farmers and ranchers said health insurance is an important or very important risk management strategy in work that can at times be dangerous.[9]

Farm workers, specifically the crop workers surveyed by the Labor Department, have very low incomes and are frequently uninsured. In 2013-2014, they reported having mean and median yearly family incomes in the range of $20,000 to $24,499, and 30 percent of farm workers had family incomes below poverty. Just 35 percent of farm workers said they had health insurance,[10] and 26 percent said health care visits were too expensive. Notably, farm workers often face risks in their jobs, such as falls, injuries from farm equipment, and exposure to chemicals, dust, and the sun that are likely to require medical attention or to affect their health over time.[11]

With so many uninsured farmers and farm workers also having modest incomes, they may be eligible for better, more affordable coverage with an ACA marketplace plan or through their state's Medicaid program — or could be eligible for coverage if their state would expand Medicaid.

For example, a 40-year-old man in Marcus, Iowa earning $18,000 per year (about 150 percent of the federal poverty level) could buy a silver-level plan through Iowa's marketplace for about $60 per month, using a federal premium credit, if he otherwise met eligibility criteria. The plan would have a $100 deductible (reduced by ACA cost-sharing subsidies due to his income), cover all essential health benefits (including generic drugs and physician visits before the deductible is met), and cap all in-network, out-of-pocket costs for this enrollee at $1,000 for the year. Or, he could use the ACA premium subsidy to purchase a bronze plan with a far higher yearly deductible ($6,000) — betting that he would be healthy — and pay nothing toward the premium cost. If he did experience medical problems or an injury, the ACA plan (even the bronze plan with a high deductible) would provide significant financial protection, as well as access to preventive care with no cost sharing.

Meanwhile, the same man (if healthy) could buy a short-term plan (which is exempt from ACA standards and consumer protections) for about $50 per month, not much less than his net cost for a silver marketplace plan.[12] Yet the short-term plan would have severe limitations and impose high costs on enrollees who need health care: a $10,000 deductible; no coverage of outpatient prescription drugs, mental health care, or pre-existing conditions; plus a $25 application fee.[13]

Many uninsured farmers and farm workers with modest incomes are likely eligible for subsidized ACA marketplace coverage or Medicaid but have not enrolled. For one thing, awareness of ACA coverage options remains low among the public in general.[14] Applying and enrolling in a plan can be a complex process. People who have not yet enrolled may need more information or assistance with enrolling in coverage. And people working in agriculture may face additional challenges that need to be addressed, such as less access to in-person assistance with health care enrollment and to the internet. Some farm workers migrate from place to place within the United States and need help with proving their residency and other factors related to eligibility. And many farm workers in need of coverage also may need language assistance; among farm workers (as distinct from farmers), 74 percent reported being most comfortable speaking Spanish.[15] Farm owners may have volatile incomes from year to year, as is the case for many self-employed people, and may need expert help estimating and providing proof of their incomes.

Backers of expanding skimpy plans (such as short-term plans) sometimes claim the ability to pay a lower premium would help people in the Medicaid "coverage gap." These are people who live in states (including many disproportionately rural states) that have not adopted the ACA's Medicaid expansion, which extended that program to people with incomes up to 138 percent of the poverty level. In a state that chose not to expand Medicaid, adults with incomes below the poverty level generally are not eligible for ACA marketplace subsidies and often won't meet the restrictive non-expansion Medicaid requirements.

But skimpy plans are a terrible option for people with incomes below the poverty line who are caught in the coverage gap. Someone with income at 75 percent of the poverty level (about $750 per month) likely could not afford even the $50 short-term plan described above, and a plan with an even lower premium would have to include sharp limits on benefits and provide little health and financial protection. Moreover, proposing skimpy plans as a solution to the coverage gap problem ignores the fact that states have a better solution readily available: taking up the ACA's expansion of Medicaid, for which the federal government will cover 90 percent of the cost on a permanent basis.

In addition to income, other factors help determine a person's eligibility for ACA subsidies or Medicaid, including the number of people in a person's family, whether anyone in the household has access to employer-sponsored coverage, and a person's immigration or citizenship status.[16] Immigrants who are undocumented are not eligible for Medicaid, nor can they buy a marketplace plan. But, according to 2013-2014 survey data, slightly more than half of farm workers were U.S. citizens, lawful permanent residents, or otherwise had authorization to work in the United States.[17] People who are citizens or who are otherwise lawfully present can be eligible for subsidized marketplace plans if they meet all other eligibility requirements and are eligible for Medicaid in some cases. And even for people whose immigration status disqualifies them from Medicaid or marketplace coverage — as for workers in the Medicaid coverage gap — plans with more limited benefits will generally be an inadequate, unaffordable option.

Instead of focusing on getting people to enroll in health plan options that are subject to weaker consumer protections and standards, policymakers should make efforts to improve enrollment in

existing, more affordable health coverage for farmers and farm workers, and seek to expand Medicaid in more states.

Skimpy Plans Are No Answer for Higher-Income Agricultural Workers

More limited plans are also a flawed response to the needs of higher-income farmers who are experiencing problems affording health coverage. Any benefits they provide to healthy farmers will impose costs on the many farmers who, as noted above, have pre-existing conditions or other serious health needs. To the extent that skimpy plans with lower premiums lure healthier people out of the regular insurance risk pools for individuals and small businesses, the market will become fragmented, driving up premiums for people who remain. In the individual insurance market, the people who are not eligible for subsidies (such as middle-income farmers) would be the ones paying any additional costs. People who want more comprehensive coverage — for example because they are older or have health conditions — could face dwindling plan options as well.

Some skimpier coverage options supposedly geared toward farmers could turn out to have a far broader reach — and therefore a significant adverse impact on the insurance markets in the states where they operate. For example, the Iowa Farm Bureau estimates that some 60,000 Iowans who are not members of the group will sign up for the new health plans, a larger population than is currently enrolled in the state's ACA marketplace.[18]

As a statement from 16 patient groups including the American Cancer Society and the American Heart Association explained, expanding enrollment of skimpier health plans that are subject to weaker rules "has the potential to price millions of people with pre-existing conditions and serious illnesses out of the individual insurance market and put millions more at risk through the sale of insurance plans that won't cover all the services patients want to stay healthy or the critical care they need when they get sick."[19]

State and federal policymakers should instead consider better policy options to make health coverage more affordable for middle-income consumers, including farmers with incomes above 400 percent of the poverty level. For example, either the federal government or states could extend subsidies to people at higher income levels, as a number of members of Congress have proposed[20] and as Minnesota did for 2017.[21] The federal government and states could also set up reinsurance programs, as several states have already done, in order to reduce the cost of health insurance for unsubsidized consumers by reimbursing insurers for a portion of the cost associated with high-cost enrollees. For farmers and farm workers who have lower incomes, policymakers should invest in targeted outreach and enrollment assistance to help eligible people access coverage they are already eligible for and expand Medicaid in more states. Such approaches would maintain consumer protections and improve access to adequate coverage for farmers and farm workers (as well as other groups), without upending states' insurance markets.

Appendix

The main data used in this analysis come from the Census Bureau's 2016 American Community Survey data on people who identify as having jobs in the "Agriculture, Forestry, Fishing and Hunting" category of the North American Industry Classification System used by the Bureau of Labor Statistics. This category includes a range of occupations, from farm owners and farm workers to people who own or work in businesses related to agriculture, such as those that spray crops, board horses, and prepare soil. The category includes people who own or work at establishments that primarily grow crops (such as farms, orchards, groves, greenhouses, and nurseries), that produce animals (such as ranches and fisheries), that grow and harvest timber, and that involve fishing, hunting, or trapping. The overall number of people who are in this category is 1.7 million, as shown in the table below.

The Census data are thought to undercount the number of people who are hired to work on farms. A separate 2014 analysis estimated that there are 2.5 million farm workers (as distinct from farm owners) laboring on farms and ranches in the United States.[22] The Census data also combine farm owners with farm workers — two very different groups in terms of income and access to health coverage — so this report also references the Labor Department survey of farm workers, which is based on in-person interviews with people working in crop production. Nevertheless, the Census data offer important insights into the income distribution of uninsured farmers and farm workers and, if anything, a more complete picture would likely show even larger portions of low-income, uninsured workers.

APPENDIX TABLE 1

Farmers and Farm Workers, Ages 19 to 64

State	Farmers/ farm workers	Uninsured farmers/ farm workers	Uninsured rate	Of uninsured, share ... Under 200% of poverty	200% to 399% of poverty	At least 400% of poverty
United States	1,711,430	453,440	26%	58%	32%	9%
Alabama	18,100	3,730	21%	74%	16%	10%
Arizona	26,760	8,130	30%	41%	47%	13%
Arkansas	26,210	6,140	23%	49%	32%	20%
California	366,880	113,980	31%	69%	27%	5%
Colorado	26,280	5,930	23%	71%	21%	8%
Florida	75,050	34,700	46%	66%	30%	4%
Georgia	45,150	19,480	43%	58%	35%	6%
Idaho	29,640	8,690	29%	46%	35%	19%
Illinois	43,660	3,220	7%	60%	20%	19%
Indiana	30,520	5,960	20%	42%	45%	13%
Iowa	51,550	4,680	9%	57%	33%	10%
Kansas	27,210	3,390	12%	33%	46%	21%
Kentucky	22,120	5,060	23%	73%	17%	10%
Louisiana	20,970	6,840	33%	63%	26%	11%
Maine	12,750	2,370	19%	32%	55%	13%
Maryland	13,010	4,080	31%	34%	51%	15%
Massachusetts	11,310	1,110	10%	26%	63%	11%
Michigan	43,910	11,190	25%	67%	28%	5%
Minnesota	49,720	4,220	8%	49%	38%	13%
Mississippi	19,100	6,010	31%	48%	35%	17%
Missouri	33,430	5,190	16%	61%	27%	12%
Montana	20,030	1,940	10%	58%	24%	18%
Nebraska	31,390	2,780	9%	38%	58%	4%
New Jersey	12,720	4,470	35%	54%	41%	5%
New Mexico	9,810	2,200	22%	69%	31%	0%
New York	45,340	11,340	25%	44%	35%	20%
North Carolina	53,520	18,860	35%	75%	22%	3%
North Dakota	18,570	2,380	13%	21%	40%	38%
Ohio	32,950	5,680	17%	64%	25%	11%
Oklahoma	22,150	4,940	22%	44%	35%	21%
Oregon	54,100	12,660	23%	68%	15%	17%
Pennsylvania	49,380	15,840	32%	32%	51%	17%
South Carolina	19,070	6,470	34%	69%	27%	4%
South Dakota	21,140	2,930	14%	24%	50%	26%
Tennessee	23,160	7,500	32%	50%	41%	9%
Texas	83,350	30,700	37%	58%	29%	13%
Utah	10,710	2,620	24%	67%	32%	1%
Virginia	26,660	8,540	32%	53%	27%	21%
Washington	79,710	29,430	37%	49%	47%	4%

APPENDIX TABLE 1

Farmers and Farm Workers, Ages 19 to 64

				Of uninsured, share ...		
State	Farmers/ farm workers	Uninsured farmers/ farm workers	Uninsured rate	Under 200% of poverty	200% to 399% of poverty	At least 400% of poverty
Wisconsin	60,860	11,710	19%	39%	50%	11%

Note: The following states and jurisdictions are omitted due to inadequate sample size: Alaska, Connecticut, Delaware, District of Columbia, Hawaii, Nevada, New Hampshire, Rhode Island, Vermont, West Virginia, and Wyoming. Data for these states and jurisdictions are included in the aggregated findings for the United States. Shaded states are Medicaid expansion states. Estimates are rounded to the nearest ten agricultural workers. Percentages may not sum to 100 percent due to rounding.

Source: CBPP analysis of 2016 American Community Survey data from the Census Bureau.

End Notes

[1] CBPP analysis of the Census Bureau's 2016 American Community Survey data. The Appendix includes a more thorough discussion of the data used in this analysis.

[2] Findings from the National Agricultural Workers Survey (NAWS) 2013-2014, Department of Labor, https://www.doleta.gov/agworker/pdf/NAWS_Research_Report_12_Final_508_Compliant.pdf.

[3] Sarah Lueck, "Iowa Health Plan Proposal Would Raise Consumer Costs, Weaken Protections," Center on Budget and Policy Priorities, February 28, 2018, https://www.cbpp.org/blog/iowa-health-plan-proposal-would-raise-consumer-costs-weaken-protections.

[4] Letter from CMS Administrator Seema Verma to Idaho Governor C.L. "Butch" Otter and Department of Insurance Director Dean L. Cameron, March 8, 2018, https://www.cms.gov/CCIIO/Resources/Letters/Downloads/letter-to-Otter.pdf.

[5] Rebecca Boone, "Idaho officials working on 'state-based' insurance plan," *Lewiston Tribune*, May 7, 2018, https://lmtribune.com/northwest/idaho-officials-working-on-state-based-insurance-plan/article_eeb41998-2651-52fa-9059-0c3267228b2f.html.

[6] Letter to the Employee Benefits Security Administration from the Nebraska Farm Bureau, March 6, 2018, https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AB85/00470.pdf.

[7] Chris Clayton, "Health Care by Association," *The Progressive Farmer*, June 18, 2018, https://www.dtnpf.com/agriculture/web/ag/news/world-policy/article/2018/06/18/house-farm-bill-language-help-farmer-2; Sarah Lueck, "Farm Bill Funding for Association Health Plans Could Weaken

Coverage, Raise Costs," Center on Budget and Policy Priorities, May 16, 2018, https://www.cbpp.org/blog/farm-bill-funding-for-association-health-plans-could-weaken-coverage-raise-costs.

[8] Shelby Livingston, "N.C. Farm Bureau asks lawmakers to OK coverage that skirts the ACA," *Modern Healthcare,* June 7, 2018, http://www.modernhealthcare.com/article/20180607/NEWS/180609935; Katarina Sostaric, "Bill Allowing Health Plans Not Compliant with Affordable Care Act Goes to Iowa Governor's Desk," Iowa Public Radio, March 27, 2018, http://iowapublicradio.org/post/bill-allowing-health-plans-not-compliant-affordable-care-act-goes-iowa-governors-desk#stream/0.

[9] "Health Insurance is Key to Farm & Ranch Economic Viability," 2017 National Farmer and Rancher Survey Findings, July 2017, http://docs.wixstatic.com/ugd/85136a_2cc79e77a6ab471688a5b76bf9ec1c04.pdf.

[10] NAWS, *op cit.* Under the ACA, expanded Medicaid and subsidized marketplace coverage became available in 2014, so the survey interviews were conducted both before and after those options became available.

[11] "Rural Agricultural Health and Safety," The Rural Health Information Hub, the Health Resources and Services Administration (HRSA), Department of Health and Human Services, August 27, 2017, https://www.ruralhealthinfo.org/topics/agricultural-health-and-safety#risks.

[12] Premium and benefit details of the Iowa Farm Bureau plans have not been made public. But like the Farm Bureau plans, short-term plans are exempt from ACA benefit and premium-rating standards. Short-term plans are currently limited, under federal rules, to lasting less than three months. But a proposed federal rule change would allow them to last up to one year or possibly longer.

[13] Connect Lite health plan, underwritten by Independence American Insurance Company (IAIC), found on ehealthinsurance.com, July 12, 2018, https://www.ehealthinsurance.com/ehealthinsurance/benefits/st/IAIC/Connect_Lite__0518.pdf.

[14] In 2018, four years after ACA marketplaces were established, 35 percent of uninsured adults surveyed said they were not aware of them. Sara R. Collins *et al.,* "Americans' Views on Health Insurance at the End of a Turbulent Year," Commonwealth Fund, March 1, 2018, https://www.commonwealthfund.org/publications/issue-briefs/2018/mar/americans-views-health-insurance-end-turbulent-year?stream=top-stories.

[15] NAWS, *op cit.*

[16] People who are not citizens generally are not eligible for Medicaid coverage, but people who are lawfully residing (including people working in agriculture using a temporary visa) can be eligible for subsidized marketplace coverage.

[17] NAWS, *op cit.*

[18] Steve Jordon, "Iowa Farm Bureau will sell health plans outside 'Obamacare' exchange," Live Well Nebraska, April 3, 2018, https://www.omaha.com/livewellnebraska/consumer/iowa-farm-bureau-will-sell-health-plans-outside-obamacare-exchange/article_0ca98a68-9b97-54e6-a39d-81c282570442.html.

[19] Jessie Hellman, "Health groups warn Trump's executive order could hurt patients," *The Hill*, October 12, 2017, http://thehill.com/policy/healthcare/355221-health-groups-warn-trumps-executive-order-could-hurt-patients.

[20] See, for example, H.R. 5155, the Undo Sabotage and Expand Affordability of Health Insurance Act of 2018, and S. 2582, the Consumer Health Insurance Protection Act of 2018.

[21] David Montgomery, "MN just passed health insurance premium subsidies. Here's what it means," *Pioneer Press*, January 26, 2017, https://www.twincities.com/2017/01/26/mn-just-passed-health-insurance-premium-subsidies-heres-what-you-need-to-know/.

[22] "Selected Statistics on Farmworkers," Farmworker Justice, 2014, https://www.farmworkerjustice.org/sites/default/files/NAWS%20data%20factsht%201-13-15FINAL.pdf.

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MORE ON THIS TOPIC

BLOG

Iowa Health Plan Proposal Would Raise Consumer Costs, Weaken Protections

FEBRUARY 28, 2018

BLOG

Farm Bill Funding for Association Health Plans Could Weaken Coverage, Raise Costs

MAY 16, 2018

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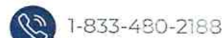

WELCOME TO LOWER HEALTH PREMIUMS

We've been looking out for South Dakota's #1 industry for over 100 years. As a voice for farmers and ranchers across the state, we're now extending that voice by offering affordable health plans for our members. Most will save over 35% on their premiums.

The best part? You don't have to be a farmer or rancher to join South Dakota Farm Bureau, and membership starts at only $60/year.

If you're under 65 years of age, SDFB Health Plans has a range of plan options for a healthier South Dakota. Choose your:

- Level of coverage
- Deductible
- Out-of-pocket payments
- Preventative health benefits

Apply for coverage at any time without waiting for an enrollment period. You'll also get personal customer service you can trust from our South Dakota Farm Bureau Health Plans representatives. So, if you ever have questions, we're standing by ready to help. Our Health Plans rely on the UnitedHealthcare Choice Plus network and physicians can be found at most health care providers across the state – and even the nation.

PLAN OPTIONS

Here's an overview of all South Dakota Farm Bureau Health Plans. Each plan has different terms depending on whether you choose to use in-network or out-of-network providers. These plans require medical underwriting that may affect eligibility and rates. South Dakota Farm Bureau membership is required.

ADVANCED CHOICE

An Advanced Choice plan for families or individuals offers peace of mind coverage and includes limited dental and vision benefits. With this plan you get a choice of two different deductible amounts.

CLASSIC CHOICE

Classic Choice is for those who are looking for a health plan with preventative health, dental and vision benefits. Get the trifecta -- health, limited dental and vision -- under one health plan. Available for individuals only.

MAJOR MEDICAL

Our Major Medical plan is ideal for those who want catastrophic protection with the advantage of a lower premium. This plan provides benefits for physician services, hospitalization, prescription drugs and more. Available for individuals or families.

HIGH DEDUCTIBLE HEALTH PLAN (HSA-QUALIFIED)

South Dakota Farm Bureau Health Plans offers a range of High Deductible Health Plans (HDHP) which meet all federal requirements necessary to open a Health Savings Account (HSA).

ADVANCED CHOICE SCHEDULE OF BENEFITS
(for individuals & families)

THIS SCHEDULE IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

This is a comprehensive health coverage plan that includes hospitalization, medical and prescription benefits. South Dakota Farm Bureau Health Plans uses UnitedHealthcare Choice Plus Network of providers. Please keep in mind that in-network payments are based on negotiated fees; if an out-of-network provider is used, the member's liability will increase significantly.

		In-Network	Out-of-Network
CALENDAR YEAR DEDUCTIBLE (CYD) • Per individual, per calendar year. • Unless otherwise indicated, all benefits are subject to the CYD		**Option 1:** $1,500 per individual **Option 2:** $3,000 per individual	
OUT OF POCKET MAXIMUM (OOP) • Once the OOP maximum is met, eligible benefits are provided at 100% for an individual for the remainder of the calendar year. • This applies to in-network provider services only. • Copayments do not apply to OOP and must still be paid after OOP is met.	For $1,500 CYD: **Option 1:**	$5,000 for individual coverage $10,000 for family coverage	Unlimited
	For $3,000 CYD: **Option 2:**	$10,000 for individual coverage $20,000 for family coverage	
LIFETIME BENEFIT MAXIMUM		Unlimited	

Services

		In-Network		Out-of-Network	
OFFICE VISIT · Not subject to CYD	**Option 1** For $1,500 CYD:	$25 copayment* per visit		CYD/Coinsurance	
	Option 2 For $3,000 CYD:	$35 copayment* per visit			
TELADOC · Not subject to CYD		$0 copayment per visit		No Coverage	
TELADOC EXPERT MEDICAL SERVICES · Not subject to CYD		$0 copayment per visit		No Coverage	
COINSURANCE · Based on the maximum allowable charge		**Plan Pays** 80%	**Your Responsibility** 20%	**Plan Pays** 60%	**Your Responsibility** 40%
PREVENTATIVE CARE BENEFITS · No waiting period · In-Network benefits not subject to CYD		**Plan Pays**	**Your Responsibility**	**Plan Pays**	**Your Responsibility**
• Preventative Health Exam[1]		100%	0%	60%	40%
• Annual Well-Woman Exam[2]		100%	0%	60%	40%
• Routine Colonoscopy[3]		100%	0%	60%	40%
• Annual Routine PSA[4]		100%	0%	60%	40%
PRESCRIPTION DRUG COVERAGE		**Plan Pays**	**Your Responsibility**	**Plan Pays**	**Your Responsibility**
• Generic - 30 day supply		All but copayment	$4 copayment[5]	60%	40%
• Brand		80%	20%	60%	40%
• $7,500 individual maximum per calendar year					
EMERGENCY ROOM SERVICES · Not resulting in admission		$75 Deductible per visit (In addition to CYD and Coinsurance)			

DENTAL - All Individuals

Routine dental services, including two exams, cleanings, x-rays and fillings per calendar yea

- Subject to a six month waiting period
- There is a copayment per visit and a $500 calendar year maximum per individual per calendar year.

VISION

Pediatric (Under Age 19) Routine vision benefits including eye exams, eyeglasses and contact lenses.

- No waiting period.
- Eye exams are covered at 100% once every calendar year, no dollar limit.
- Eyeglass frames, eyeglass lenses or contact lenses are covered once every calendar year at 100% up to a maximum of $100 per member, not subject to deductible and coinsurance.

Age 19 and Over - Routine vision benefits including eye exams, eyeglasses and contact lense

- Subject to a six month waiting period.
- Eye exams are covered once every calendar year with a $40 limit per individual.
- Eyeglass lenses or contact lenses are covered once every calendar year at 100% up to a maximum of $100 per individual, not subject to deductible.

FOOTNOTES

1. Preventative health exam for adults and children and related services as outlined below and performed by the physician during the preventative health exam or referred by the physician as appropriate, including:
   - Screenings and counseling services with an A or B recommendation by the United States Preventive Services Task Force (USPSTF).
   - Bright Futures recommendations for infants, children and adolescents supported by the Health Resources and Services Administration (HRSA).
   - Preventative care and screening for women as provided in the guidelines supported by HRSA and immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) that have been adopted by the Centers for Disease Control and Prevention (CDC).
2. Annual well-woman exam
   - Routine well-woman preventative exam office visi
   - Cervical cancer screening
   - Screening mammography at age 40 and older, with one baseline mammogram between the ages of 35 and 39
   - Other USPSTF screenings with an A or B rating
   - Pap smears
   - Bone density measurement screening
3. Colorectal cancer screening for individuals age 45 and older.
4. Prostate cancer screening for men age 50 and older.
5. Prescription copayment does not apply toward deductibles or out-of-pocket maximums.

*OFFICE COPAYMENT GUIDELINES

A copayment will be applied to each office visit for the covered services performed in the office and provided and billed by a physician who is an in-network provider. The remaining charges for covered services rendered during the office visit will be paid at 100% of the maximum allowable charge. If a physician who is an out-of-network provider is utilized for covered services, benefits will be determined on the basis of the out-of-network coinsurance percentage after deductible is met. Copayments will not be applied toward deductibles or out-of-pocket maximums.

Copayments do not apply to the following services: advanced radiological imaging, allergy testing and injections, biopsy interpretation, bone density testing, cardiac diagnostic testing, chemotherapy services, chiropractic services, complex diagnostic services, dental services except preventative and restorative for all individuals, diagnostic services sent out, durable medical equipment, growth hormone injections, IV therapy, Lupron injections, mammography, maternity services, nerve conduction studies, neuropsychological or neurological tests, nuclear cardiology, nuclear medicine, orthotics, preventative services as indicated in contract, prosthetics, provider administered specialty pharmacy products, sleep studies, surgery performed in a physician's office the and related surgical supplies, Synagis injections, therapeutic/rehabilitative services, ultrasounds and vision services. These services are subject to the terms and conditions of the contract. Deductibles and coinsurance will apply except where otherwise indicated.

MATERNITY BENEFITS

Maternity Benefits will be provided after an individual's coverage on a family contract has been in effect for nine consecutive months. Individual coverage has NO maternity benefits except for complications of pregnancy.

PRE-EXISTING CONDITION WAITING PERIOD

Benefits will not be provided for any pre-existing condition until an individual has completed a waiting period of at least six months. In rare circumstances, the pre-existing condition waiting period may be longer. A pre-existing condition is defined in the contract as "An illness, injury, pregnancy or any other medical condition which existed at any time preceding the effective date of coverage under this contract for which: Medical advice or treatment was recommended by, or received from, a provider of health care services; or symptoms existed which would cause an ordinarily prudent person to seek diagnosis, care or treatment." The pre-existing condition waiting period will not apply to individuals under the age of 19 enrolled as dependents in a family coverage.

Additional waiting periods may apply as indicated in the contract.

CLASSIC CHOICE SCHEDULE OF BENEFITS
(for individuals)

THIS SCHEDULE IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

This is a comprehensive health coverage plan that includes hospitalization, medical and prescription benefits. South Dakota Farm Bureau Health Plans uses UnitedHealthcare Choice Plus Network of providers. Please keep in mind that in-network payments are based on negotiated fees; if an out-of-network provider is used, the member's liability will increase significantly.

	In-Network		Out-of-Network
CALENDAR YEAR DEDUCTIBLE (CYD) • Unless otherwise indicated, all benefits are subject to the CYD.	Option 1:	$3,000 per individual	
	Option 2:	$6,000 per individual	
OUT OF POCKET MAXIMUM (OOP) • Once the OOP maximum is met, eligible benefits are provided at 100% for an individual for the remainder of the calendar year. • This applies to in-network provider services only. • Copayments do not apply to OOP and must still be paid after OOP is met).	Option 1:	$10,000	Unlimited
	Option 2:	$20,000	
LIFETIME BENEFIT MAXIMUM	Unlimited		

Services

		In-Network		Out-of-Network	
OFFICE VISIT · Not subject to CYD	**Option 1** For $3,000 CYD:	$40 copayment* per visit		CYD/Coinsurance	
	Option 2 For $6,000 CYD:	$40 copayment* per visit			
TELADOC · Not subject to CYD		$0 copayment per visit		No Coverage	
TELADOC EXPERT MEDICAL SERVICES · Not subject to CYD		$0 copayment per visit		No Coverage	
COINSURANCE · Based on the maximum allowable charges for eligible benefits		**Plan Pays** 80%	**Your Responsibility** 20%	**Plan Pays** 60%	**Your Responsibility** 40%
PREVENTATIVE CARE BENEFITS · No waiting period · 'In-Network benefits' not subject to CYD.		**Plan Pays**	**Your Responsibility**	**Plan Pays**	**Your Responsibility**
• Preventative Health Exam[1]		100%	0%	60%	40%
• Annual Well-Woman Exam[2]		100%	0%	60%	40%
• Routine Colonoscopy[3]		100%	0%	60%	40%
• Annual Routine PSA[4]		100%	0%	60%	40%
PRESCRIPTION DRUG COVERAGE		**Plan Pays**	**Your Responsibility**	**Plan Pays**	**Your Responsibility**
• Generic - 30 day supply		All but copayment	$4 copayment[5]	60%	40%
• Brand		80%	20%	60%	40%
• Unlimited Calendar Year Maximum Per Individual					
EMERGENCY ROOM SERVICES · Not resulting in admission		$75 Deductible per visit (In addition to CYD and Coinsurance)			

DENTAL - No waiting periods

Pediatric (Under Age 19)

- Preventative services, as outlined by the U.S. Preventative Task Force (USPTF) and Health Resources and Services Administration (HRSA)
- Other eligible dental services subject to CYD and coinsurance
- Limited orthodontic care

Age 19 and Over

- $40 copay for preventative and restorative services
- Maximum benefit per calendar year is $500

VISION

No waiting periods

Pediatric (Under Age 19)

- Eye exams are covered at 100% once every calendar year.
- Eyeglass frames, eyeglass lenses or contact lenses are covered once every calendar year at 100% up to a maximum of $100 per member, not subject to deductible and coinsurance.

Age 19 and Over

- Eye exams are covered once every calendar year with a limit of $40.
- Eyeglass lenses or contact lenses are covered once every calendar year at 100% up to a maximum of $100 per individual, not subject to deductible.

FOOTNOTES

1. Preventative health exam for adults and children and related services as outlined below and performed by the physician during the preventative health exam or referred by the physician as appropriate, including:
   - Screenings and counseling services with an A or B recommendation by the United States Preventative Services Task Force (USPSTF).
   - Bright Futures recommendations for infants, children and adolescents supported by the Health Resources and Services Administration (HRSA).
   - Preventative care and screening for women as provided in the guidelines supported by HRSA, and immunizations recommended by the Advisory Committee of Immunization Practices (ACIP) that have been adopted by the Centers for Disease Control and Prevention (CDC).
2. Annual well-woman exam
   - Routine well-woman preventative exam office visit
   - Cervical cancer screening
   - Screening mammography at age 40 and older, with one baseline mammogram between the ages of 35-39
   - Other USPSTF screenings with an A or B rating
     - Pap smears
     - Bone density measurement screening
3. Colorectal cancer screening for individuals age 45 and older
4. Prostate cancer screening for men age 50 and older
5. Prescription copayment does not apply toward deductibles or out-of-pocket maximums.

*OFFICE COPAYMENT GUIDELINES

A copayment will be applied to each office visit for the covered services performed in the office and provided and billed by a physician who is an in-network provider. The remaining charges for covered services rendered during the office visit will be paid at 100% of the maximum allowable charge. If a physician who is an out-of-network provider is utilized for covered services, benefits will be determined on the basis of the out-of-network coinsurance percentage after deductible is met.

Copayments do not apply to the following services: advanced radiological imaging, allergy testing and injections, biopsy interpretation, bone density testing, cardiac diagnostic testing, chemotherapy services, chiropractic services, complex diagnostic services, dental services except preventative and restorative for all individuals age 19 and over, diagnostic services sent out, durable medical equipment, growth hormone injections, IV therapy, Lupron injections, mammography, maternity services, nerve conduction studies, neuropsychological or neurological tests, nuclear cardiology, nuclear medicine, orthotics, preventative services as indicated in the contract, prosthetics, provider administered specialty pharmacy products, sleep studies, surgery performed in a physician's office and related surgical supplies, Synagis injections, therapeutic/ rehabilitative/ habilitative services, ultrasounds and vision services. These services are subject to the terms and conditions of the contract. Deductibles and coinsurance will apply except where otherwise indicated. Copayments will not be applied to the deductibles or out-of-pocket maximums.

MATERNITY BENEFITS

Maternity benefits will be eligible as long as the pregnancy is not considered a pre-existing condition.

PRE-EXISTING CONDITION WAITING PERIOD

Benefits will not be provided for any pre-existing condition until an individual has completed a waiting period of at least six months. A pre-existing condition is defined in the contract as "An illness, injury, pregnancy or any other medical condition which existed at any time preceding the effective date of coverage under this contract for which: Medical advice or treatment was recommended by, or received from, a provider of health care services; or symptoms existed which would cause an ordinarily prudent person to seek diagnosis, care or treatment."

HIGH DEDUCTIBLE HEALTH PLAN SCHEDULE OF BENEFITS
(for individuals & families)

THIS SCHEDULE IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

This is a comprehensive health coverage plan that includes hospitalization, medical and prescription benefits. South Dakota Farm Bureau Health Plans uses UnitedHealthcare Choice Plus Network of providers. Please keep in mind that in-network payments are based on negotiated fees; if an out-of-network provider is used, the member's liability will increase significantly.

	In-Network	Out-of-Network
CALENDAR YEAR DEDUCTIBLE (CYD)[1] • Unless otherwise indicated, all benefits apply toward CYD. • Family Deductible can be satisfied by one or more covered individuals during a calendar year. • In-Network and Out-of-Network deductibles are met separately.	$1,500 for individual $2,500 for individual $3,000 for family $5,000 for 2-person/3-person/family	$1,500 for individual $2,500 for individual $3,000 for family $5,000 for 2-person/3-person/family
OUT OF POCKET MAXIMUM (OOP)[2] • Family Out of Pocket Maximum can be satisfied by one or more covered individuals during a calendar year. • Once the OOP maximum is met, eligible benefits are provided at 100% for the remainder of the calendar year. • This applies to in-network provider services only.	$3,000 for $1,500 deductible $3,750 for $2,500 deductible $6,000 for $3,000 deductible $7,500 for $5,000 deductible	Unlimited
LIFETIME BENEFIT MAXIMUM	Unlimited	

Services

	In-Network Plan Pays	In-Network Your Responsibility	Out-of-Network Plan Pays	Out-of-Network Your Responsibility
COINSURANCE · Based on the maximum allowable charges for eligible benefits. ·	80%	20%	60%	40%
PREVENTATIVE CARE BENEFITS · Subject to CYD				
• Well Child Services[3]	80%	20%	Not Covered	
• Routine Colonoscopy[4]	80%	20%	60%	40%
• Annual Routine PSA[5]	80%	20%	60%	40%
• Annual Routine OB/GYN Exam[6]	80%	20%	Not Covered	
• Annual Routine Pap Smear[7]	80%	20%	60%	40%
• Mammogram[8]	80%	20%	60%	40%
PRESCRIPTION DRUG COVERAGE[9]				
• Generic and Brand Prescriptions	80%	20%	60%	40%
• Unlimited calendar year maximum per individual				
• Home Delivery Services are available				

TELADOC

Member must pay 100% of the current Teladoc consultation fee until CYD is met. Once CYD is met, no consultation fee for Teladoc. All Teladoc Expert Medical Services are at no charge.

FOOTNOTES

1. Deductible – the dollar amount of covered services that must be incurred and paid first by an individual each calendar year before plan benefits begin.
2. Once the OOP maximum is met, benefits are provided at 100% for an individual(s) for the remainder of the calendar year. This applies to in-network provider services only. There is no Out of Pocket Maximum when out-of-network providers are used.
3. Benefits are available, subject to deductible and coinsurance, for an individual under the age of 7 (on plan deductibles $3,000 and $5,000) for physical examinations and appropriate immunizations/vaccinations when services are rendered by an in-network provider. Exams not used during the time periods below do not carry over to the next time period.

AGE	NUMBER OF EXAMS
Under age one	Four exams from birth to the child's first birthday
Age one	Two exams from the child's first birthday to the child's second birthday
Age two through six	One exam per year (determined by the child's birthday)

4. Benefits will be provided for one routine colonoscopy every four years for individuals age 50 and over when provided by an in-network or out-of-network provider, subject to the deductible and coinsurance.
5. Benefits will be provided, subject to deductible and coinsurance, for one routine PSA per calendar year when services are rendered by an independent laboratory or other outpatient setting.
6. Benefits will be available for one routine OB/GYN exam per calendar year, subject to deductible and coinsurance. Services must be rendered by an in-network physician's office and billed by the in-network provider. Related pathology, including pap smear, which is provided as a part of the routine OB/GYN exam, will be covered when the services are rendered by an in-network physician's office and billed by the in-network provider. Related pathology that the physician sends to an independent laboratory will be subject to deductible and coinsurance. No benefit is available for routine OB/GYN exams provided by an out-of-network provider.
7. Benefits will be provided for the interpretation of one routine pap smear per calendar year when services are rendered by an independent laboratory or other outpatient setting, subject to deductible and coinsurance.
8. For routine mammography screening provided such examinations are conducted upon the recommendation of the individual's physician. One baseline routine mammogram will be allowed for individuals between the ages of 35-39. One routine mammogram will be allowed annually for individuals age 40 and above. All routine mammography screens are subject to deductible and coinsurance.
9. Benefits will be provided, subject to deductible and coinsurance.

MATERNITY BENEFITS

Maternity Benefits will be available after an individual's coverage on a 2-person, 3-person or family contract has been in effect for nine consecutive months. Individual coverage has NO maternity benefits.

PRE-EXISTING CONDITION WAITING PERIOD

Benefits will not be provided for any pre-existing condition until an individual has completed a waiting period of at least 12 months. A pre-existing condition is defined in the contract as "An illness, injury, pregnancy or any other medical condition which existed at any time preceding the effective date of coverage under this contract for which: Medical advice or treatment was recommended by, or received from, a provider of health care services; or symptoms existed which would cause an ordinarily prudent person to seek diagnosis, care or treatment." The pre-existing condition waiting period does not apply to individuals under the age of 19 on a family plan.

MAJOR MEDICAL SCHEDULE OF BENEFITS
(for individuals & families)

THIS SCHEDULE IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

This is a comprehensive health coverage plan that includes hospitalization, medical and prescription benefits. South Dakota Farm Bureau Health Plans uses UnitedHealthcare Choice Plus Network of providers. Please keep in mind that in-network payments are based on negotiated fees; if an out-of-network provider is used, the member's liability will increase significantly.

	In-Network	Out-of-Network
CALENDAR YEAR DEDUCTIBLE (CYD)[1] • Unless otherwise indicated, all benefits are subject to the CYD.	$5,000 per individual	
OUT OF POCKET MAXIMUM (OOP)[2] • Once the OOP maximum is met, eligible benefits are provided at 100% for an individual for the remainder of the calendar year. • This applies to in-network provider services only.	$10,000 individual $20,000 family	Unlimited
LIFETIME BENEFIT MAXIMUM	Unlimited	

Services

	In-Network		Out-of-Network	
COINSURANCE · Based on the maximum allowable charge.	**Plan Pays**	**Your Responsibility**	**Plan Pays**	**Your Responsibility**
	80%	20%	60%	40%
PREVENTATIVE CARE BENEFITS · Subject to CYD	**Plan Pays**	**Your Responsibility**	**Plan Pays**	**Your Responsibility**
• Well-Child Services[3]	80%	20%	Not Covered	
• Routine Colonoscopy[4]	80%	20%	60%	40%
• Annual Routine PSA[5]	80%	20%	60%	40%
• Annual Routine OB/GYN Exam[6]	80%	20%	Not Covered	
• Annual Routine Pap Smear[7]	80%	20%	60%	40%
• Mammogram[8]	80%	20%	60%	40%
PRESCRIPTION DRUG COVERAGE	**Plan Pays**	**Your Responsibility**	**Plan Pays**	**Your Responsibility**
• Generic - 30 day supply	All but copayment	$4 copayment[9]	60%	40%
• Brand	80%	20%	60%	40%
• Unlimited Calendar Year Maximum Per Individual				
TELADOC · Not subject to CYD	$0 copayment per visit		No Coverage	
TELADOC EXPERT MEDICAL SERVICES · Not subject to CYD	$0 copayment per visit		No Coverage	

FOOTNOTES

1. Deductible – the dollar amount of covered services that must be incurred and paid first by an individual each calendar year before plan benefits begin.
2. Once the OOP maximum is met, benefits are provided at 100% for an individual(s) for the remainder of the calendar year. This applies to in-network provider services only. There is no Out of Pocket Maximum when out-of-network providers are used.
3. Benefits are available, subject to deductible and coinsurance, for an individual under the age of 7 for physical examinations and appropriate immunizations/vaccinations when services are rendered by an in-network provider. Exams not used during the time periods below do not carry over to the next time period.

AGE	NUMBER OF EXAMS
Under age one	Four exams from birth to the child's first birthday
Age one	Two exams from the child's first birthday to the child's second birthday
Age two through six	One exam per year (determined by the child's birthday)

4. Benefits will be provided for one routine colonoscopy every four years for individuals age 50 and over when provided by an in-network or out-of-network provider, subject to the deductible and coinsurance.
5. Benefits will be provided, subject to deductible and coinsurance, for one routine PSA per calendar year when services are rendered by an independent laboratory or other outpatient setting.
6. Benefits will be available for one routine OB/GYN exam per calendar year, subject to deductible and coinsurance. Services must be rendered by an in-network physician's office and billed by the in-network provider. Related pathology, including pap smear, which is provided as a part of the routine OB/GYN exam, will be covered when the services are rendered by an in-network physician's office and billed by the in-network provider. Related pathology that the physician sends to an independent laboratory will be subject to deductible and coinsurance. No benefit is available for routine OB/GYN exams provided by an out-of-network provider.
7. Benefits will be provided for the interpretation of one routine pap smear per calendar year when services are rendered by an independent laboratory or other outpatient setting, subject to deductible and coinsurance.
8. Benefits will be provided, subject to deductible and coinsurance, for routine mammography screening provided such examinations are conducted upon the recommendation of the individual's physician. One baseline routine mammogram will be allowed for individuals between the ages of 35-39. One routine mammogram will be allowed annually for individuals age 40 and above. All routine mammography screens are subject to deductible and coinsurance.
9. Prescription copayment does not apply toward deductible or out-of-pocket maximum.

MATERNITY BENEFITS

Maternity Benefits will be available after an individual's coverage on a family contract has been in effect for nine consecutive months. Individual coverage has NO maternity benefits.

PRE-EXISTING CONDITION WAITING PERIOD

Benefits will not be provided for any pre-existing condition until an individual has completed a waiting period of at least 12 months. A pre-existing condition is defined in the contract as "An illness, injury, pregnancy or any other medical condition which existed at any time preceding the effective date of coverage under this contract for which: Medical advice or treatment was recommended by, or received from, a provider of health care services; or symptoms existed which would cause an ordinarily prudent person to seek diagnosis, care or treatment." The pre-existing condition waiting period does not apply to individuals under the age of 19 enrolled in a family plan.

PLAN ENHANCEMENTS

TELADOC.

TELADOC provides access to doctors by phone or video, as part of your benefits. Our U.S. board-certified doctors can diagnose, treat and even prescribe medicine, if needed, for a wide range of medical needs, including the flu, allergies, rash, upset stomach and much more.

Expert Medical Services is another valuable service from Teladoc. This benefit offers expert medical advice available at no cost to you and/or your eligible dependents. Expert Medical Services can provide answers to medical questions, a confirmation or modification of a diagnosis, guidance on picking a treatment option, or help deciding if a surgery is right for you.
teladoc.com | 1-800-Teladoc

Optum Rx®

OptumRx® HOME DELIVERY is an option for all members and is safe and reliable. You may pay less for your medication with a three-month supply through OptumRx. Get convenient, free standard shipping on medications delivered to your mailbox.
1-800-788-4863, TTY 711 to place home delivery orders anytime.

LIVE WELL

Finding ways to stay healthy doesn't have to be difficult. Healthy choices are all around us every day. FBHP has teamed with UMR Wellness CARE to offer a Clinical Health Risk Assessment to help you recognize and make the most of your health care opportunities. Additional wellness resources are available at **umr.com**, including a library of health information, videos and interactive "action plan" tutorials to help you get and stay healthy.

The Maternity CARE Program informs members who are thinking about having a baby or are in the early stages of pregnancy about how improving their own health can influence the future health of their baby.

With the CARE app, members can access a wide range of wellness information to improve overall health and wellbeing.

Getting started is easy

Enroll today! We'll need some basic information along with an email address, mobile phone number and your UMR member ID and group ID numbers. Simply scan the **QR code** or access the enrollment page at **go.umr.com/get-care-app**

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talkspace

Talkspace Programs | Mental Health Care for All
Talkspace's therapist-led virtual care services and same-day start times can provide responsive and reliable mental health support to those experiencing a wide range of challenges - including stress, anxiety, depression and more.
talkspace.com/connect

*Deductibles and co-pays apply

NurseLine℠

NurseLine will connect you to a team of registered nurses who can answer your questions and provide advice. Nurses are standing by to help any time of day, seven days a week as part of your UMR health benefits, at no cost to you.

Reach out by phone using the toll-free number on the back of your member ID card or chat online with a nurse at umr.com, select Health Center from myMenu and look for the link in the "I need to..." section. You have questions, UMR nurses have answers.

*Deductibles and co-pays apply

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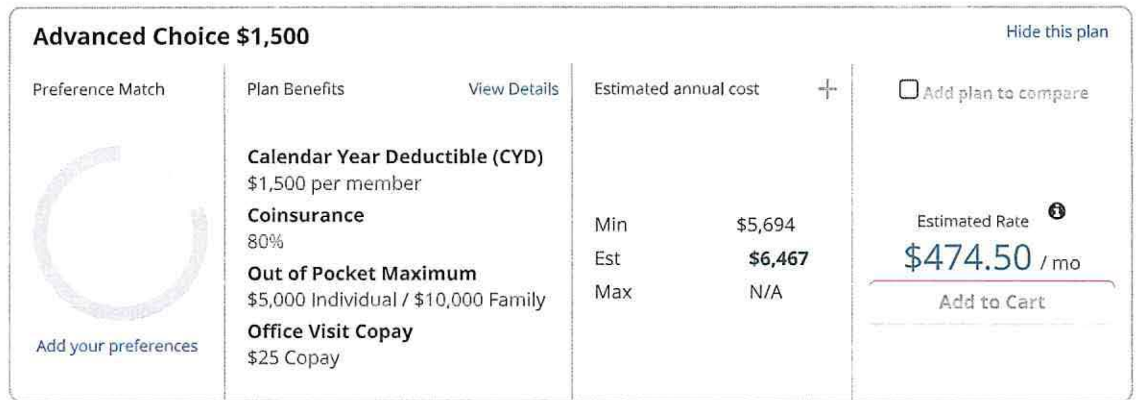


Advanced Choice $1,500

Hide this plan

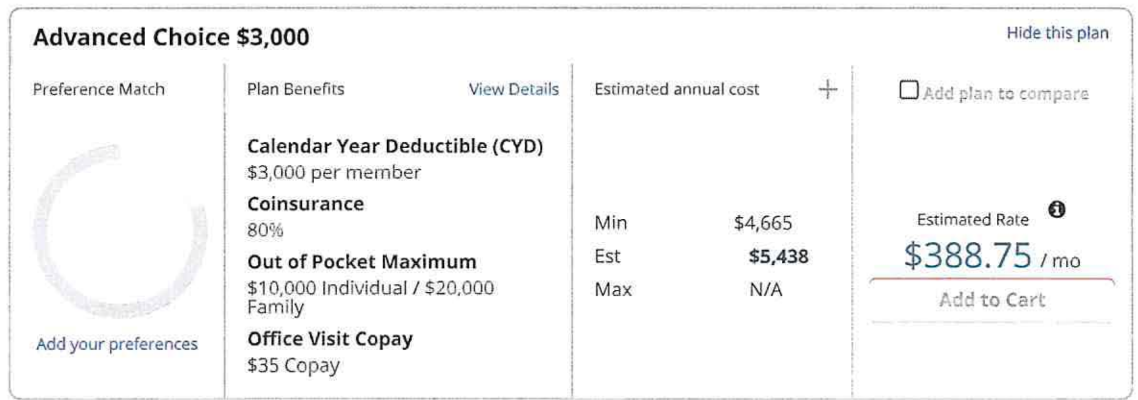
Preference Match | Plan Benefits | View Details | Estimated annual cost | Add plan to compare

Calendar Year Deductible (CYD)
$1,500 per member
Coinsurance
80%
Out of Pocket Maximum
$5,000 Individual / $10,000 Family
Office Visit Copay
$25 Copay

Min	$5,694
Est	**$6,467**
Max	N/A

Estimated Rate
$474.50 / mo
Add to Cart

Add your preferences



Advanced Choice $3,000

Hide this plan

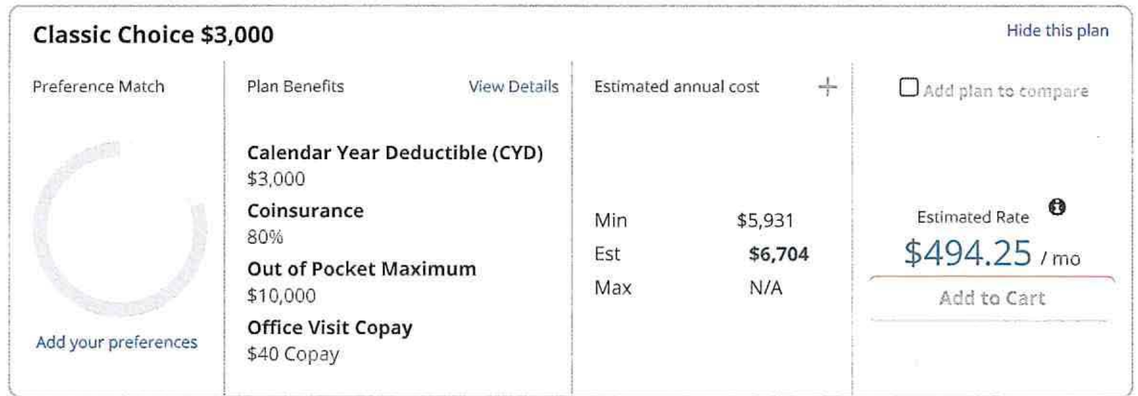
Preference Match | Plan Benefits | View Details | Estimated annual cost | Add plan to compare

Calendar Year Deductible (CYD)
$3,000 per member
Coinsurance
80%
Out of Pocket Maximum
$10,000 Individual / $20,000 Family
Office Visit Copay
$35 Copay

Min	$4,665
Est	**$5,438**
Max	N/A

Estimated Rate
$388.75 / mo
Add to Cart

Add your preferences



Classic Choice $3,000

Hide this plan

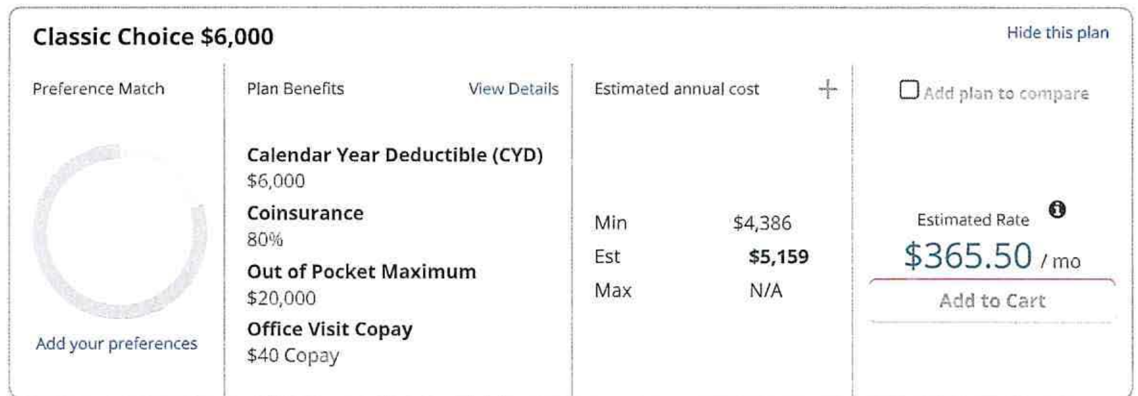
Preference Match | Plan Benefits | View Details | Estimated annual cost | Add plan to compare

Calendar Year Deductible (CYD)
$3,000
Coinsurance
80%
Out of Pocket Maximum
$10,000
Office Visit Copay
$40 Copay

Min	$5,931
Est	**$6,704**
Max	N/A

Estimated Rate
$494.25 / mo
Add to Cart

Add your preferences



Classic Choice $6,000

Hide this plan

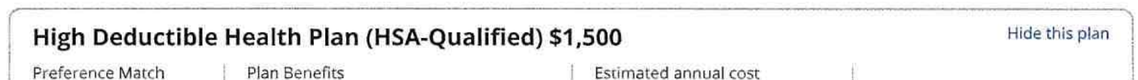
Preference Match | Plan Benefits | View Details | Estimated annual cost | Add plan to compare

Calendar Year Deductible (CYD)
$6,000
Coinsurance
80%
Out of Pocket Maximum
$20,000
Office Visit Copay
$40 Copay

Min	$4,386
Est	**$5,159**
Max	N/A

Estimated Rate
$365.50 / mo
Add to Cart

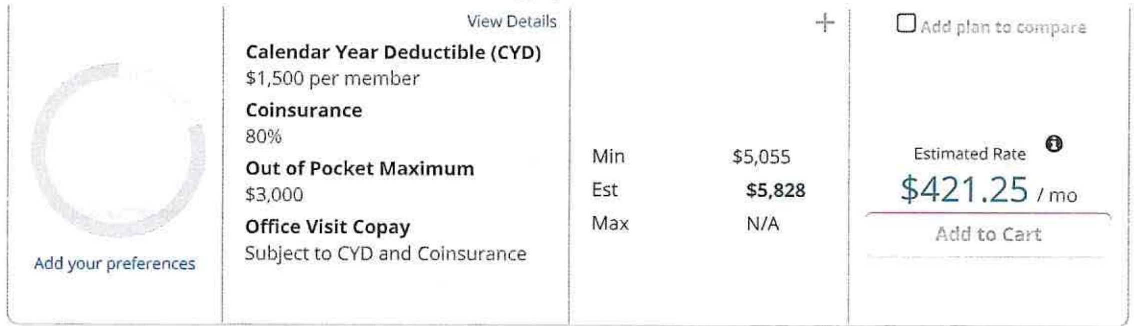
Add your preferences

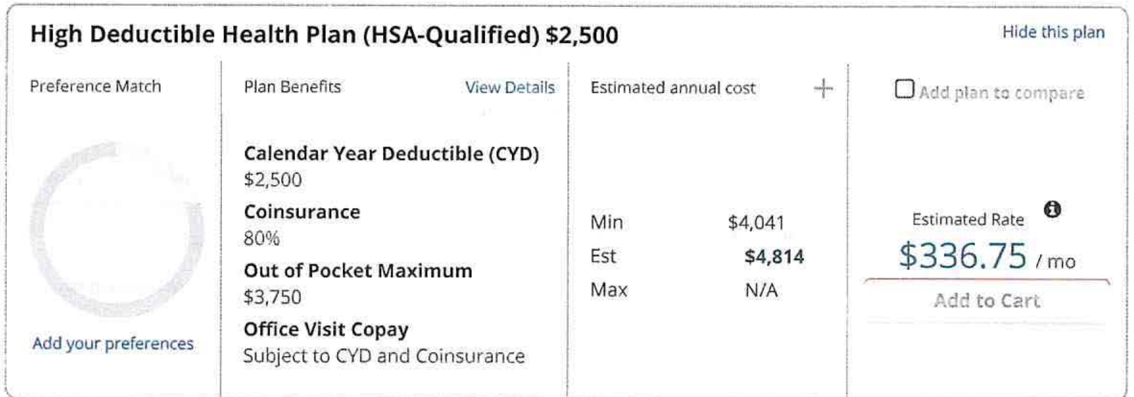


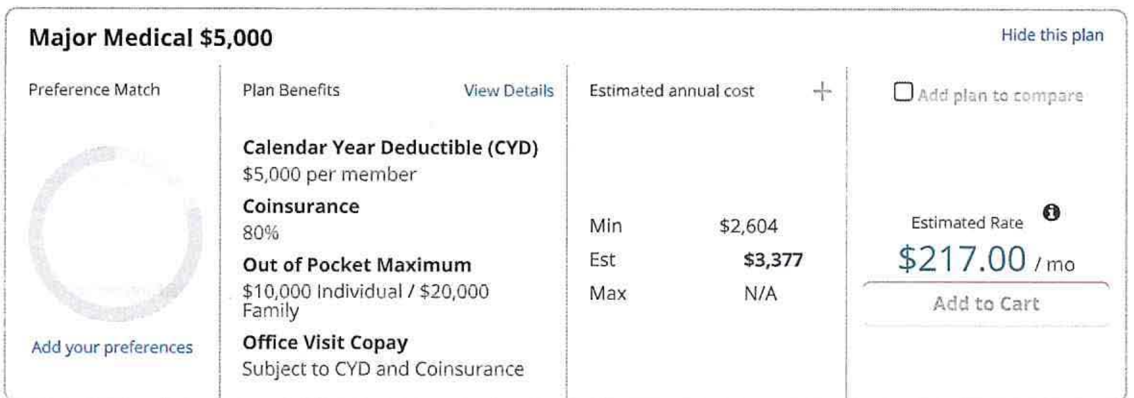
High Deductible Health Plan (HSA-Qualified) $1,500

Hide this plan

Preference Match | Plan Benefits | Estimated annual cost







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Medicare Supplements insured by Members Health Insurance Company, Columbia, Tennessee. Supplements not connected with or endorsed by the U.S. or state government. This is a solicitation of insurance. A representative from South Dakota Bureau Health Plans or Members Health Insurance Company may contact you. Benefits not provided for expenses incurred while coverage under the policy is not in force, expenses payable by Medicare, non-Medicare eligible expenses or any Medicare deductible or copayment/coinsurance or other expenses not covered under the policy.

Medicare Supplements insured by Members Health Insurance Company, Columbia, TN
MH-SDG-LG-FL21-033; MH-SDG-LG-FL21-039; MH-SDG-LG-FL21-041; MH-SDG-PR-FL21-045; MH-SDG-LG-FL21-048 ; MH-SDG-LG-FL21-049; MH-SDG-PR-FL21-050; MH-SDC-LG-FL21-055; MH-SDC-LG-FL21-056; MH-SDC-LG-FL21-058; MH-SDC-BL-FL21-059; MH-SDC-LG-FL21-061; MH-SDC-LG-FL21-062

MAJOR MEDICAL SCHEDULE OF BENEFITS
(for individuals & families)

THIS SCHEDULE IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

This is a comprehensive health coverage plan that includes hospitalization, medical and prescription benefits. South Dakota Farm Bureau Health Plans uses UnitedHealth care Choice Plus Network of providers. Please keep in mind that in-network payments are based on negotiated fees; if an out-of-network provider is used, the member's liability will increase significantly.

	In-Network	Out-of-Network
CALENDAR YEAR DEDUCTIBLE (CYD)[1] • Unless otherwise indicated, all benefits are subject to the CYD.	$5,000 per individual	
OUT OF POCKET MAXIMUM (OOP)[2] • Once the OOP maximum is met, eligible benefits are provided at 100% for an individual for the remainder of the calendar year. • This applies to in-network provider services only.	$10,000 individual $20,000 family	Unlimited
LIFETIME BENEFIT MAXIMUM	Unlimited	

Services

	In-Network		Out-of-Network	
COINSURANCE • Based on the maximum allowable charge.	Plan Pays	Your Responsibility	Plan Pays	Your Responsibility
	80%	20%	60%	40%
PREVENTATIVE CARE BENEFITS • Subject to CYD	Plan Pays	Your Responsibility	Plan Pays	Your Responsibility
• Well-Child Services[3]	80%	20%	Not Covered	
• Routine Colonoscopy[4]	80%	20%	60%	40%
• Annual Routine PSA[5]	80%	20%	60%	40%
• Annual Routine OB/GYN Exam[6]	80%	20%	Not Covered	
• Annual Routine Pap Smear[7]	80%	20%	60%	40%
• Mammogram[8]	80%	20%	60%	40%
PRESCRIPTION DRUG COVERAGE	Plan Pays	Your Responsibility	Plan Pays	Your Responsibility
• Generic - 30 day supply	All but copayment	$4 copayment[9]	60%	40%
• Brand	80%	20%	60%	40%
• Unlimited Calendar Year Maximum Per Individual				
TELADOC • Not subject to CYD	$0 copayment per visit		No Coverage	
TELADOC EXPERT MEDICAL SERVICES • Not subject to CYD	$0 copayment per visit		No Coverage	

FOOTNOTES

1. Deductible – the dollar amount of covered services that must be incurred and paid first by an individual each calendar year before plan benefits begin.
2. Once the OOP maximum is met, benefits are provided at 100% for an individual(s) for the remainder of the calendar year. This applies to in-network provider services only. There is no Out of Pocket Maximum when out-of-network providers are used.
3. Benefits are available, subject to deductible and coinsurance, for an individual under the age of 7 for physical examinations and appropriate immunizations/vaccinations when services are rendered by an in-network provider. Exams not used during the time periods below do not carry over to the next time period.

AGE	NUMBER OF EXAMS
Under age one	Four exams from birth to the child's first birthday
Age one	Two exams from the child's first birthday to the child's second birthday
Age two through six	One exam per year (determined by the child's birthday)

4. Benefits will be provided for one routine colonoscopy every four years for individuals age 50 and over when provided by an in-network or out-of-network provider, subject to the deductible and coinsurance.
5. Benefits will be provided, subject to deductible and coinsurance, for one routine PSA per calendar year when services are rendered by an independent laboratory or other outpatient setting.
6. Benefits will be available for one routine OB/GYN exam per calendar year, subject to deductible and coinsurance. Services must be rendered by an in-network physician's office and billed by the in-network provider. Related pathology, including pap smear, which is provided as a part of the routine OB/GYN exam, will be covered when the services are rendered by an in-network physician's office and billed by the in-network provider. Related pathology that the physician sends to an independent laboratory will be subject to deductible and coinsurance. No benefit is available for routine OB/GYN exams provided by an out-of-network provider.
7. Benefits will be provided for the interpretation of one routine pap smear per calendar year when services are rendered by an independent laboratory or other outpatient setting, subject to deductible and coinsurance.
8. Benefits will be provided, subject to deductible and coinsurance, for routine mammography screening provided such examinations are conducted upon the recommendation of the individual's physician. One baseline routine mammogram will be allowed for individuals between the ages of 35-39. One routine mammogram will be allowed annually for individuals age 40 and above. All routine mammography screens are subject to deductible and coinsurance.
9. Prescription copayment does not apply toward deductible or out-of-pocket maximum.

MATERNITY BENEFITS

Maternity Benefits will be available after an individual's coverage on a family contract has been in effect for nine consecutive months. Individual coverage has NO maternity benefits.

PRE-EXISTING CONDITION WAITING PERIOD

Benefits will not be provided for any pre-existing condition until an individual has completed a waiting period of at least 12 months. A pre-existing condition is defined in the contract as "An illness, injury, pregnancy or any other medical condition which existed at any time preceding the effective date of coverage under this contract for which: Medical advice or treatment was recommended by, or received from, a provider of health care services; or symptoms existed which would cause an ordinarily prudent person to seek diagnosis, care or treatment." The pre-existing condition waiting period does not apply to individuals under the age of 19.

HIGH DEDUCTIBLE HEALTH PLAN SCHEDULE OF BENEFITS
(for individuals & families)

THIS SCHEDULE IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

This is a comprehensive health coverage plan that includes hospitalization, medical and prescription benefits. South Dakota Farm Bureau Health Plans uses UnitedHealth care Choice Plus Network of providers. Please keep in mind that in-network payments are based on negotiated fees; if an out-of-network provider is used, the member's liability will increase significantly.

	In-Network	Out-of-Network
CALENDAR YEAR DEDUCTIBLE (CYD)[1] • Unless otherwise indicated, all benefits apply toward CYD. • Family Deductible can be satisfied by one or more covered individuals during a calendar year. • In-Network and Out-of-Network deductibles are met separately.	$1,500 for individual $2,500 for individual $3,000 for family $5,000 for 2-person/3-person/family	$1,500 for individual $2,500 for individual $3,000 for family $5,000 for 2-person/3-person/family
OUT OF POCKET MAXIMUM (OOP)[2] • Unless otherwise indicated, all benefits apply toward CYD. • Family Out of Pocket Maximum can be satisfied by one or more covered individuals during a calendar year. • In-Network and Out-of-Network deductibles are met separately.	$3,000 for $1,500 deductible $3,750 for $2,500 deductible $6,000 for $3,000 deductible $7,500 for $5,000 deductible	Unlimited
LIFETIME BENEFIT MAXIMUM	Unlimited	

Services

	In-Network		Out-of-Network	
COINSURANCE · Based on the maximum allowable charges for eligible benefits. · Family deductible can be satisfied by one or more covered individuals during a calendar year.	**Plan Pays**	**Your Responsibility**	**Plan Pays**	**Your Responsibility**
	80%	20%	60%	40%
PREVENTATIVE CARE BENEFITS · Subject to CYD	**Plan Pays**	**Your Responsibility**	**Plan Pays**	**Your Responsibility**
• Well Child Services[3]	80%	20%	Not Covered	
• Routine Colonoscopy[4]	80%	20%	60%	40%
• Annual Routine PSA[5]	80%	20%	60%	40%
• Annual Routine OB/GYN Exam[6]	80%	20%	Not Covered	
• Annual Routine Pap Smear[7]	80%	20%	60%	40%
• Mammogram[8]	80%	20%	60%	40%
PRESCRIPTION DRUG COVERAGE[9]	**Plan Pays**	**Your Responsibility**	**Plan Pays**	**Your Responsibility**
• Generic and Brand Prescriptions	80%	20%	60%	40%
• Unlimited calendar year maximum per individual				
• Home Delivery Services are available				

TELADOC

Your Responsibility: Member must pay current Teladoc copay until CYD is met. Once CYD is met, no copay for Teladoc. All Teladoc Expert Medical Services are at no charge.

FOOTNOTES

1. Deductible – the dollar amount of covered services that must be incurred and paid first by an individual each calendar year before plan benefits begin.
2. Once the OOP maximum is met, benefits are provided at 100% for an individual(s) for the remainder of the calendar year. This applies to in-network provider services only. There is no Out of Pocket Maximum when out-of-network providers are used.
3. Benefits are available, subject to deductible and coinsurance, for an individual under the age of 7 (on plan deductibles $3,000 and $5,000) for physical examinations and appropriate immunizations/vaccinations when services are rendered by an in-network provider. Exams not used during the time periods below do not carry over to the next time period.

AGE	NUMBER OF EXAMS
Under age one	Four exams from birth to the child's first birthday
Age one	Two exams from the child's first birthday to the child's second birthday
Age two through six	One exam per year (determined by the child's birthday)

4. Benefits will be provided for one routine colonoscopy every four years for individuals age 50 and over when provided by an in-network or out-of-network provider, subject to the deductible and coinsurance.
5. Benefits will be provided, subject to deductible and coinsurance, for one routine PSA per calendar year when services are rendered by an independent laboratory or other outpatient setting.
6. Benefits will be available for one routine OB/GYN exam per calendar year, subject to deductible and coinsurance. Services must be rendered by an in-network physician's office and billed by the in-network provider. Related pathology, including pap smear, which is provided as a part of the routine OB/GYN exam, will be covered when the services are rendered by an in-network physician's office and billed by the in-network provider. Related pathology that the physician sends to an independent laboratory will be subject to deductible and coinsurance. No benefit is available for routine OB/GYN exams provided by an out-of-network provider.
7. Benefits will be provided for the interpretation of one routine pap smear per calendar year when services are rendered by an independent laboratory or other outpatient setting, subject to deductible and coinsurance.
8. For routine mammography screening provided such examinations are conducted upon the recommendation of the individual's physician. One baseline routine mammogram will be allowed for individuals between the ages of 35-39. One routine mammogram will be allowed annually for individuals age 40 and above. All routine mammography screens are subject to deductible and coinsurance.
9. Benefits will be provided, subject to deductible and coinsurance.

MATERNITY BENEFITS

Maternity Benefits will be available after an individual's coverage on a 2-person, 3-person or family contract has been in effect for nine consecutive months. Individual coverage has NO maternity benefits.

PRE-EXISTING CONDITION WAITING PERIOD

Benefits will not be provided for any pre-existing condition until an individual has completed a waiting period of at least 12 months. A pre-existing condition is defined in the contract as "An illness, injury, pregnancy or any other medical condition which existed at any time preceding the effective date of coverage under this contract for which: Medical advice or treatment was recommended by, or received from, a provider of health care services; or symptoms existed which would cause an ordinarily prudent person to seek diagnosis, care or treatment." The pre-existing condition waiting period does not apply to individuals under the age of 19.

CLASSIC CHOICE SCHEDULE OF BENEFITS
(for individuals)

THIS SCHEDULE IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

This is a comprehensive health coverage plan that includes hospitalization, medical and prescription benefits. South Dakota Farm Bureau Health Plans uses UnitedHealth care Choice Plus Network of providers. Please keep in mind that in-network payments are based on negotiated fees; if an out-of-network provider is used, the member's liability will increase significantly.

	In-Network		Out-of-Network
CALENDAR YEAR DEDUCTIBLE (CYD) • Unless otherwise indicated, all benefits are subject to the CYD.		**Option 1:** **Option 2:**	$3,000 per individual $6,000 per individual
OUT OF POCKET MAXIMUM (OOP) • Once the OOP maximum is met, eligible benefits are provided at 100% for an individual for the remainder of the calendar year. • This applies to in-network provider services only. • Copayments do not apply to OOP and must still be paid after OOP is met).	**Option 1:** **Option 2:**	$10,000 $20,000	Unlimited
LIFETIME BENEFIT MAXIMUM		Unlimited	

Services

		In-Network		Out-of-Network	
OFFICE VISIT · Not subject to CYD	**Option 1** For $3,000 CYD: **Option 2** For $6,000 CYD:	$40 copayment* per visit $40 copayment* per visit		CYD/Coinsurance	
TELADOC · Not subject to CYD		$0 copayment per visit		No Coverage	
TELADOC EXPERT MEDICAL SERVICES · Not subject to CYD		$0 copayment per visit		No Coverage	
COINSURANCE · Based on the maximum allowable charges for eligible benefits		**Plan Pays** 80%	**Your Responsibility** 20%	**Plan Pays** 60%	**Your Responsibility** 40%
PREVENTATIVE CARE BENEFITS · No waiting period · Not subject to CYD		**Plan Pays**	**Your Responsibility**	**Plan Pays**	**Your Responsibility**
• Preventative Health Exam[1]		100%	0%	60%	40%
• Annual Well-Woman Exam[2]		100%	0%	60%	40%
• Routine Colonoscopy[3]		100%	0%	60%	40%
• Annual Routine PSA[4]		100%	0%	60%	40%
PRESCRIPTION DRUG COVERAGE		**Plan Pays**	**Your Responsibility**	**Plan Pays**	**Your Responsibility**
• Generic - 30 day supply		All but copayment	$4 copayment[5]	60%	40%
• Brand		80%	20%	60%	40%
• Unlimited Calendar Year Maximum Per Individual					
EMERGENCY ROOM SERVICES · Not resulting in admission		$75 Deductible per visit (In addition to CYD and Coinsurance)			

DENTAL - No waiting periods

Pediatric (Under Age 19)
- Oral risk assessment paid at 100%
- Other eligible dental services subject to CYD and coinsurance
- Limited orthodontic care

Age 19 and Over
- $40 copay for preventative and restorative services
- Maximum benefit per calendar year is $500

VISION

No waiting periods

Pediatric (Under Age 19)

- Eye exams are covered at 100% once every calendar year.
- Eyeglass frames, eyeglass lenses or contact lenses are covered once every calendar year at 100% up to a maximum of $100 per member, not subject to deductible and coinsurance.

Age 19 and Over

- Eye exams are covered once every calendar year with a limit of $40.
- Eyeglass lenses or contact lenses are covered once every calendar year at 100% up to a maximum of $100 per individual, not subject to deductible.

FOOTNOTES

1. Preventative health exam for adults and children and related services as outlined below and performed by the physician during the preventative health exam or referred by the physician as appropriate, including:
   - Screenings and counseling services with an A or B recommendation by the United States Preventative Services Task Force (USPSTF).
   - Bright Futures recommendations for infants, children and adolescents supported by the Health Resources and Services Administration (HRSA).
   - Preventative care and screening for women as provided in the guidelines supported by HRSA, and immunizations recommended by the Advisory Committee of Immunization Practices (ACIP) that have been adopted by the Centers for Disease Control and Prevention (CDC).
2. Annual well-woman exam
   - Routine well-woman preventative exam office visit
   - Cervical cancer screening
   - Screening mammography at age 40 and older, with one baseline mammogram between the ages of 35-39
   - Other USPSTF screenings with an A or B rating
     - Pap smears
     - Bone density measurement screening
3. Colorectal cancer screening for individuals age 45 and older
4. Prostate cancer screening for men age 50 and older
5. Prescription copayment does not apply toward deductibles or out-of-pocket maximums.

*OFFICE COPAYMENT GUIDELINES

A copayment will be applied to each office visit for the covered services performed in the office and provided and billed by a physician who is an in-network provider. The remaining charges for covered services rendered during the office visit will be paid at 100% of the maximum allowable charge. If a physician who is an out-of-network provider is utilized for covered services, benefits will be determined on the basis the out-of-network coinsurance percentage after deductible is met.

Copayments do not apply to the following services: advanced radiological imaging, allergy testing and injections, biopsy interpretation, bone density testing, cardiac diagnostic testing, chemotherapy services, chiropractic services, complex diagnostic services, dental services except preventative and restorative for all individuals age 19 and over, diagnostic services sent out, durable medical equipment, growth hormone injections, IV therapy, Lupron injections, mammography, maternity services, nerve conduction studies, neuropsychological or neurological tests, nuclear cardiology, nuclear medicine, orthotics, preventative services as indicated in contract, prosthetics, provider administered specialty pharmacy products, sleep studies, surgery performed in a physician's office and related surgical supplies, Synagis injections, therapeutic/ rehabilitative/ habilitative services, ultrasounds and vision services. These services are subject to the terms and conditions of the contract and deductibles and coinsurance will apply except where otherwise indicated. Copayments will not be applied to the deductibles or out-of-pocket maximums.

MATERNITY BENEFITS

Maternity benefits will be eligible as long as the pregnancy is not considered a pre-existing condition.

PRE-EXISTING CONDITION WAITING PERIOD

Benefits will not be provided for any pre-existing condition until an individual has completed a waiting period of at least six months. A pre-existing condition is defined in the contract as "An illness, injury, pregnancy or any other medical condition which existed at any time preceding the effective date of coverage under this contract for which: Medical advice or treatment was recommended by, or received from, a provider of health care services; or symptoms existed which would cause an ordinarily prudent person to seek diagnosis, care or treatment."

ADVANCED CHOICE SCHEDULE OF BENEFITS
(for individuals & families)

THIS SCHEDULE IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

This is a comprehensive health coverage plan that includes hospitalization, medical and prescription benefits. South Dakota Farm Bureau Health Plans uses UnitedHealth care Choice Plus Network of providers. Please keep in mind that in-network payments are based on negotiated fees; if an out-of-network provider is used, the member's liability will increase significantly.

		In-Network	Out-of-Network
CALENDAR YEAR DEDUCTIBLE (CYD) • Per individual, per calendar year. • Unless otherwise indicated, all benefits are subject to the CYD.		Option 1: $1,500 per individual Option 2: $3,000 per individual	
OUT OF POCKET MAXIMUM (OOP) • Once the OOP maximum is met, eligible benefits are provided at 100% for an individual for the remainder of the calendar year. • This applies to in-network provider services only. • Copayments do not apply to OOP and must still be paid after OOP is met.	For $1,500 CYD: Option 1:	$5,000 for individual coverage $10,000 for family coverage	Unlimited
	For $3,000 CYD: Option 2:	$10,000 for individual coverage $20,000 for family coverage	
LIFETIME BENEFIT MAXIMUM		Unlimited	

Services

		In-Network		Out-of-Network	
OFFICE VISIT · Not subject to CYD	Option 1 For $1,500 CYD:	$25 copayment* per visit		CYD/Coinsurance	
	Option 2 For $3,000 CYD:	$35 copayment* per visit			
TELADOC · Not subject to CYD		$0 copayment per visit		No Coverage	
TELADOC EXPERT MEDICAL SERVICES · Not subject to CYD		$0 copayment per visit		No Coverage	
COINSURANCE · Based on the maximum allowable charge		Plan Pays 80%	Your Responsibility 20%	Plan Pays 60%	Your Responsibility 40%
PREVENTATIVE CARE BENEFITS · No waiting period · Not subject to CYD		Plan Pays	Your Responsibility	Plan Pays	Your Responsibility
• Preventative Health Exam[1]		100%	0%	60%	40%
• Annual Well-Woman Exam[2]		100%	0%	60%	40%
• Routine Colonoscopy[3]		100%	0%	60%	40%
• Annual Routine PSA[4]		100%	0%	60%	40%
PRESCRIPTION DRUG COVERAGE		Plan Pays	Your Responsibility	Plan Pays	Your Responsibility
• Generic - 30 day supply		All but copayment	$4 copayment[5]	60%	40%
• Brand		80%	20%	60%	40%
• $7,500 individual maximum per calendar year					
EMERGENCY ROOM SERVICES · Not resulting in admission		$75 Deductible per visit (In addition to CYD and Coinsurance)			

DENTAL - All Individuals

Routine dental services, including two exams, cleanings, x-rays and fillings per calendar year

- Subject to a six month waiting period
- There is a copayment per visit and a $500 calendar year maximum per individual per calendar year.

VISION

Pediatric (Under Age 19) Routine vision benefits including eye exams, eyeglasses and contact lenses.

- No waiting period.
- Eye exams are covered at 100% once every calendar year, no dollar limit.
- Eyeglass frames, eyeglass lenses or contact lenses are covered once every calendar year at 100% up to a maximum of $100 per member, not subject to deductible and coinsurance.

Age 19 and Over - Routine vision benefits including eye exams, eyeglasses and contact lenses

- Subject to a six month waiting period.
- Eye exams are covered once every calendar year with a $40 limit per individual.
- Eyeglass lenses or contact lenses are covered once every calendar year at 100% up to a maximum of $100 per individual, not subject to deductible.

FOOTNOTES

1. Preventative health exam for adults and children and related services as outlined below and performed by the physician during the preventative health exam or referred by the physician as appropriate, including:
    - Screenings and counseling services with an A or B recommendation by the United States Preventive Services Task Force (USPSTF).
    - Bright Futures recommendations for infants, children and adolescents supported by the Health Resources and Services Administration (HRSA).
    - Preventative care and screening for women as provided in the guidelines supported by HRSA and immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) that have been adopted by the Centers for Disease Control and Prevention (CDC).
2. Annual well-woman exam
    - Routine well-woman preventative exam office visit
    - Cervical cancer screening
    - Screening mammography at age 40 and older, with one baseline mammogram between the ages of 35 and 39
    - Other USPSTF screenings with an A or B rating
    - Pap smears
    - Bone density measurement screening
3. Colorectal cancer screening for individuals age 45 and older.
4. Prostate cancer screening for men age 50 and older.
5. Prescription copayment does not apply toward deductibles or out-of-pocket maximums.

*OFFICE COPAYMENT GUIDELINES

A copayment will be applied to each office visit for the covered services performed in the office and provided and billed by a physician who is an in-network provider. The remaining charges for covered services rendered during the office visit will be paid at 100% of the maximum allowable charge. If a physician who is an out-of-network provider is utilized for covered services, benefits will be determined on the basis of the out-of-network coinsurance percentage after deductible is met. Copayments will not be applied toward deductibles or out-of-pocket maximums.

Copayments do not apply to the following services: advanced radiological imaging, allergy testing and injections, biopsy interpretation, bone density testing, cardiac diagnostic testing, chemotherapy services, chiropractic services, complex diagnostic services, dental services except preventative and restorative for all individuals, diagnostic services sent out, durable medical equipment, growth hormone injections, IV therapy, Lupron injections, mammography, maternity services, nerve conduction studies, neuropsychological or neurological tests, nuclear cardiology, nuclear medicine, orthotics, preventative services as indicated in contract, prosthetics, provider administered specialty pharmacy products, sleep studies, surgery performed in a physician's office and related surgical supplies, Synagis injections, therapeutic/rehabilitative services, ultrasounds and vision services. These services are subject to the terms and conditions of the contract and deductibles and coinsurance will apply except where otherwise indicated.

MATERNITY BENEFITS

Maternity Benefits will be provided after an individual's coverage on a family contract has been in effect for nine consecutive months. Individual coverage has NO maternity benefits except for complications of pregnancy.

PRE-EXISTING CONDITION WAITING PERIOD

Benefits will not be provided for any pre-existing condition until an individual has completed a waiting period of at least six months. In rare circumstances, the pre-existing condition waiting period may be longer. A pre-existing condition is defined in the contract as "An illness, injury, pregnancy or any other medical condition which existed at any time preceding the effective date of coverage under this contract for which: Medical advice or treatment was recommended by, or received from, a provider of health care services; or symptoms existed which would cause an ordinarily prudent person to seek diagnosis, care or treatment." The pre-existing condition waiting period will not apply to individuals under the age of 19 enrolled as dependents in a family coverage.

Additional waiting periods may apply as indicated in the contract.

23.1070.01001
Title.

Prepared by the Legislative Council staff for
Representative Thomas
March 6, 2023

PROPOSED AMENDMENTS TO SENATE BILL NO. 2349

Page 1, line 8, replace "A" with "Except as provided under this section, a"

Page 1, line 13, replace "may" with "must"

Page 1, line 15, after "3." insert "A nonprofit agricultural membership organization may not provide health care coverage under this section unless the organization has filed with the commissioner verification the organization meets the requirements of this section.

4. Health care coverage under this section may be sold only by an insurance producer who is both appointed by the nonprofit agricultural membership organization and licensed as an insurance producer to sell or solicit health insurance in this state.

5. Health care coverage under this section must provide benefits under a self-funded arrangement administered by an entity that holds a certificate of authority under section 26.1-27-03.

6. A health care coverage application for coverage under this section and any related contract provided to the member prominently must state the health care coverage is not insurance, is not provided by an insurance company, is not subject to the laws and rules governing insurance, and is not subject to the jurisdiction of the commissioner.

7."

Page 1, line 18, after "health" insert "care"

Renumber accordingly