LEGISLATIVE COMMITTEE MINUTES

SB4

Bill as Introduced

SB 4 - AS INTRODUCED

2019 SESSION

19-1101
01/04

SENATE BILL 4

AN ACT relative to the group and individual health insurance market.

SPONSORS: Sen. Feltes, Dist 15; Sen. Cavanaugh, Dist 16; Sen. Chandley, Dist 11; Sen. D'Allesandro, Dist 20; Sen. Dietsch, Dist 9; Sen. Fuller Clark, Dist 21; Sen. Hennessey, Dist 5; Sen. Kahn, Dist 10; Sen. Levesque, Dist 12; Sen. Morgan, Dist 23; Sen. Rosenwald, Dist 13; Sen. Sherman, Dist 24; Sen. Soucy, Dist 18; Sen. Watters, Dist 4; Rep. Butler, Carr. 7; Rep. McMahon, Rock. 7

COMMITTEE: Health and Human Services

ANALYSIS

This bill establishes the provisions of the Patient Protection and Affordable Care Act of 2009, Public Law 111-148, as amended in statute.

Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

19-1101
01/04

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Nineteen

AN ACT relative to the group and individual health insurance market.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 New Paragraphs; Health Coverage; Definitions. Amend RSA 420-G:2 by inserting after paragraph VI the following new paragraphs:

VI-a. "Employee" means "employee" as defined in the Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1002(6).

VI-b. "Essential health benefits" means the categories of coverage identified in 42 U.S.C. section 18022(b)(1) and as further defined and implemented by the Secretary of the Department of Health and Human Services from time to time.

2 Health Coverage; Definitions; Small Employer. Amend RSA 420-G:2, XVI(a) to read as follows:

XVI.(a) "Small employer" means a business or organization which employed on average, one and up to 50 employees[~~, including owners and self-employed persons,~~] on business days during the previous calendar year. A small employer is subject to this chapter whether or not it becomes part of an association, multi-employer plan, trust, or any other entity cited in RSA 420-G:3 provided it meets this definition.

3 Health Benefits; Premium Rates. RSA 420-G:4, I(d) is repealed and reenacted to read as follows:

(d)(1) In establishing the premium charged, health carriers providing coverage to individuals and small employers shall vary the premium rate with respect to the particular plan or coverage involved only by:

(A) Whether the plan or coverage covers an individual or family;

(B) Geographic rating area, except that the state shall constitute a single geographic rating area;

(C) Age, except that the maximum premium differential for age as determined by ratio shall be 3 to 1 for adults; and

(D) Tobacco use, except that the maximum differential rate due to tobacco use shall be 1.5 to 1.

(2) With respect to family coverage under an individual or small group health insurance policy, the rating variations permitted under subparagraphs (1)(A) and (D) shall be applied based on the portion of the premium that is attributable to each family member covered under the plan.

(3) Carriers shall adjust each health coverage plan or premium rate for age, based

on the portion of the premium that is attributable to each family member covered under the plan or certificate, using the uniform age rating factors established by the commissioner pursuant to RSA 420-G:14, I(a)(2).

4 New Section; Essential Health Benefits. Amend RSA 420-G by inserting after section 4-c the following new section:

420-G:4-d Essential Health Benefits.

I. All health coverage offered by health carriers to individuals or small employers shall include coverage for essential health benefits and provide essential health benefits in a plan substantially equivalent to New Hampshire's Essential Health Benefit Benchmark Plan in effect for the plan year 2019.

II. If the federal government ceases to define essential health benefits, the commissioner shall define essential health benefits for New Hampshire by rulemaking pursuant to RSA 541-A. The New Hampshire essential health benefits shall include at least the following general categories and the items and services covered within the categories:

(a) Ambulatory patient services.

(b) Emergency services.

(c) Hospitalization.

(d) Maternity and newborn care.

(e) Mental health and substance use disorder services, including behavioral health treatment.

(f) Prescription drugs.

(g) Rehabilitative and habilitative services and devices.

(h) Laboratory services.

(i) Preventive and wellness services and chronic disease management.

(j) Pediatric services, including oral and vision care.

III. In defining the essential health benefits under paragraph II, the commissioner shall:

(a) Ensure that such essential health benefit reflects an appropriate balance among the categories described in such subparagraph, so that benefits are not unduly weighted toward any category;

(b) Not define essential health benefits in a manner which would allow carriers to make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life;

(c) Consider the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups;

(d) Ensure that health benefits established as essential are not subject to denial to individuals against their wishes on the basis of the individuals' age or expected length of life or of the individuals' present or predicted disability, degree of medical dependency, or quality of life;

(e) Ensure that a health plan shall not be treated as providing coverage for the essential health benefits unless the plan provides that:

(1) Coverage for emergency department services shall be provided without imposing any requirement under the plan for prior authorization of services or any limitation on coverage where the provider of services does not have a contractual relationship with the plan for the provision of services which is more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have such a contractual relationship with the plan; and

(2) If such services are provided out-of-network, the cost-sharing requirement, such as a copayment amount or coinsurance rate is the same requirement which would apply if such services were provided in-network; and

(f) Ensure that the New Hampshire essential benefits are at least actuarially equivalent to the essential health benefits previously established by the federal government.

(g) Ensure essential health benefits are provided in a plan substantially equivalent to New Hampshire's Essential Health Benefit Benchmark Plan in effect for plan year 2019.

5 Health Coverage; Medical Underwriting. Amend RSA 420-G:5, I and II to read as follows:

I. Health carriers providing health coverage [~~for individuals may~~] ***shall not*** perform medical underwriting, including the use of health statements or screenings or the use of prior claims history[~~, to the extent necessary to establish or modify premium rates as provided in RSA 420-G:4~~].

II. [~~Health carriers providing health coverage for individuals may refuse to write or issue coverage to an individual because of his or her health status.~~] Regardless of claim experience, health status, or medical history, health carriers providing health coverage for ***individual or*** small employers shall not refuse to write or issue any of their available coverages or health benefit plans to any ***individual or*** small employer group that elects to be covered under that plan and agrees to make premium payments and meet the other requirements of the plan.

6 Health Coverage; Guaranteed Issue. Amend RSA 420-G:6, III to read as follows:

III. Health carriers shall actively market, issue, and renew all of the health coverages they sell in the ***individual and*** small employer market to all ***individuals and*** small employers ***in that market. Health carriers offering health coverage to small employers shall permit small employers to purchase health coverage at any point during the year, with the small employer's health coverage consisting of the 12-month period beginning with the small employer's effective date of coverage.***

III-a. A health carrier shall not rescind health coverage issued to an individual or with respect to an individual covered under health coverage issued to a small or large employer, including a group to which the individual belongs or family coverage in which the individual is included, after the individual is covered under the plan, unless:

(a) The individual, or a person seeking coverage on behalf of the individual,

performs an act, practice, or omission that constitutes fraud; or

(b) The individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage.

III-b. For the purposes of subparagraph III-a(a), a person seeking coverage on behalf of an individual shall not include a producer, or an employee or authorized representative of the health carrier.

7 Health Coverage; Guaranteed Issue. Amend RSA 420-G:6, V(d)-(g) and paragraph V-a to read as follows:

(d) Failure *of an employer sponsoring group coverage* to meet the minimum employee participation number or percentage requirement of the health coverage.

(e) [~~The small employer is no longer actively engaged in the business that it was engaged in on the effective date of the health coverage.~~

~~(f)~~] The employer medically underwrites or otherwise violates a provision of this chapter.

[~~(g)~~] *(f)* The health carrier is ceasing to offer health coverage in such market, in accordance with paragraph VII.

V-a. Health carriers shall not underwrite insureds at time of renewal [~~unless an insured has applied for an increase in his or her coverage~~].

8 Health Coverage; Preexisting Conditions. RSA 420-G:7 is repealed and reenacted to read as follows:

420-G:7 Preexisting Condition Exclusion Periods. A health carrier shall not impose any preexisting condition exclusion with respect to coverage in the individual, small group, or large group market.

9 Health Coverage; Open Enrollment. RSA 420-G:8 is repealed and reenacted to read as follows:

420-G:8 Open Enrollment.

I. Each small employer group shall have an annual employee open enrollment period 60 days in length, occurring prior to the small employer group's anniversary date. During open enrollment, employees or eligible dependents may apply to the small employer for health coverage or make a change in their membership status becoming effective upon the small employer group's anniversary date, subject to providing the health carrier 30-days notice.

(a) A health carrier shall not refuse any small employer employees or eligible dependents applying for health coverage during the open enrollment period.

(b) Employees or eligible dependents coming on at the time of an open enrollment period shall have the same premiums as the rest of the small employer group shall have upon the new or renewal effective date.

II. A small employer employee who has met any employer imposed waiting period and is otherwise eligible for health coverage, who declines a small employer's health coverage plan during

the initial offering or subsequent open enrollment period, shall be a late enrollee and shall not be allowed on the plan until the next open enrollment period.

III. A large employer employee, who has met any employer imposed waiting period and is otherwise eligible for health coverage, may enroll within 31 days of becoming eligible and shall not be required to submit evidence of insurability based on medical conditions. If a person does not enroll at this time, that person is a late enrollee. Each large employer group shall have an open enrollment period during which late enrollees may enroll and shall not be required to submit evidence of insurability based on medical conditions.

IV. Paragraphs II and III notwithstanding, an eligible employee or eligible dependent shall not be considered a late enrollee if:

(a) The person was covered under public or private health coverage at the time the person was able to enroll; and

(1) Has lost public or private health coverage as a result of termination of employment or eligibility, the termination of the other plan's coverage, death of a spouse, or divorce; and

(2) Requests enrollment within 30 days after termination of such health coverage; or

(b) Is employed by an employer that offers multiple health coverages and the person elects a different plan during an open enrollment period; or

(c) Was ordered by a court to provide health coverage for an ex-spouse or a minor child under a covered employee's plan and the request for enrollment is made within 30 days after issuance of such court order.

V.(a) If individual coverage offered by a health carrier or a large or small employer group's health coverage plan offers dependent coverage and the individual is enrolled in such coverage or the employee is enrolled or has met any applicable waiting period and is eligible to be enrolled, but for a failure to do so during a previous open enrollment period, a person who becomes a dependent of the individual or employee through marriage, birth, adoption or placement for adoption, and the employee if not otherwise enrolled, shall be provided with a special enrollment period.

(b) If an individual has minimum essential coverage through individual coverage offered by a health carrier or as an employee through a large or small employer group's health coverage plan, and the individual loses such coverage for any reason other than failure to pay premiums or a basis on which rescission is permitted pursuant to RSA 420-G:6, IV, the individual shall be provided with a special open enrollment period under any other individual health coverage or any large or small employer group health coverage plan for which the individual becomes eligible.

(c) The special enrollment period shall be at least 60 days in length and shall begin on the later of:

(1) The date dependent health coverage is made available; or

(2) The date of the marriage, birth, adoption, placement for adoption, or loss of minimum essential coverage, as the case may be.

(d) If the person seeks enrollment during such special enrollment period, the health coverage shall become effective:

(1) In the case of marriage or loss of minimum essential coverage, on or before the first day of the first month following the completed request for enrollment;

(2) In the case of birth, as of the date of birth; or

(3) In the case of adoption or placement for adoption, the date of such adoption or placement for adoption.

10 New Paragraphs; Health Coverage; Participation Requirements. Amend RSA 420-G:9 by inserting after paragraph IV the following new paragraphs:

V. For the purpose of calculating whether or not a small employer group's enrollment meets a carrier's minimum participation requirements:

(a) Any full-time or part-time employee who is covered as a dependent on another person's health coverage or is enrolled in a governmental plan such as Medicare, Medicaid, or TRICARE shall be excluded from the count.

(b) Any full-time or part-time employee who has been found eligible for a premium tax credit and is enrolled in a qualified health plan (QHP) purchased through an exchange shall be excluded from the count.

(c) The total number of full-time employees and part-time employees who are otherwise eligible for health coverage shall be counted.

VI. The requirements under this section shall be the only participation requirements. Minimum employer contributions, or other criteria, shall not be permitted.

11 Health Coverage; Rulemaking. RSA 420-G:14, I is repealed and reenacted to read as follows:

I.(a) The commissioner may adopt rules, under RSA 541-A, relative to:

(1) Uniform age rating levels that are consistent with 45 C.F.R. 147.102.

(2) Special enrollment periods designed to allow employees to purchase individual coverage on the exchange during their employer's open enrollment period, even if the employer's open enrollment period does not coincide with the open enrollment period in the individual market.

(3) Essential health benefits, in accordance with RSA 420-G:4-d, II and III.

(b) The commissioner may adopt further rules, pursuant to RSA 541-A, necessary to the proper administration of this chapter.

12 Standards for Accident and Health Insurance; Preexisting Conditions. RSA 415-A:5, III is repealed and reenacted to read as follows:

III. Health carriers issuing policies subject to RSA 420-G shall not impose any preexisting condition exclusion that is inconsistent with that chapter.

13 Health Coverage; Applicability and Scope of Chapter. Amend RSA 420-G:3, I(b) to read as

follows:

(b) This chapter shall not apply to student major medical expense coverage, except student major medical expense coverage shall be given credit and shall count as credit for previous health coverage as defined in RSA 420-G:7, [~~III~~] *II*.

14 Repeal. RSA 420-G:4-c, II, relative to a health coverage tax incentive plan, is repealed.

15 Effective Date. This act shall take effect 60 days after its passage.

SB 4 - AS AMENDED BY THE SENATE

03/27/2019 1176s

2019 SESSION

19-1101
01/04

SENATE BILL *4*

AN ACT relative to the group and individual health insurance market.

SPONSORS: Sen. Feltes, Dist 15; Sen. Cavanaugh, Dist 16; Sen. Chandley, Dist 11; Sen. D'Allesandro, Dist 20; Sen. Dietsch, Dist 9; Sen. Fuller Clark, Dist 21; Sen. Hennessey, Dist 5; Sen. Kahn, Dist 10; Sen. Levesque, Dist 12; Sen. Morgan, Dist 23; Sen. Rosenwald, Dist 13; Sen. Sherman, Dist 24; Sen. Soucy, Dist 18; Sen. Watters, Dist 4; Rep. Butler, Carr. 7; Rep. McMahon, Rock. 7

COMMITTEE: Health and Human Services

ANALYSIS

This bill establishes the provisions of the Patient Protection and Affordable Care Act of 2009, Public Law 111-148, as amended in statute.

Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Nineteen

AN ACT relative to the group and individual health insurance market.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 New Paragraphs; Health Coverage; Definitions. Amend RSA 420-G:2 by inserting after paragraph VI the following new paragraphs:

VI-a. "Employee" means "employee" as defined in the Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1002(6).

VI-b. "Essential health benefits" means the categories of coverage identified in 42 U.S.C. section 18022(b)(1) and as further defined and implemented by the Secretary of the Department of Health and Human Services from time to time.

2 Health Coverage; Definitions; Small Employer. Amend RSA 420-G:2, XVI(a) to read as follows:

XVI.(a) "Small employer" means a business or organization which employed on average, one and up to 50 employees[~~, including owners and self-employed persons,~~] on business days during the previous calendar year. A small employer is subject to this chapter whether or not it becomes part of an association, multi-employer plan, trust, or any other entity cited in RSA 420-G:3 provided it meets this definition.

3 Health Benefits; Premium Rates. RSA 420-G:4, I(d) is repealed and reenacted to read as follows:

(d)(1) In establishing the premium charged, health carriers providing coverage to individuals and small employers shall vary the premium rate with respect to the particular plan or coverage involved only by:

(A) Whether the plan or coverage covers an individual or family;

(B) Geographic rating area, except that the state shall constitute a single geographic rating area;

(C) Age, except that the maximum premium differential for age as determined by ratio shall be 3 to 1 for adults; and

(D) Tobacco use, except that the maximum differential rate due to tobacco use shall be 1.5 to 1.

(2) With respect to family coverage under an individual or small group health insurance policy, the rating variations permitted under subparagraphs (1)(A) and (D) shall be applied based on the portion of the premium that is attributable to each family member covered under the plan.

(3) Carriers shall adjust each health coverage plan or premium rate for age, based on the portion of the premium that is attributable to each family member covered under the plan or certificate, using the uniform age rating factors established by the commissioner pursuant to RSA 420-G:14, I(a)(2).

4 New Section; Essential Health Benefits. Amend RSA 420-G by inserting after section 4-c the following new section:

420-G:4-d Essential Health Benefits.

I. All health coverage offered by health carriers to individuals or small employers shall include coverage for essential health benefits and provide essential health benefits in a plan substantially equivalent to New Hampshire's Essential Health Benefit Benchmark Plan in effect for the plan year 2019.

II. If the federal government ceases to define essential health benefits, the commissioner shall define essential health benefits for New Hampshire by rulemaking pursuant to RSA 541-A. The New Hampshire essential health benefits shall include at least the following general categories and the items and services covered within the categories:

(a) Ambulatory patient services.

(b) Emergency services.

(c) Hospitalization.

(d) Maternity and newborn care.

(e) Mental health and substance use disorder services, including behavioral health treatment.

(f) Prescription drugs.

(g) Rehabilitative and habilitative services and devices.

(h) Laboratory services.

(i) Preventive and wellness services and chronic disease management.

(j) Pediatric services, including oral and vision care; provided, that health coverage that does not specifically include such pediatric services shall be deemed to have offered the essential health benefit under this subparagraph if the health carrier has obtained reasonable assurance that such pediatric services are provided to the purchaser of the health coverage.

III. In defining the essential health benefits under paragraph II, the commissioner shall:

(a) Ensure that such essential health benefit reflects an appropriate balance among the categories described in such subparagraph, so that benefits are not unduly weighted toward any category;

(b) Not define essential health benefits in a manner which would allow carriers to make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life;

(c) Consider the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups;

(d) Ensure that health benefits established as essential are not subject to denial to individuals against their wishes on the basis of the individuals' age or expected length of life or of the individuals' present or predicted disability, degree of medical dependency, or quality of life;

(e) Ensure that a health plan shall not be treated as providing coverage for the essential health benefits unless the plan provides that:

(1) Coverage for emergency department services shall be provided without imposing any requirement under the plan for prior authorization of services or any limitation on coverage where the provider of services does not have a contractual relationship with the plan for the provision of services which is more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have such a contractual relationship with the plan; and

(2) If such services are provided out-of-network, the cost-sharing requirement, such as a copayment amount or coinsurance rate is the same requirement which would apply if such services were provided in-network; and

(f) Ensure that the New Hampshire essential benefits are at least actuarially equivalent to the essential health benefits previously established by the federal government.

(g) Ensure essential health benefits are provided in a plan substantially equivalent to New Hampshire's Essential Health Benefit Benchmark Plan in effect for plan year 2019.

5 Health Coverage; Medical Underwriting. Amend RSA 420-G:5, I and II to read as follows:

I. Health carriers providing health coverage [~~for individuals may~~] ***shall not*** perform medical underwriting, including the use of health statements or screenings or the use of prior claims history[~~, to the extent necessary to establish or modify premium rates as provided in RSA 420-G:4~~].

II. [~~Health carriers providing health coverage for individuals may refuse to write or issue coverage to an individual because of his or her health status.~~] Regardless of claim experience, health status, or medical history, health carriers providing health coverage for ***individual or*** small employers shall not refuse to write or issue any of their available coverages or health benefit plans to any ***individual or*** small employer group that elects to be covered under that plan and agrees to make premium payments and meet the other requirements of the plan.

II-a. Health carriers shall not establish any annual or lifetime limits on the dollar value of essential health benefits for any individual, except annual or lifetime limits may be imposed on specific covered benefits that are not essential health benefits to the extent permitted under federal law as of January 1, 2019.

6 Health Coverage; Guaranteed Issue. Amend RSA 420-G:6, III to read as follows:

III. Health carriers shall actively market, issue, and renew all of the health coverages they sell in the ***individual and*** small employer market to all ***individuals and*** small employers ***in that***

market. Health carriers offering health coverage to small employers shall permit small employers to purchase health coverage at any point during the year, with the small employer's health coverage consisting of the 12-month period beginning with the small employer's effective date of coverage.

III-a. A health carrier shall not rescind health coverage issued to an individual or with respect to an individual covered under health coverage issued to a small or large employer, including a group to which the individual belongs or family coverage in which the individual is included, after the individual is covered under the plan, unless:

(a) The individual, or a person seeking coverage on behalf of the individual, performs an act, practice, or omission that constitutes fraud; or

(b) The individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage.

III-b. For the purposes of subparagraph III-a(a), a person seeking coverage on behalf of an individual shall not include a producer, or an employee or authorized representative of the health carrier.

III-c. A health carrier in the individual, small group, or large group market shall provide individuals equal access to all health programs, coverage, or activities without discrimination on the basis of sex, sexual orientation, gender identity, race, creed, color, marital status, familial status, physical or mental disability, or national origin, as those terms are defined under RSA 354-A.

7 Health Coverage; Guaranteed Issue. Amend RSA 420-G:6, V(d)-(g) and paragraph V-a to read as follows:

(d) Failure *of an employer sponsoring group coverage* to meet the minimum employee participation number or percentage requirement of the health coverage.

(e) [~~The small employer is no longer actively engaged in the business that it was engaged in on the effective date of the health coverage.~~

[~~(f)~~] The employer medically underwrites or otherwise violates a provision of this chapter.

[~~(g)~~] *(f)* The health carrier is ceasing to offer health coverage in such market, in accordance with paragraph VII.

V-a. Health carriers shall not underwrite insureds at time of renewal [~~unless an insured has applied for an increase in his or her coverage~~].

8 Health Coverage; Preexisting Conditions. RSA 420-G:7 is repealed and reenacted to read as follows:

420-G:7 Preexisting Condition Exclusion Periods. A health carrier shall not impose any preexisting condition exclusion with respect to coverage in the individual, small group, or large group market.

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420-G:8 Open Enrollment.

I. Each small employer group shall have an annual employee open enrollment period 60 days in length, occurring prior to the small employer group's anniversary date. During open enrollment, employees or eligible dependents may apply to the small employer for health coverage or make a change in their membership status becoming effective upon the small employer group's anniversary date, subject to providing the health carrier 30-days notice.

(a) A health carrier shall not refuse any small employer employees or eligible dependents applying for health coverage during the open enrollment period.

(b) Employees or eligible dependents coming on at the time of an open enrollment period shall have the same premiums as the rest of the small employer group shall have upon the new or renewal effective date.

II. A small employer employee who has met any employer imposed waiting period and is otherwise eligible for health coverage, who declines a small employer's health coverage plan during the initial offering or subsequent open enrollment period, shall be a late enrollee and shall not be allowed on the plan until the next open enrollment period.

III. A large employer employee, who has met any employer imposed waiting period and is otherwise eligible for health coverage, may enroll within 31 days of becoming eligible and shall not be required to submit evidence of insurability based on medical conditions. If a person does not enroll at this time, that person is a late enrollee. Each large employer group shall have an open enrollment period during which late enrollees may enroll and shall not be required to submit evidence of insurability based on medical conditions.

IV. Paragraphs II and III notwithstanding, an eligible employee or eligible dependent shall not be considered a late enrollee if:

(a) The person was covered under public or private health coverage at the time the person was able to enroll; and

(1) Has lost public or private health coverage as a result of termination of employment or eligibility, the termination of the other plan's coverage, death of a spouse, or divorce; and

(2) Requests enrollment within 30 days after termination of such health coverage; or

(b) Is employed by an employer that offers multiple health coverages and the person elects a different plan during an open enrollment period; or

(c) Was ordered by a court to provide health coverage for an ex-spouse or a minor child under a covered employee's plan and the request for enrollment is made within 30 days after issuance of such court order.

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(c) The special enrollment period shall be at least 60 days in length and shall begin on the later of:

(1) The date dependent health coverage is made available; or

(2) The date of the marriage, birth, adoption, placement for adoption, or loss of minimum essential coverage, as the case may be.

(d) If the person seeks enrollment during such special enrollment period, the health coverage shall become effective:

(1) In the case of marriage or loss of minimum essential coverage, on or before the first day of the first month following the completed request for enrollment;

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(3) In the case of adoption or placement for adoption, the date of such adoption or placement for adoption.

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(b) Any full-time or part-time employee who has been found eligible for a premium tax credit and is enrolled in a qualified health plan (QHP) purchased through an exchange shall be excluded from the count.

(c) The total number of full-time employees and part-time employees who are otherwise eligible for health coverage shall be counted.

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13 Health Coverage; Applicability and Scope of Chapter. Amend RSA 420-G:3, I(b) to read as follows:

(b) This chapter shall not apply to student major medical expense coverage, except student major medical expense coverage shall be given credit and shall count as credit for previous health coverage as defined in RSA 420-G:7, [~~III~~] ***II***.

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15 Effective Date. This act shall take effect 60 days after its passage.

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AN ACT relative to the group and individual health insurance market.

SPONSORS: Sen. Feltes, Dist 15; Sen. Cavanaugh, Dist 16; Sen. Chandley, Dist 11; Sen. D'Allesandro, Dist 20; Sen. Dietsch, Dist 9; Sen. Fuller Clark, Dist 21; Sen. Hennessey, Dist 5; Sen. Kahn, Dist 10; Sen. Levesque, Dist 12; Sen. Morgan, Dist 23; Sen. Rosenwald, Dist 13; Sen. Sherman, Dist 24; Sen. Soucy, Dist 18; Sen. Watters, Dist 4; Rep. Butler, Carr. 7; Rep. McMahon, Rock. 7

COMMITTEE: Health and Human Services

ANALYSIS

This bill establishes the provisions of the Patient Protection and Affordable Care Act of 2009, Public Law 111-148, as amended in statute.

Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Nineteen

AN ACT relative to the group and individual health insurance market.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 New Paragraphs; Health Coverage; Definitions. Amend RSA 420-G:2 by inserting after paragraph VI the following new paragraphs:

VI-a. "Employee" means "employee" as defined in the Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1002(6).

VI-b. "Essential health benefits" means the categories of coverage identified in 42 U.S.C. section 18022(b)(1) and as further defined and implemented by the Secretary of the Department of Health and Human Services from time to time.

2 Health Coverage; Definitions; Small Employer. Amend RSA 420-G:2, XVI(a) to read as follows:

XVI.(a) "Small employer" means a business or organization which employed on average, one and up to 50 employees[~~, including owners and self-employed persons,~~] on business days during the previous calendar year. A small employer is subject to this chapter whether or not it becomes part of an association, multi-employer plan, trust, or any other entity cited in RSA 420-G:3 provided it meets this definition.

3 Health Benefits; Premium Rates. RSA 420-G:4, I(d) is repealed and reenacted to read as follows:

(d)(1) In establishing the premium charged, health carriers providing coverage to individuals and small employers shall vary the premium rate with respect to the particular plan or coverage involved only by:

(A) Whether the plan or coverage covers an individual or family;

(B) Geographic rating area, except that the state shall constitute a single geographic rating area;

(C) Age, except that the maximum premium differential for age as determined by ratio shall be 3 to 1 for adults; and

(D) Tobacco use, except that the maximum differential rate due to tobacco use shall be 1.5 to 1.

(2) With respect to family coverage under an individual or small group health insurance policy, the rating variations permitted under subparagraphs (1)(A) and (D) shall be applied based on the portion of the premium that is attributable to each family member covered under the plan.

(3) Carriers shall adjust each health coverage plan or premium rate for age, based on the portion of the premium that is attributable to each family member covered under the plan or certificate, using the uniform age rating factors established by the commissioner pursuant to RSA 420-G:14, I(a)(2).

4 New Section; Essential Health Benefits. Amend RSA 420-G by inserting after section 4-c the following new section:

420-G:4-d Essential Health Benefits.

I. All health coverage offered by health carriers to individuals or small employers shall include coverage for essential health benefits and provide essential health benefits in a plan substantially equivalent to New Hampshire's essential health benefit benchmark plan in effect for the plan year 2019.

II. If the federal government ceases to define essential health benefits, the commissioner shall define essential health benefits for New Hampshire by rulemaking pursuant to RSA 541-A. The New Hampshire essential health benefits shall include at least the following general categories and the items and services covered within the categories:

(a) Ambulatory patient services.

(b) Emergency services.

(c) Hospitalization.

(d) Maternity and newborn care.

(e) Mental health and substance use disorder services, including behavioral health treatment.

(f) Prescription drugs.

(g) Rehabilitative and habilitative services and devices.

(h) Laboratory services.

(i) Preventive and wellness services and chronic disease management.

(j) Pediatric services, including oral and vision care; provided, that health coverage that does not specifically include such pediatric services shall be deemed to have offered the essential health benefit under this subparagraph if the health carrier has obtained reasonable assurance that such pediatric services are provided to the purchaser of the health coverage.

III. In defining the essential health benefits under paragraph II, the commissioner shall:

(a) Ensure that such essential health benefit reflects an appropriate balance among the categories described in such subparagraph, so that benefits are not unduly weighted toward any category;

(b) Not define essential health benefits in a manner which would allow carriers to make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life;

(c) Consider the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups;

(d) Ensure that health benefits established as essential are not subject to denial to individuals against their wishes on the basis of the individuals' age or expected length of life or of the individuals' present or predicted disability, degree of medical dependency, or quality of life;

(e) Ensure that a health plan shall not be treated as providing coverage for the essential health benefits unless the plan provides that:

(1) Coverage for emergency department services shall be provided without imposing any requirement under the plan for prior authorization of services or any limitation on coverage where the provider of services does not have a contractual relationship with the plan for the provision of services which is more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have such a contractual relationship with the plan; and

(2) If such services are provided out-of-network, the cost-sharing requirement, such as a copayment amount or coinsurance rate is the same requirement which would apply if such services were provided in-network; and

(f) Ensure that the New Hampshire essential benefits are at least actuarially equivalent to the essential health benefits previously established by the federal government.

(g) Ensure essential health benefits are provided in a plan substantially equivalent to New Hampshire's essential health benefit benchmark plan in effect for plan year 2019.

5 Health Coverage; Medical Underwriting. Amend RSA 420-G:5, I and II to read as follows:

I. Health carriers providing health coverage [~~for individuals may~~] ***shall not*** perform medical underwriting, including the use of health statements or screenings or the use of prior claims history[~~, to the extent necessary to establish or modify premium rates as provided in RSA 420-G:4~~].

II. [~~Health carriers providing health coverage for individuals may refuse to write or issue coverage to an individual because of his or her health status.~~] Regardless of claim experience, health status, or medical history, health carriers providing health coverage for ***individual or*** small employers shall not refuse to write or issue any of their available coverages or health benefit plans to any ***individual or*** small employer group that elects to be covered under that plan and agrees to make premium payments and meet the other requirements of the plan.

II-a. Health carriers shall not establish any annual or lifetime limits on the dollar value of essential health benefits for any individual, except annual or lifetime limits may be imposed on specific covered benefits that are not essential health benefits to the extent permitted under federal law as of January 1, 2019.

6 Health Coverage; Guaranteed Issue. Amend RSA 420-G:6, III to read as follows:

III. Health carriers shall actively market, issue, and renew all of the health coverages they sell in the ***individual and*** small employer market to all ***individuals and*** small employers ***in that***

market. Health carriers offering health coverage to small employers shall permit small employers to purchase health coverage at any point during the year, with the small employer's health coverage consisting of the 12-month period beginning with the small employer's effective date of coverage.

III-a. A health carrier shall not rescind health coverage issued to an individual or with respect to an individual covered under health coverage issued to a small or large employer, including a group to which the individual belongs or family coverage in which the individual is included, after the individual is covered under the plan, unless:

(a) The individual, or a person seeking coverage on behalf of the individual, performs an act, practice, or omission that constitutes fraud; or

(b) The individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage.

III-b. For the purposes of subparagraph III-a(a), a person seeking coverage on behalf of an individual shall not include a producer, or an employee or authorized representative of the health carrier.

III-c. A health carrier in the individual, small group, or large group market shall provide individuals equal access to all health programs, coverage, or activities without discrimination on the basis of sex, sexual orientation, gender identity, race, creed, color, marital status, familial status, physical or mental disability, or national origin, as those terms are defined under RSA 354-A.

7 Health Coverage; Guaranteed Issue. Amend RSA 420-G:6, V(d)-(g) and paragraph V-a to read as follows:

(d) Failure *of an employer sponsoring group coverage* to meet the minimum employee participation number or percentage requirement of the health coverage.

(e) [~~The small employer is no longer actively engaged in the business that it was engaged in on the effective date of the health coverage.~~

~~(f)~~] The employer medically underwrites or otherwise violates a provision of this chapter.

[~~(g)~~] *(f)* The health carrier is ceasing to offer health coverage in such market, in accordance with paragraph VII.

V-a. Health carriers shall not underwrite insureds at time of renewal [~~unless an insured has applied for an increase in his or her coverage~~].

8 Health Coverage; Preexisting Conditions. RSA 420-G:7 is repealed and reenacted to read as follows:

420-G:7 Preexisting Condition Exclusion Periods. A health carrier shall not impose any preexisting condition exclusion with respect to coverage in the individual, small group, or large group market.

9 Health Coverage; Open Enrollment. RSA 420-G:8 is repealed and reenacted to read as follows:

420-G:8 Open Enrollment.

I. Each small employer group shall have an annual employee open enrollment period 60 days in length, occurring prior to the small employer group's anniversary date. During open enrollment, employees or eligible dependents may apply to the small employer for health coverage or make a change in their membership status becoming effective upon the small employer group's anniversary date, subject to providing the health carrier 30-days notice.

(a) A health carrier shall not refuse any small employer employees or eligible dependents applying for health coverage during the open enrollment period.

(b) Employees or eligible dependents coming on at the time of an open enrollment period shall have the same premiums as the rest of the small employer group shall have upon the new or renewal effective date.

II. A small employer employee who has met any employer imposed waiting period and is otherwise eligible for health coverage, who declines a small employer's health coverage plan during the initial offering or subsequent open enrollment period, shall be a late enrollee and shall not be allowed on the plan until the next open enrollment period.

III. A large employer employee, who has met any employer imposed waiting period and is otherwise eligible for health coverage, may enroll within 31 days of becoming eligible and shall not be required to submit evidence of insurability based on medical conditions. If a person does not enroll at this time, that person is a late enrollee. Each large employer group shall have an open enrollment period during which late enrollees may enroll and shall not be required to submit evidence of insurability based on medical conditions.

IV. Paragraphs II and III notwithstanding, an eligible employee or eligible dependent shall not be considered a late enrollee if:

(a) The person was covered under public or private health coverage at the time the person was able to enroll; and

(1) Has lost public or private health coverage as a result of termination of employment or eligibility, the termination of the other plan's coverage, death of a spouse, or divorce; and

(2) Requests enrollment within 30 days after termination of such health coverage; or

(b) Is employed by an employer that offers multiple health coverages and the person elects a different plan during an open enrollment period; or

(c) Was ordered by a court to provide health coverage for an ex-spouse or a minor child under a covered employee's plan and the request for enrollment is made within 30 days after issuance of such court order.

V.(a) If individual coverage offered by a health carrier or a large or small employer group's health coverage plan offers dependent coverage and the individual is enrolled in such coverage or the employee is enrolled or has met any applicable waiting period and is eligible to be enrolled, but for a failure to do so during a previous open enrollment period, a person who becomes a dependent of the individual or employee through marriage, birth, adoption or placement for adoption, and the employee if not otherwise enrolled, shall be provided with a special enrollment period.

(b) If an individual has minimum essential coverage through individual coverage offered by a health carrier or as an employee through a large or small employer group's health coverage plan, and the individual loses such coverage for any reason other than failure to pay premiums or a basis on which rescission is permitted pursuant to RSA 420-G:6, IV, the individual shall be provided with a special open enrollment period under any other individual health coverage or any large or small employer group health coverage plan for which the individual becomes eligible.

(c) The special enrollment period shall be at least 60 days in length and shall begin on the later of:

(1) The date dependent health coverage is made available; or

(2) The date of the marriage, birth, adoption, placement for adoption, or loss of minimum essential coverage, as the case may be.

(d) If the person seeks enrollment during such special enrollment period, the health coverage shall become effective:

(1) In the case of marriage or loss of minimum essential coverage, on or before the first day of the first month following the completed request for enrollment;

(2) In the case of birth, as of the date of birth; or

(3) In the case of adoption or placement for adoption, the date of such adoption or placement for adoption.

10 New Paragraphs; Health Coverage; Participation Requirements. Amend RSA 420-G:9 by inserting after paragraph IV the following new paragraphs:

V. For the purpose of calculating whether or not a small employer group's enrollment meets a carrier's minimum participation requirements:

(a) Any full-time or part-time employee who is covered as a dependent on another person's health coverage or is enrolled in a governmental plan such as Medicare, Medicaid, or TRICARE shall be excluded from the count.

(b) Any full-time or part-time employee who has been found eligible for a premium tax credit and is enrolled in a qualified health plan (QHP) purchased through an exchange shall be excluded from the count.

(c) The total number of full-time employees and part-time employees who are otherwise eligible for health coverage shall be counted.

VI. The requirements under this section shall be the only participation requirements. Minimum employer contributions, or other criteria, shall not be permitted.

11 Health Coverage; Rulemaking. RSA 420-G:14, I is repealed and reenacted to read as follows:

I.(a) The commissioner may adopt rules, under RSA 541-A, relative to:

(1) Uniform age rating levels that are consistent with 45 C.F.R. 147.102.

(2) Special enrollment periods designed to allow employees to purchase individual coverage on the exchange during their employer's open enrollment period, even if the employer's open enrollment period does not coincide with the open enrollment period in the individual market.

(3) Essential health benefits, in accordance with RSA 420-G:4-d, II and III.

(b) The commissioner may adopt further rules, pursuant to RSA 541-A, necessary to the proper administration of this chapter.

12 Standards for Accident and Health Insurance; Preexisting Conditions. RSA 415-A:5, III is repealed and reenacted to read as follows:

III. Health carriers issuing policies subject to RSA 420-G shall not impose any preexisting condition exclusion that is inconsistent with that chapter.

13 Health Coverage; Applicability and Scope of Chapter. Amend RSA 420-G:3, I(b) to read as follows:

(b) This chapter shall not apply to student major medical expense coverage, except student major medical expense coverage shall be given credit and shall count as credit for previous health coverage as defined in RSA 420-G:7[~~, III~~].

14 Repeal. RSA 420-G:4-c, II, relative to a health coverage tax incentive plan, is repealed.

15 Effective Date. This act shall take effect 60 days after its passage.

CHAPTER 220
SB 4 - FINAL VERSION

03/27/2019 1176s
06/06/2019 2379EBA

2019 SESSION

19-1101
01/04

SENATE BILL *4*

AN ACT relative to the group and individual health insurance market.

SPONSORS: Sen. Feltes, Dist 15; Sen. Cavanaugh, Dist 16; Sen. Chandley, Dist 11; Sen. D'Allesandro, Dist 20; Sen. Dietsch, Dist 9; Sen. Fuller Clark, Dist 21; Sen. Hennessey, Dist 5; Sen. Kahn, Dist 10; Sen. Levesque, Dist 12; Sen. Morgan, Dist 23; Sen. Rosenwald, Dist 13; Sen. Sherman, Dist 24; Sen. Soucy, Dist 18; Sen. Watters, Dist 4; Rep. Butler, Carr. 7; Rep. McMahon, Rock. 7

COMMITTEE: Health and Human Services

ANALYSIS

This bill establishes the provisions of the Patient Protection and Affordable Care Act of 2009, Public Law 111-148, as amended in statute.

Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

CHAPTER 220
SB 4 - FINAL VERSION

03/27/2019 1176s
06/06/2019 2379EBA

19-1101
01/04

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Nineteen

AN ACT relative to the group and individual health insurance market.

Be it Enacted by the Senate and House of Representatives in General Court convened:

220:1 New Paragraphs; Health Coverage; Definitions. Amend RSA 420-G:2 by inserting after paragraph VI the following new paragraphs:

VI-a. "Employee" means "employee" as defined in the Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1002(6).

VI-b. "Essential health benefits" means the categories of coverage identified in 42 U.S.C. section 18022(b)(1) and as further defined and implemented by the Secretary of the Department of Health and Human Services from time to time.

220:2 Health Coverage; Definitions; Small Employer. Amend RSA 420-G:2, XVI(a) to read as follows:

XVI.(a) "Small employer" means a business or organization which employed on average, one and up to 50 employees[~~, including owners and self-employed persons,~~] on business days during the previous calendar year. A small employer is subject to this chapter whether or not it becomes part of an association, multi-employer plan, trust, or any other entity cited in RSA 420-G:3 provided it meets this definition.

220:3 Health Benefits; Premium Rates. RSA 420-G:4, I(d) is repealed and reenacted to read as follows:

(d)(1) In establishing the premium charged, health carriers providing coverage to individuals and small employers shall vary the premium rate with respect to the particular plan or coverage involved only by:

(A) Whether the plan or coverage covers an individual or family;

(B) Geographic rating area, except that the state shall constitute a single geographic rating area;

(C) Age, except that the maximum premium differential for age as determined by ratio shall be 3 to 1 for adults; and

(D) Tobacco use, except that the maximum differential rate due to tobacco use shall be 1.5 to 1.

(2) With respect to family coverage under an individual or small group health insurance policy, the rating variations permitted under subparagraphs (1)(A) and (D) shall be

applied based on the portion of the premium that is attributable to each family member covered under the plan.

(3) Carriers shall adjust each health coverage plan or premium rate for age, based on the portion of the premium that is attributable to each family member covered under the plan or certificate, using the uniform age rating factors established by the commissioner pursuant to RSA 420-G:14, I(a)(2).

220:4 New Section; Essential Health Benefits. Amend RSA 420-G by inserting after section 4-c the following new section:

420-G:4-d Essential Health Benefits.

I. All health coverage offered by health carriers to individuals or small employers shall include coverage for essential health benefits and provide essential health benefits in a plan substantially equivalent to New Hampshire's essential health benefit benchmark plan in effect for the plan year 2019.

II. If the federal government ceases to define essential health benefits, the commissioner shall define essential health benefits for New Hampshire by rulemaking pursuant to RSA 541-A. The New Hampshire essential health benefits shall include at least the following general categories and the items and services covered within the categories:

(a) Ambulatory patient services.

(b) Emergency services.

(c) Hospitalization.

(d) Maternity and newborn care.

(e) Mental health and substance use disorder services, including behavioral health treatment.

(f) Prescription drugs.

(g) Rehabilitative and habilitative services and devices.

(h) Laboratory services.

(i) Preventive and wellness services and chronic disease management.

(j) Pediatric services, including oral and vision care; provided, that health coverage that does not specifically include such pediatric services shall be deemed to have offered the essential health benefit under this subparagraph if the health carrier has obtained reasonable assurance that such pediatric services are provided to the purchaser of the health coverage.

III. In defining the essential health benefits under paragraph II, the commissioner shall:

(a) Ensure that such essential health benefit reflects an appropriate balance among the categories described in such subparagraph, so that benefits are not unduly weighted toward any category;

(b) Not define essential health benefits in a manner which would allow carriers to make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits

in ways that discriminate against individuals because of their age, disability, or expected length of life;

(c) Consider the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups;

(d) Ensure that health benefits established as essential are not subject to denial to individuals against their wishes on the basis of the individuals' age or expected length of life or of the individuals' present or predicted disability, degree of medical dependency, or quality of life;

(e) Ensure that a health plan shall not be treated as providing coverage for the essential health benefits unless the plan provides that:

(1) Coverage for emergency department services shall be provided without imposing any requirement under the plan for prior authorization of services or any limitation on coverage where the provider of services does not have a contractual relationship with the plan for the provision of services which is more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have such a contractual relationship with the plan; and

(2) If such services are provided out-of-network, the cost-sharing requirement, such as a copayment amount or coinsurance rate is the same requirement which would apply if such services were provided in-network; and

(f) Ensure that the New Hampshire essential benefits are at least actuarially equivalent to the essential health benefits previously established by the federal government.

(g) Ensure essential health benefits are provided in a plan substantially equivalent to New Hampshire's essential health benefit benchmark plan in effect for plan year 2019.

220:5 Health Coverage; Medical Underwriting. Amend RSA 420-G:5, I and II to read as follows:

I. Health carriers providing health coverage [~~for individuals may~~] ***shall not*** perform medical underwriting, including the use of health statements or screenings or the use of prior claims history[~~, to the extent necessary to establish or modify premium rates as provided in RSA 420-G:4~~].

II. [~~Health carriers providing health coverage for individuals may refuse to write or issue coverage to an individual because of his or her health status.~~] Regardless of claim experience, health status, or medical history, health carriers providing health coverage for ***individual or*** small employers shall not refuse to write or issue any of their available coverages or health benefit plans to any ***individual or*** small employer group that elects to be covered under that plan and agrees to make premium payments and meet the other requirements of the plan.

II-a. Health carriers shall not establish any annual or lifetime limits on the dollar value of essential health benefits for any individual, except annual or lifetime limits may be imposed on specific covered benefits that are not essential health benefits to the extent permitted under federal law as of January 1, 2019.

220:6 Health Coverage; Guaranteed Issue. Amend RSA 420-G:6, III to read as follows:

III. Health carriers shall actively market, issue, and renew all of the health coverages they sell in the ***individual and*** small employer market to all ***individuals and*** small employers ***in that market. Health carriers offering health coverage to small employers shall permit small employers to purchase health coverage at any point during the year, with the small employer's health coverage consisting of the 12-month period beginning with the small employer's effective date of coverage.***

III-a. A health carrier shall not rescind health coverage issued to an individual or with respect to an individual covered under health coverage issued to a small or large employer, including a group to which the individual belongs or family coverage in which the individual is included, after the individual is covered under the plan, unless:

(a) The individual, or a person seeking coverage on behalf of the individual, performs an act, practice, or omission that constitutes fraud; or

(b) The individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage.

III-b. For the purposes of subparagraph III-a(a), a person seeking coverage on behalf of an individual shall not include a producer, or an employee or authorized representative of the health carrier.

III-c. A health carrier in the individual, small group, or large group market shall provide individuals equal access to all health programs, coverage, or activities without discrimination on the basis of sex, sexual orientation, gender identity, race, creed, color, marital status, familial status, physical or mental disability, or national origin, as those terms are defined under RSA 354-A.

220:7 Health Coverage; Guaranteed Issue. Amend RSA 420-G:6, V(d)-(g) and paragraph V-a to read as follows:

(d) Failure ***of an employer sponsoring group coverage*** to meet the minimum employee participation number or percentage requirement of the health coverage.

(e) [~~The small employer is no longer actively engaged in the business that it was engaged in on the effective date of the health coverage.~~

~~(f)~~] The employer medically underwrites or otherwise violates a provision of this chapter.

[~~(g)~~] ***(f)*** The health carrier is ceasing to offer health coverage in such market, in accordance with paragraph VII.

V-a. Health carriers shall not underwrite insureds at time of renewal [~~unless an insured has applied for an increase in his or her coverage~~].

220:8 Health Coverage; Preexisting Conditions. RSA 420-G:7 is repealed and reenacted to read as follows:

420-G:7 Preexisting Condition Exclusion Periods. A health carrier shall not impose any preexisting condition exclusion with respect to coverage in the individual, small group, or large group market.

220:9 Health Coverage; Open Enrollment. RSA 420-G:8 is repealed and reenacted to read as follows:

420-G:8 Open Enrollment.

I. Each small employer group shall have an annual employee open enrollment period 60 days in length, occurring prior to the small employer group's anniversary date. During open enrollment, employees or eligible dependents may apply to the small employer for health coverage or make a change in their membership status becoming effective upon the small employer group's anniversary date, subject to providing the health carrier 30-days notice.

(a) A health carrier shall not refuse any small employer employees or eligible dependents applying for health coverage during the open enrollment period.

(b) Employees or eligible dependents coming on at the time of an open enrollment period shall have the same premiums as the rest of the small employer group shall have upon the new or renewal effective date.

II. A small employer employee who has met any employer imposed waiting period and is otherwise eligible for health coverage, who declines a small employer's health coverage plan during the initial offering or subsequent open enrollment period, shall be a late enrollee and shall not be allowed on the plan until the next open enrollment period.

III. A large employer employee, who has met any employer imposed waiting period and is otherwise eligible for health coverage, may enroll within 31 days of becoming eligible and shall not be required to submit evidence of insurability based on medical conditions. If a person does not enroll at this time, that person is a late enrollee. Each large employer group shall have an open enrollment period during which late enrollees may enroll and shall not be required to submit evidence of insurability based on medical conditions.

IV. Paragraphs II and III notwithstanding, an eligible employee or eligible dependent shall not be considered a late enrollee if:

(a) The person was covered under public or private health coverage at the time the person was able to enroll; and

(1) Has lost public or private health coverage as a result of termination of employment or eligibility, the termination of the other plan's coverage, death of a spouse, or divorce; and

(2) Requests enrollment within 30 days after termination of such health coverage; or

(b) Is employed by an employer that offers multiple health coverages and the person elects a different plan during an open enrollment period; or

(c) Was ordered by a court to provide health coverage for an ex-spouse or a minor child under a covered employee's plan and the request for enrollment is made within 30 days after issuance of such court order.

V.(a) If individual coverage offered by a health carrier or a large or small employer group's health coverage plan offers dependent coverage and the individual is enrolled in such coverage or the employee is enrolled or has met any applicable waiting period and is eligible to be enrolled, but for a failure to do so during a previous open enrollment period, a person who becomes a dependent of the individual or employee through marriage, birth, adoption or placement for adoption, and the employee if not otherwise enrolled, shall be provided with a special enrollment period.

(b) If an individual has minimum essential coverage through individual coverage offered by a health carrier or as an employee through a large or small employer group's health coverage plan, and the individual loses such coverage for any reason other than failure to pay premiums or a basis on which rescission is permitted pursuant to RSA 420-G:6, IV, the individual shall be provided with a special open enrollment period under any other individual health coverage or any large or small employer group health coverage plan for which the individual becomes eligible.

(c) The special enrollment period shall be at least 60 days in length and shall begin on the later of:

(1) The date dependent health coverage is made available; or

(2) The date of the marriage, birth, adoption, placement for adoption, or loss of minimum essential coverage, as the case may be.

(d) If the person seeks enrollment during such special enrollment period, the health coverage shall become effective:

(1) In the case of marriage or loss of minimum essential coverage, on or before the first day of the first month following the completed request for enrollment;

(2) In the case of birth, as of the date of birth; or

(3) In the case of adoption or placement for adoption, the date of such adoption or placement for adoption.

220:10 New Paragraphs; Health Coverage; Participation Requirements. Amend RSA 420-G:9 by inserting after paragraph IV the following new paragraphs:

V. For the purpose of calculating whether or not a small employer group's enrollment meets a carrier's minimum participation requirements:

(a) Any full-time or part-time employee who is covered as a dependent on another person's health coverage or is enrolled in a governmental plan such as Medicare, Medicaid, or TRICARE shall be excluded from the count.

(b) Any full-time or part-time employee who has been found eligible for a premium tax credit and is enrolled in a qualified health plan (QHP) purchased through an exchange shall be excluded from the count.

(c) The total number of full-time employees and part-time employees who are otherwise eligible for health coverage shall be counted.

VI. The requirements under this section shall be the only participation requirements. Minimum employer contributions, or other criteria, shall not be permitted.

220:11 Health Coverage; Rulemaking. RSA 420-G:14, I is repealed and reenacted to read as follows:

I.(a) The commissioner may adopt rules, under RSA 541-A, relative to:

(1) Uniform age rating levels that are consistent with 45 C.F.R. 147.102.

(2) Special enrollment periods designed to allow employees to purchase individual coverage on the exchange during their employer's open enrollment period, even if the employer's open enrollment period does not coincide with the open enrollment period in the individual market.

(3) Essential health benefits, in accordance with RSA 420-G:4-d, II and III.

(b) The commissioner may adopt further rules, pursuant to RSA 541-A, necessary to the proper administration of this chapter.

220:12 Standards for Accident and Health Insurance; Preexisting Conditions. RSA 415-A:5, III is repealed and reenacted to read as follows:

III. Health carriers issuing policies subject to RSA 420-G shall not impose any preexisting condition exclusion that is inconsistent with that chapter.

220:13 Health Coverage; Applicability and Scope of Chapter. Amend RSA 420-G:3, I(b) to read as follows:

(b) This chapter shall not apply to student major medical expense coverage, except student major medical expense coverage shall be given credit and shall count as credit for previous health coverage as defined in RSA 420-G:7[~~, III~~].

220:14 Repeal. RSA 420-G:4-c, II, relative to a health coverage tax incentive plan, is repealed.

220:15 Effective Date. This act shall take effect 60 days after its passage.

Approved: July 12, 2019
Effective Date: September 10, 2019

Amendments

Sen. Feltes, Dist 15
February 5, 2019
2019-0296s
01/04

Amendment to SB 4

Amend the bill by replacing section 6 with the following:

6 Health Coverage; Guaranteed Issue. Amend RSA 420-G:6, III to read as follows:

III. Health carriers shall actively market, issue, and renew all of the health coverages they sell in the ***individual and*** small employer market to all ***individuals and*** small employers ***in that market. Health carriers offering health coverage to small employers shall permit small employers to purchase health coverage at any point during the year, with the small employer's health coverage consisting of the 12-month period beginning with the small employer's effective date of coverage.***

III-a. A health carrier shall not rescind health coverage issued to an individual or with respect to an individual covered under health coverage issued to a small or large employer, including a group to which the individual belongs or family coverage in which the individual is included, after the individual is covered under the plan, unless:

(a) The individual, or a person seeking coverage on behalf of the individual, performs an act, practice, or omission that constitutes fraud; or

(b) The individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage.

III-b. For the purposes of subparagraph III-a(a), a person seeking coverage on behalf of an individual shall not include a producer, or an employee or authorized representative of the health carrier.

III-c. A health carrier in the individual, small group, or large group market shall not discriminate against any person protected under RSA 354-A, Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), Title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), the Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.), or section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), nor shall any such person be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity. The enforcement mechanism provided for in RSA 354-A shall apply for purposes of violations of this paragraph, and any violation of this paragraph shall be considered an unlawful discriminatory practice under RSA 354-A:7.

Health and Human Services
March 19, 2019
2019-1176s
01/06

Amendment to SB 4

Amend RSA 420-G:4-d, II(j) as inserted by section 4 of the bill by replacing it with the following:

(j) Pediatric services, including oral and vision care; provided, that health coverage that does not specifically include such pediatric services shall be deemed to have offered the essential health benefit under this subparagraph if the health carrier has obtained reasonable assurance that such pediatric services are provided to the purchaser of the health coverage.

Amend the bill by replacing section 5 with the following:

5 Health Coverage; Medical Underwriting. Amend RSA 420-G:5, I and II to read as follows:

I. Health carriers providing health coverage [~~for individuals may~~] ***shall not*** perform medical underwriting, including the use of health statements or screenings or the use of prior claims history[~~, to the extent necessary to establish or modify premium rates as provided in RSA 420-G:4~~].

II. [~~Health carriers providing health coverage for individuals may refuse to write or issue coverage to an individual because of his or her health status.~~] Regardless of claim experience, health status, or medical history, health carriers providing health coverage for ***individual or*** small employers shall not refuse to write or issue any of their available coverages or health benefit plans to any ***individual or*** small employer group that elects to be covered under that plan and agrees to make premium payments and meet the other requirements of the plan.

II-a. Health carriers shall not establish any annual or lifetime limits on the dollar value of essential health benefits for any individual, except annual or lifetime limits may be imposed on specific covered benefits that are not essential health benefits to the extent permitted under federal law as of January 1, 2019.

Amend the bill by replacing section 6 with the following:

6 Health Coverage; Guaranteed Issue. Amend RSA 420-G:6, III to read as follows:

III. Health carriers shall actively market, issue, and renew all of the health coverages they sell in the ***individual and*** small employer market to all ***individuals and*** small employers ***in that market. Health carriers offering health coverage to small employers shall permit small employers to purchase health coverage at any point during the year, with the small***

employer's health coverage consisting of the 12-month period beginning with the small employer's effective date of coverage.

III-a. A health carrier shall not rescind health coverage issued to an individual or with respect to an individual covered under health coverage issued to a small or large employer, including a group to which the individual belongs or family coverage in which the individual is included, after the individual is covered under the plan, unless:

(a) The individual, or a person seeking coverage on behalf of the individual, performs an act, practice, or omission that constitutes fraud; or

(b) The individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage.

III-b. For the purposes of subparagraph III-a(a), a person seeking coverage on behalf of an individual shall not include a producer, or an employee or authorized representative of the health carrier.

III-c. A health carrier in the individual, small group, or large group market shall provide individuals equal access to all health programs, coverage, or activities without discrimination on the basis of sex, sexual orientation, gender identity, race, creed, color, marital status, familial status, physical or mental disability, or national origin, as those terms are defined under RSA 354-A.

Committee Minutes

SENATE CALENDAR NOTICE
Health and Human Services

Sen Tom Sherman, Chair
Sen Martha Fuller Clark, Vice Chair
Sen Shannon Chandley, Member
Sen Jeb Bradley, Member
Sen James Gray, Member

Date: January 30, 2019

HEARINGS

Tuesday		02/05/2019	
(Day)		(Date)	
Health and Human Services		LOB 101	1:00 p.m.
(Name of Committee)		(Place)	(Time)

1:00 p.m.	**SB 88-FN**	relative to registry identification cards under the use of cannabis for therapeutic purposes law.
1:15 p.m.	**SB 259-FN**	expanding eligibility for the Medicaid for employed adults with disabilities (MEAD) program.
1:30 p.m.	**SB 236-FN-A**	making an appropriation to the department of health and human services for the purposes of upgrades to substance use disorder treatment facilities.
1:45 p.m.	**SB 289-FN**	relative to health and human services.
2:00 p.m.	**SB 260-FN**	relative to a program for prescription drug costs for certain seniors and making an appropriation therefor.
2:15 p.m.	**SB 4**	relative to the group and individual health insurance market.

EXECUTIVE SESSION MAY FOLLOW

Sponsors:

SB 88-FN

Sen. Kahn	Sen. Sherman	Sen. Rosenwald	Sen. Dietsch
Sen. Levesque	Sen. Cavanaugh		

SB 259-FN

Sen. Watters	Sen. Hennessey	Sen. Fuller Clark	Sen. Bradley
Sen. Chandley	Sen. Feltes	Sen. Kahn	Sen. Morgan
Sen. Morse	Sen. Rosenwald	Sen. Sherman	Sen. Soucy
Rep. Cannon	Rep. McMahon		

SB 236-FN-A

Sen. Morgan	Sen. Sherman	Sen. Hennessey	Sen. Rosenwald
Sen. Feltes	Sen. Fuller Clark	Sen. Levesque	Sen. Watters

SB 289-FN

Sen. Fuller Clark	Rep. Knirk		

SB 260-FN

Sen. Feltes	Sen. Fuller Clark	Rep. Merchant	

SB 4

Sen. Feltes	Sen. Cavanaugh	Sen. Chandley	Sen. D'Allesandro
Sen. Dietsch	Sen. Fuller Clark	Sen. Hennessey	Sen. Kahn
Sen. Levesque	Sen. Morgan	Sen. Rosenwald	Sen. Sherman
Sen. Soucy	Sen. Watters	Rep. Butler	Rep. McMahon

Doug Marino 271-8631

Tom Sherman
Chairman

Senate Health and Human Services Committee

Doug Marino 271-8631

SB 4, relative to the group and individual health insurance market.

Hearing Date: February 5, 2019

Time Opened: 3:52 p.m. **Time Closed:** 4:54 p.m.

Members of the Committee Present: Senators Sherman, Fuller Clark, Chandley, Bradley and Gray

Members of the Committee Absent : None

Bill Analysis: This bill establishes the provisions of the Patient Protection and Affordable Care Act of 2009, Public Law 111-148, as amended in statute.

Sponsors:

Sen. Feltes	Sen. Cavanaugh	Sen. Chandley
Sen. D'Allesandro	Sen. Dietsch	Sen. Fuller Clark
Sen. Hennessey	Sen. Kahn	Sen. Levesque
Sen. Morgan	Sen. Rosenwald	Sen. Sherman
Sen. Soucy	Sen. Watters	Rep. Butler
Rep. McMahon		

Who supports the bill: Senator Jon Morgan (District 23), Senator Tom Sherman (District 24), Senator Cindy Rosenwald (District 13), Senator Dan Feltes (District 15), Senator Donna Soucy (District 18), Kayla Montgomery (Planned Parenthood), Senator Jay Kahn (District 10), Alexandria Sosnowski (Northeast Delta Dental), Holly Stevens (New Futures), Chris Rueggeberg (New Hampshire Council on Developmental Disabilities), Louise Spencer, Kristine Stoddard (Bi-State Primary Care), Zandra Rice-Hawkins (Granite State Progress), Paula Rogers (Anthem)

Who opposes the bill:

Who is neutral on the bill: Jennifer Patterson (New Hampshire Insurance Department)

Summary of testimony presented:

Senator Dan Feltes, District 15

- This bill has been referred to as the "ACA backstop". It codifies many of the Affordable Care Act's (ACA) protections into state law, including the provision protecting coverage for patients with pre-existing conditions.

- There is currently a case making its way to the Supreme Court which could threaten some of the protections outlined in the Affordable Care Act.
- SB 4 protects the essential health benefits that could be in jeopardy if the ACA is overturned.
- SB 4 will also codify the benchmark plans currently in existence.
- Senator Feltes is proposing an amendment to codify the anti-discrimination protections outlined in the Affordable Care Act.
- This amendment adds a new subsection which specifies that providers will not discriminate against patients based on protected identities under state and federal law.
- There may be some dispute over whether the Human Rights Commission is the proper entity to deal with these discrimination complaints.
- Senator Bradley asked Senator Feltes if he agrees that many of these protections have been included under NH law in the past. Senator Feltes indicated that he agrees that some but not all the protections outlined in SB 4 were present in NH law before the ACA.
- Senator Bradley asked Senator Feltes about his amendment. Specifically, would it make sense to have the insurance department deal with enforcement of the anti-discrimination provision. Senator Feltes indicated that he is open to having the insurance department deal with such complaints.

Jennifer Patterson, NH Insurance Department

- The department is not taking a position on the bill.
- The language of this bill is very similar to HB 233.
- New Hampshire's laws were never amended fully to reflect the regulations in the Affordable Care Act.
- The insurance department is concerned about the language of Senator Feltes' amendment. The amendment would potentially add new requirements that the department will need to enforce. Mrs. Patterson is concerned that the department does not have the necessary mechanisms to enforce the amendment.
- Senator Bradley asked Mrs. Patterson about Senator Feltes' amendment. Specifically, whether it would add new requirements for the department that are not currently outlined in statute. Senator Bradley noted that the department already must comply with some of these regulations under the guaranteed issue statute. Mrs. Patterson indicated that she believes that the language of the amendment would require the insurance department to enforce anti-discrimination policies that are currently regulated by the federal government or the New Hampshire Human Rights Commission. Mrs. Patterson further indicated that she believes that the amendment will add additional responsibilities that are not currently outlined under the guaranteed issue statute.
- Senator Sherman asked Mrs. Patterson if the department has the necessary mechanisms to deal with areas detailed in Senator Feltes' amendment. Mrs. Patterson indicated that the department doesn't have staff with the necessary expertise to properly enforce the provisions in the amendment.
- Senator Sherman asked Mrs. Patterson if the insurance department is unable to deal with anti-discrimination complaints, what other state agencies could deal with it. Mrs. Patterson indicated that the Human Rights Commission could potentially address them.
- Senator Fuller Clark asked Mrs. Patterson what New Hampshire provided for individuals with pre-existing conditions prior to the ACA. Mrs. Patterson indicated that New Hampshire does have protections for individuals with pre-existing conditions, although it is not as expansive as the regulations set forward in the ACA.

Alexandria Sosnowski, Staff Attorney at Northeast Delta Dental (Provided written testimony)

- Northeast Delta Dental is proposing an amendment to SB 4.
- The amendment amends the portion of the bill addressing essential health benefits.
- The amendment would ensure that SB 4 is consistent with federal provisions on dental health care.

Holly Stevens, New Futures (Provided written testimony on behalf of herself as well as Timothy Giddish)

- New Futures supports SB 4.
- Prior to the ACA, many insurance plans did not cover benefits for mental health care as well as substance abuse treatment.
- SB 4 would ensure that patients in New Hampshire will continue to have access to these benefits even if the ACA is overturned.

- The US Congress conducted a study between 2007 and 2009 which found that among four large insurance companies, roughly 651,000 people were denied insurance based on pre-existing conditions.
- The Insurance Department has convened meetings with stakeholders around the association of health plans. Mrs. Stevens had the opportunity to attend all four of the meetings. She says that people who attended the meetings stressed the need to preserve essential health benefits, as well as protections for people with pre-existing conditions.
- Senator Sherman asked Mrs. Stevens if the topic of lifetime limits was discussed at any of the meetings. Mrs. Stevens indicated that the topic was not discussed.

Zandra Rice-Hawkins, Executive Director of Granite State Progress (Provided written testimony on behalf of herself and three other individuals who support SB 4)

- Granite State Progress supports SB 4.
- Prior to the ACA, families faced barriers gaining access to the health care coverage that they need.
- SB 4 would ensure that patients in New Hampshire would still have access to many of the consumer protections under the Affordable Care Act, even if the law was overturned by the Supreme Court.
- Mrs. Rice-Hawkins brought forward stories from patients in New Hampshire who have pre-existing conditions and rely on the ACA's protections for essential health coverage.
- Granite State Progress also supports Senator Feltes' amendment.
- Senator Fuller Clark asked if Mrs. Rice-Hawkins believes that the Human Rights Commission should deal with anti-discrimination complaints. Mrs. Rice-Hawkins indicated that she does not have a strong feeling concerning which state agency should be responsible for dealing with discrimination claims.

Paula Rogers, Anthem

- Anthem supported the House version of this bill.
- If the ACA was overturned, the individual market in New Hampshire would be in serious jeopardy. Subsidies would likely be eliminated.
- SB 4 is a fine measure for the interim, if the ACA was overturned. However, there may be additional steps that the legislature needs to take to create a long-term health care policy that works for New Hampshire.
- Mrs. Rogers indicated that the department has worked to address insurance coverage for transgender patients, as well as patients who do not speak English as their primary language. This was done in accordance with section 1557 of the ACA.
- Senator Sherman asked Mrs. Rogers if there is anything that insurance carriers do which is governed outside of the insurance department. Mrs. Rogers indicated that there are other regulators that Anthem works with to meet different requirements. She noted that she had to work with different regulators to comply with section 1557 of the ACA.
- Senator Gray asked Mrs. Rogers for a breakdown on who would be covered and who would not be covered if the ACA was to be overturned. Mrs. Patterson came forward to address Senator Gray's question. Mrs. Patterson indicated that people who are covered under Medicaid expansion would lose their coverage under the program. However, she does not have exact numbers currently. She will work to provide those statistics to the committee.
- Senator Bradley asked Mrs. Rogers about her opinion on Senator Feltes' amendment. Mrs. Rogers indicated that she does not object to having these provisions codified in New Hampshire law, given the fact that Anthem has already worked to cover health services for transgender patients.

Louise Spencer, Kent Street Coalition

- Mrs. Spencer would be impacted if the ACA was overturned.
- Mrs. Spencer and her husband both have pre-existing conditions and are hoping that New Hampshire will continue to protect patients with pre-existing conditions if the ACA is overturned.

DLM
Date Hearing Report completed: February 8, 2019

Speakers

SENATE HEALTH AND HUMAN SERVICES COMMITTEE

Date: February 5, 2019 **Time:** 2:15PM **Public Hearing on** SB 4

SB 4 –

Please check box(es) that apply:

SPEAKING	FAVOR	OPPOSED	NAME (Please print)	REPRESENTING
☐	☒	☐	Sen. Tom Sherman	SD24
☐	☒	☐	Sen. Jon Morgan	SD23
☐	☒	☐	Sen Cindy Rosenwald	SD13
☑	☑	☐	Sen. Dan Feltes	SD #15
☐	☑	☐	Sen Donna Soucy	SD #18
☐	☑	☐	Kayla Montgomery	Planned Parenthood
☐	☑	☐	Sen Jay Kahn	SD #10
☒	☐ no position	☐	Jennifer Patterson	NH Ins. Dept
☒	☒ in favor	☐	Alexandra Sosnowski	Delta Dental
☒	☒	☐	Holly Stevens	New Futures
☐	☒	☐	Chris Ruggeberg	NH Council on Developmental Disabilities
☐	☐	☐		
☒	☒	☐	Louise Spencer	Self
☐	☒	☐	Kristine Stoddard	Bi-State Primary Care Assn.
☒	☒	☐	Zandra Rice Hawkins	Granite State Progress
☒	☒	☐	Paula Rogers	Anthem
☐	☐	☐		
☐	☐	☐		
☐	☐	☐		

Testimony

February 5, 2019

The Honorable Tom Sherman
Senate Health and Human Services Committee
Legislative Office Building, Room 101
33 North State Street
Concord, NH 03301

Re: New Futures' support of SB 4

Dear Chairman Sherman and Members of the Committee:

New Futures appreciates the opportunity to testify in support of SB 4, which would codify certain protections of the Affordable Care Act (ACA) into New Hampshire law. New Futures is a nonpartisan, nonprofit organization that advocates, educates and collaborates to improve the health and wellness of all New Hampshire residents. In this role, we work extensively with policy makers, health care providers and families to increase access to quality, affordable health care throughout the Granite State.

Prior to the ACA, many insurance plans did not cover mental health and substance use disorder services. At the time, the Mental Health Parity and Addiction Act of 1996 (Parity Act) mandated that any mental health and substance use disorder benefits on the market be in parity with physical health care benefits. However, the Act did not require that insurers cover these benefits. In fact, it had exemptions for plans that did not provide mental health benefits, for small employers, and for businesses that could demonstrate an increase in premiums due to the parity.

If the ACA were to be repealed or found unconstitutional, insurance plans would once again not be required to cover the essential health benefits, including mental health and substance use disorder services. They could stop providing behavioral health benefits to avoid complying with the Parity Act.. Given New Hampshire's current mental health and substance use disorder crises, this could have devastating consequences for our state. The investments that the state and behavioral health treatment providers have made will be for naught, if insurance carries no longer cover mental health and substance use disorder services. Therefore, we must codify the essential health benefits in state law so that insurance plans continue to cover these crucial benefits and be subject to The Mental Health Parity and Addiction Act of 1996.

Additionally, prior to the ACA, health insurers were permitted to deny coverage, charge higher premiums, or impose waiting periods before treatment for pre-existing conditions were covered. Congress surveyed four of the large insurers between 2007 and 2009. They found that over 400 medical conditions or diagnoses were used to justify a denial of coverage. These diagnoses included cancer, diabetes, hepatitis, mental health disorders, and pregnancy among others. All told, these four companies denied health coverage to 651,000 people because of pre-existing conditions.[1] Even when coverage was provided, it would often be offered at much higher premiums. With the

[1] Pre existing conditions before the Affordable Care Act, Meredith Miller, published June 14, 2018.

prohibition on denying coverage to individuals with pre-existing conditions and the rating requirements of the ACA, these practices ended.

Over the past few months, the New Hampshire Insurance Department (NHID) has convened a series of stakeholder meetings regarding Association Health Plans (AHP). During these sessions, it became clear that nearly all stakeholders in attendance believe that coverage of the EHB and pre-existing conditions are essential. The recent changes at the federal level around AHP would allow states much flexibility with these plans. There is no requirement for them to cover the EHB or pre-existing conditions. However, stakeholders believe strongly that for AHP to move forward in New Hampshire under the new federal regulations, they would need to include those provisions. This demonstrates that these protections are extremely important to New Hampshire residents.

At this time, the atmosphere in Washington, D.C. is highly volatile, and there is much uncertainty from day to day regarding the future of the ACA Further, the lawsuit filed in the Northern District of Texas challenging constitutionality provides even more uncertainty regarding the sustainability of the ACA at this time.

If the ACA was standing on solid ground, there would be no need for SB 4. However, because that is not the case, New Hampshire's legislators have a duty to make sure the health care protections afforded Granite Staters through the health care law continue in the event that action at the federal level jeopardizes them. These are protections that New Hampshire's residents both want and need. If the state is to continue to beat back the ongoing mental health and substance misuse crisis, it is crucial that people have access to affordable services which requires insurance coverage with reasonable premiums. For these reasons, New Futures strongly supports SB 4 and urges the committee vote ought to pass.

Please do not hesitate to contact me if you have any questions.

Respectfully submitted,

Holly A. Stevens, Esq.
Health Policy Coordinator

Robert Wood Johnson Foundation

URBAN INSTITUTE

Support for this research was provided by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation.

How Repealing and Replacing the ACA Could Reduce Access to Mental Health and Substance Use Disorder Treatment and Parity Protections

Jane B. Wishner

Timely Analysis of Immediate Health Policy Issues **JUNE 2017**

In Brief

Millions of Americans gained coverage for mental health (MH) and substance use disorder (SUD) treatment through the expansion of Medicaid and private insurance coverage under the Affordable Care Act (ACA). The law also included parity protections ensuring that MH/SUD benefits were not subject to plan provisions stricter than those for medical care (e.g., higher co-payments and lower visit limits).[1] Bipartisan support for MH/SUD treatment and parity has increased since the 1990s, most recently in response to the opioid epidemic. Congress has addressed coverage parity between MH/SUD and medical benefits in piecemeal fashion, initially requiring parity in annual and lifetime dollar limits for MH and medical benefits in large employer-sponsored plans. The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) expanded those parity protections to SUD benefits and required large employer-sponsored plans with MH/SUD coverage to use comparable financial requirements and treatment limitations for medical and MH/SUD benefits.

The ACA closed a significant coverage gap by extending the parity protections of the MHPAEA to the individual insurance market and to certain plans that cover low-income adults through the ACA Medicaid expansion. Unlike the MHPAEA, which does not require health plans to cover MH/SUD, the ACA required nongrandfathered individual and fully insured small group plans and Medicaid expansion benefit plans to include coverage for both MH and SUD treatment. Efforts to repeal and replace the ACA—such as the American Health Care Act (AHCA), which passed the House of Representatives on May 4, 2017—could cause millions of people to lose MH/SUD coverage and the parity protections of the MHPAEA.

Introduction

In recent years, bipartisan support for expanded MH/SUD treatment has grown along with the recognition that these health conditions should be covered like other medical conditions in health insurance programs and not subject to higher financial or treatment barriers. Congress first addressed mental health coverage restrictions in private insurance in the Mental Health Parity Act of 1996. That law required large employer-sponsored health plans to offer comparable annual and lifetime dollar limits for medical and mental health benefits when the latter were offered as part of an insurance package. The Mental Health Parity Act applied only to MH benefits, not SUD benefits, and did not require plans to cover MH benefits. It also exempted health plans from the parity requirement if the cost of compliance was at least 1 percent more than the original cost of coverage.

In 2002, President George W. Bush created the New Freedom Commission on Mental Health to identify barriers to obtaining mental health services, including the stigma surrounding mental illness and the "unfair" treatment limitations and financial requirements placed on mental health benefits in private insurance. The commission's final report stated, "Understanding that mental health is essential to overall health is fundamental for establishing a health system that treats mental illnesses with the same urgency as it treats physical illnesses."[2]

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) included the 1996 law's requirement that large group plans offer comparable annual and lifetime dollar limits for medical and mental health benefits and extended these protections to SUD treatment. The MHPAEA also significantly expanded parity protections for large-group employer-sponsored insurance (ESI) to other financial requirements, such as enrollee out-of-pocket costs, and to quantitative and nonquantitative treatment limitations for medical care and MH/SUD care. Like the 1996 law, the MHPAEA did not mandate coverage of MH/SUD benefits, but required parity if a plan included them. The MHPAEA exempted plans that would incur an increased cost of at least 2 percent to comply with the parity requirements in the first year, or at least 1 percent in any subsequent year.[3]

Also in 2008, Congress enacted the Medicare Improvements for Patients and Providers Act, which eliminated higher

co-payments for outpatient MH/SUD services in Medicare Part B. In 2009, Congress adopted the Children's Health Insurance Program Reauthorization Act (CHIPRA), which applied the MHPAEA to the Children's Health Insurance Program (CHIP).[4]

In 2009, before the ACA was adopted, an estimated 2 percent of people with ESI had no coverage for MH benefits, and 7 percent had no coverage for SUD benefits.[5] The MHPAEA provided protections to the remaining people with ESI who had coverage for these services in the large group market. However, coverage of MH/SUD services in the individual market was much more limited. Approximately one-third of people in the individual market had no coverage for SUD, and nearly 20 percent had no coverage for MH services, including outpatient therapy and inpatient crisis intervention and stabilization.[6] Those who had some MH/SUD coverage in the individual market had no parity protections for those services, and those benefits were typically very limited. According to data from 2008 to 2013 analyzed by the Government Accountability Office (GAO), approximately 17 percent of ***low-income uninsured adults*** (3 million people) had a serious mental illness, substance use condition, or both.[7]

The ACA was enacted in this coverage environment. It substantially expanded coverage to previously uninsured Americans and extended the parity protections of the MHPAEA to the individual market and to low-income adults covered through the ACA Medicaid expansion.[8] The ACA went further than earlier legislation, requiring coverage of MH/SUD benefits in nongrandfathered individual and fully insured small group plans and in Medicaid alternative benefit plans, the health plans for the Medicaid expansion population.[9] Under these types of coverage, health plans must include MH/SUD treatment as one of ten categories of essential health benefits (EHBs). These plans also are required to include prescription drug benefits, which are critical for many people with mental illness and SUDs. U.S. Department of Health and Human Services regulations on EHB requirements also applied the protections of the MHPAEA to nongrandfathered plans in the small group market.[10]

The EHB requirement ***combined*** with the extension of the MHPAEA to individual and small group plans and Medicaid alternative benefit plans ensures that millions of previously uninsured Americans now receive MH/SUD benefits ***with*** the parity protections once available only to people in large group ESI plans.

Through these provisions, the ACA substantially increased MH/SUD coverage both in the private insurance market and in Medicaid. Table 1 shows how Congress has expanded the scope of parity protections in the private insurance market since 1996.

The ACA Medicaid expansion has increased access to behavioral health care in the United States. According to the GAO, Medicaid was the largest source of public funding for behavioral health treatment in 2014.[7] Of the estimated 3 million low-income uninsured adults who had a behavioral health condition before the Medicaid expansion, more than half lived in states that had expanded Medicaid as of February 2015.[11] Under the ACA and regulatory guidance from the Centers for Medicare & Medicaid Services (CMS), the MHPAEA applies to alternative benefit plans offered to Medicaid expansion enrollees under the ACA.[12,13] In 2016, CMS issued a final rule that established standards for applying the MHPAEA to alternative benefit plans, Medicaid plans offered by Medicaid managed care organizations, and CHIP.[14]

How Essential Health Benefits and Parity Protections Increase Access to Health Care for People With a Mental Illness or Substance Use Disorder

MHPAEA parity protections apply to financial and treatment provisions of insurance plans. Combined with ACA essential health benefit requirements and limits on annual and lifetime costs in individual and small group plans,

Table 1: Federal Parity Protections for Mental Health and Substance Use Disorder Benefits in the Private Insurance Market

Federal law	Year enacted	Types of benefits included	Plan provisions subject to parity requirements	Plans included
Mental Health Parity Act	1996	MH only	Annual and lifetime dollar limits only	Large employer-sponsored group health plans
Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA)	2008	MH and SUD	Annual and lifetime dollar limits, other financial requirements, quantitative and nonquantitative treatment limits	Large employer-sponsored group health plans
Affordable Care Act	2010	MH and SUD	Same as MHPAEA	Individual (nongroup) plans*
Affordable Care Act EHB regulations	2013	MH and SUD	Same as MHPAEA	Nongrandfathered small employer-sponsored group health plans

Sources: Mental Health and Substance Use Disorder Parity Task Force. Final Report. Washington: US Dept of Health and Human Services; 2016. https://www.hhs.gov/sites/default/files/mental-health-substance-use-disorder-parity-task-force-final-report.pdf. Department of Health and Human Services, Final Rule, Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation. 45 C.F.R. parts 147, 155, and 156. 78 Fed. Reg. 12834 (February 25, 2013). https://www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf.

Notes: EHB = essential health benefits; MH = mental health; SUD = substance use disorder.

**Under the ACA, the MHPAEA applies to both grandfathered and nongrandfathered individual plans, but because grandfathered individual plans are not required to provide essential health benefits, MHPAEA protections only apply if grandfathered plans include MH/SUD benefits.*

people who are currently covered by nongrandfathered individual and small group plans have the following protections:[15]

- Coverage of MH/SUD benefits and prescription drugs as part of ACA essential health benefits.
- No lifetime or annual dollar limits on MH/SUD services (or on any other essential health benefits).
- Patient out-of-pocket costs (e.g., deductibles, co-payments, and coinsurance) for MH/SUD care cannot be more restrictive than those for medical care within the same general classification of benefits, and cumulative financial requirements within each classification must include both medical and MH/SUD services. The six classifications of benefits are:
  - » Outpatient in-network
  - » Outpatient out-of-network
  - » Inpatient in-network
  - » Inpatient out-of-network
  - » Emergency care
  - » Prescription drugs
- Quantitative treatment limitations (e.g., limits on the number of days for inpatient coverage or on the number of visits to a provider) cannot be more restrictive than those for medical care within each of the six classifications.
- Nonquantitative treatment limitations (e.g., medical management, step therapy, and pre-authorization requirements) for MH/SUD benefits must be comparable to and applied no more stringently than such limitations for medical benefits, within each of the six classifications.
- MH/SUD benefits may not be subject to any separate cost-sharing requirements or treatment limitations that only apply to such benefits.
- If a plan provides for out-of-network medical benefits, it must provide for out-of-network MH/SUD benefits.
- Plan standards limiting the scope or duration of benefits (e.g., geographic or facility type limits or network adequacy standards) for MH/SUD benefits must be comparable to and applied no more stringently than those for medical benefits.
- Criteria for medical necessity determinations and reasons for any denial of benefits for MH/SUD services must be provided upon request.

These parity protections help ensure that consumers receive meaningful MH/SUD coverage and that these benefits are comparable to and not subject to more restrictive financial and treatment limitations than medical benefits.

Millions of People Are at Risk of Losing Coverage and Parity Protections for Mental Health and Substance Use Disorder Treatment Under Proposed ACA Repeal-and-Replace Measures

Everyone currently covered through the Medicaid expansion and the individual and fully insured small group markets is at risk of losing MH/SUD benefits and MHPAEA parity protections if Congress repeals and replaces the ACA. The Trump administration and congressional Republican leadership announced a three-step plan to repeal and replace the ACA: (1) use of the budget reconciliation process to repeal and replace certain provisions of the ACA; (2) significant deregulation efforts by the administration; and (3) legislation that budget reconciliation (under current rules) cannot address.[16]

On May 4, 2017, after several months of negotiation and numerous amendments, the U.S. House of Representatives passed the American Health Care Act, which would dramatically alter the ACA. Though it is unclear what will happen to the AHCA in the Senate, several provisions of the current bill could have a major impact on MH/SUD coverage and benefits.[17] The AHCA would allow states to waive EHB requirements in the individual and small group markets. Parity protections only apply to plans that offer MH/SUD benefits, so if EHB requirements are eliminated, states request the waiver, and insurers choose not to cover MH/SUD benefits, then the parity provisions alone would offer no access to coverage for mental illness or substance use disorder treatment.[18]

The AHCA would also phase out enhanced federal funding for the Medicaid expansion, eliminate the EHB requirement for Medicaid alternative benefit plans, and change Medicaid from an open-ended matching grant program to a block grant or per capita cap program under which federal funding for Medicaid would grow more slowly than under current law.[19]

The AHCA would eliminate cost-sharing subsidies and replace income-based tax credits with fixed age-based tax credits that would not be available to higher-income consumers. Finally, the bill would allow states to seek additional waivers enabling insurers to charge people higher premiums based on their health status if they experienced a gap in insurance coverage. These provisions could make private insurance unaffordable for many consumers who need MH/SUD treatment.

Some legislative action will be necessary to eliminate EHBs in the private insurance market. The ACA requires that health plans offered in the individual and fully insured small group markets include the essential health benefits package.[20] Although the ACA gives the Secretary of Health and Human Services significant authority to implement the EHB requirement, it also provides that he or she "shall ensure that the scope of the essential health benefits under paragraph (1) is equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary."[21] Because employer plans typically provided coverage for MH and SUD benefits before the ACA, any effort to eliminate MH/SUD coverage through regulatory action alone would likely meet with legal challenges.

Depending on the outcome of ACA repeal-and-replace efforts, the administration could initiate new rulemaking for essential health benefits and alter or eliminate the

extension of the MHPAEA to the small group market. Similarly, it may seek to amend the rule applying the MHPAEA to alternative benefit plans, Medicaid managed care, and CHIP. Whether the administration could succeed in doing so and whether such efforts would be subject to legal challenge is beyond the scope of this analysis.

Conclusion

Parity protections were developed to address significant health plan limitations on MH/SUD services. Before the MHPAEA was implemented, nearly two-thirds of people with ESI had special limits on inpatient behavioral health coverage, and three-quarters had limits on outpatient behavioral health coverage.[5] The Affordable Care Act provides coverage and parity protections for mental illness and substance use disorder treatment to millions of Americans, many of whom were previously uninsured. The elimination of any essential health benefits requirement likely would cause many, if not all, affected insurers to stop offering that benefit or to charge significantly more to include that benefit. Under the AHCA, states also might redefine the scope of MH/SUD benefits included in the EHB requirements, for example, by eliminating inpatient but not outpatient MH/SUD benefits or by eliminating SUD benefits but not MH benefits. Either approach would diminish access to the services newly excluded or limited, making necessary care unaffordable for many. Congress also could repeal the ACA provisions that extend MHPAEA parity protections to the individual market and to Medicaid alternative benefit plans for those plans that still offer MH/SUD benefits. But federal regulatory action alone will not eliminate those benefits and parity protections. The ACA filled a significant gap in MH/SUD coverage and, by extending parity protections to those benefits, helped eliminate financial and treatment barriers to MH/SUD services. Repealing and replacing the ACA could reverse the decades-long effort to reduce historical disparities in the treatment of mental illness and substance use disorders.

NOTES

1 In this paper, the term "medical" refers to both medical and surgical benefits and services.

2 President's New Freedom Commission on Mental Health. *Achieving the Promise: Transforming Mental Health Care in America*. Washington: Substance Abuse and Mental Health Services Administration; 2003. http://govinfo.library.unt.edu/mentalhealthcommission/reports/FinalReport/FullReport-1.htm.

3 42 U.S.C. § 300gg-26(c)(2).

4 For a summary of the legislative history of federal parity efforts, see: Mental Health and Substance Use Disorder Parity Task Force. *Final Report*. Washington: US Dept of Health and Human Services; 2016. https://www.hhs.gov/sites/default/files/mental-health-substance-use-disorder-parity-task-force-final-report.pdf.

5 Frank RG, Beronio K, Glied SA. Behavioral health parity and the Affordable Care Act. *J Soc Work Disabil Rehabil*. 2014;13(0):31–43. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4334111/.

6 Beronio K, Po R, Skopec L, Glied S. *Affordable Care Act Will Expand Mental Health and Substance Use Disorder Benefits and Parity Protections for 62 Million Americans*. Washington: Office of the Assistant Secretary for Planning and Evaluation; 2013. https://aspe.hhs.gov/system/files/pdf/76591/rb_mental.pdf.

7 Government Accountability Office. *Behavioral Health: Options for Low-Income Adults to Receive Treatment in Selected States*. Washington: Government Accountability Office; 2015. http://www.gao.gov/products/GAO-15-449.

8 Two sections of the ACA apply the MHPAEA to the individual market: section 1311(j) (affordable choices of health benefit plans) and section 1563(c)(4) (conforming amendments), codified at 42 U.S.C. § 300gg-26(a) (parity in mental health and substance use disorder benefits). ACA section 2001(c)(3) requires MHPAEA compliance in plans offered to people covered under the Medicaid expansion by entities that are not Medicaid managed care organizations.

9 The statutory language in the ACA applied to benchmark benefit and benchmark equivalent packages, but CMS uses the term "alternative benefit plans" to encompass both in its rulemaking. See 42 C.F.R. parts 438, 440, 456, and 457. 81 Fed. Reg. 18390 (March 30, 2016). https://www.federalregister.gov/documents/2016/03/30/2016-06876/medicaid-and-childrens-health-insurance-programs-mental-health-parity-and-addiction-equity-act-of.

10 Department of Health and Human Services, Final Rule, Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation. 45 C.F.R. parts 147, 155, and 156. 78 Fed. Reg. 12834 (February 25, 2013). https://www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf.

11 The GAO report included state-by-state estimates of low-income uninsured adults with behavioral health conditions. In March 2016, the Office of the Assistant Secretary for Planning and Evaluation published an analysis showing that approximately 1.9 million uninsured people who had a mental illness or SUD and had incomes below 138 percent of the federal poverty level lived in states that had not expanded Medicaid: Dey J, Rosenoff E, West K, et al. *Benefits of Medicaid Expansion for Behavioral Health*. Washington: Office of the Assistant Secretary for Planning and Evaluation; 2016. https://aspe.hhs.gov/system/files/pdf/190506/BHMedicaidExpansion.pdf.

12 Patient Protection and Affordable Care Act, section 2001(c)(3).

13 Mann C. Letter to state health officials and state Medicaid directors on application of the Mental Health Parity and Addiction Equity Act to Medicaid MCOs, CHIP, and alternative benefit (benchmark) plans. Baltimore: Centers for Medicare & Medicaid Services; 2013. https://www.medicaid.gov/federal-policy-guidance/downloads/sho-13-001.pdf.

14 Centers for Medicare & Medicaid Services, Final Rule, Medicaid and Children's Health Insurance Programs; Mental Health Parity and Addiction Equity Act of 2008; the Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children's Health Insurance Program (CHIP), and Alternative Benefit Plans. 81 Fed. Reg. 18389 (March 20, 2016). https://www.federalregister.gov/documents/2016/03/30/2016-06876/medicaid-and-childrens-health-insurance-programs-mental-health-parity-and-addiction-equity-act-of.

15 For a summary of MHPAEA protections, see: The Mental Health Parity and Addiction Equity Act (MHPAEA). Center for Consumer Information & Insurance Oversight website. https://www.cms.gov/cciio/programs-and-initiatives/other-insurance-protections/mhpaea_factsheet.html. The final rule applying the MHPAEA to the large group and individual markets can be found at 45 C.F.R. parts 146 and 147 (https://www.gpo.gov/fdsys/pkg/FR-2013-11-13/pdf/2013-27086.pdf). This paper summarizes the specific provisions governing the private insurance market. Medicaid is structured differently than private insurance, so its parity protections are applied differently in some respects. The final rule applying the parity protections of the MHPAEA to Medicaid and CHIP can be found at 42 C.F.R. parts 438, 440, 456, and 457 (https://www.federalregister.gov/documents/2016/03/30/2016-06876/medicaid-and-childrens-health-insurance-programs-mental-health-parity-and-addiction-equity-act-of).

16 The American Health Care Act. House Republicans website. https://housegop.leadpages.co/healthcare/.

17 Jost T. House passes AHCA: how it happened, what it would do, and its uncertain Senate future. Health Affairs Blog. Posted May 4, 2017. http://healthaffairs.org/blog/2017/05/04/house-passes-ahca-how-it-happened-what-it-would-do-and-its-uncertain-senate-future/.

18 An amendment to the AHCA added funding to cover maternity and MH/SUD care in a federally run "Patient and State Stability Fund," but states would have to apply for the funding.

19 Holahan J, Buettgens M, Pan CW, Blumberg LJ. *The Impact of Per Capita Caps on Federal and State Medicaid Spending.* Washington: Urban Institute; 2017. http://www.urban.org/sites/default/files/publication/89061/2001186-the_imapct-of-per-capita-caps-on-federal-spending-and-state-medicaid-spending_2.pdf.

20 42 U.S.C. § 300gg-6(a).

21 42 U.S.C. § 18022(b).

The views expressed are those of the author and should not be attributed to the Robert Wood Johnson Foundation or the Urban Institute, its trustees, or its funders.

ABOUT THE AUTHORS & ACKNOWLEDGMENTS

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Pre existing conditions before the Affordable Care Act

Meredith Miller

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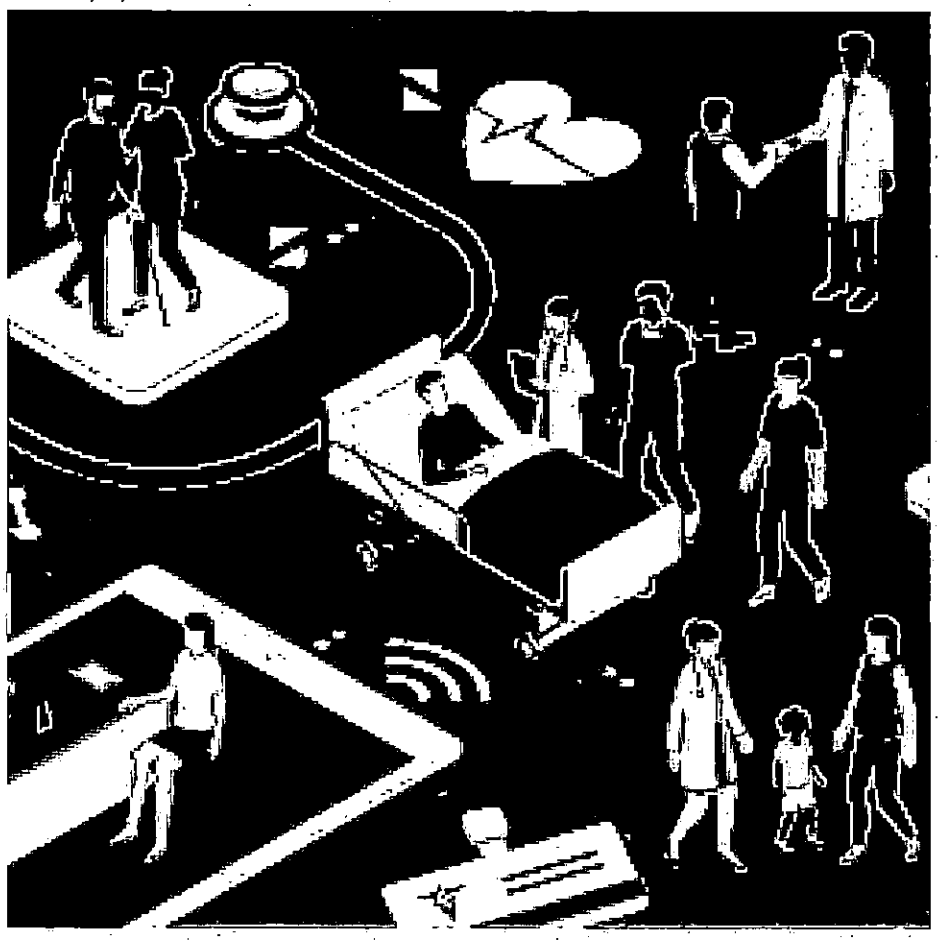

In the news recently, you have probably been hearing a lot of pre existing conditions in reference to health insurance. Currently, the GOP is trying to repeal and replace the Obama-era healthcare act known as the Affordable Care Act. They plan to replace it with the American Health Care Act, popularly referred to as Trumpcare. Because of this, many Americans are concerned about what will happen to their health insurance if they have a pre existing condition like diabetes, obesity, or pregnancy. At the moment, the ACA offers protections to those with pre existing conditions. However, this was not always the case. Let's take a look at what obtaining health insurance was like before Obamacare was enacted.

Before the ACA

In 2010, President Obama passed the Affordable Care Act. Before this, it was up to states and insurance companies to set regulations about pre existing conditions. Unfortunately, during this time, many insurance companies denied coverage to those with this type of condition. They also charged them higher premium rates and could offer coverage for everything except the pre existing condition. Companies were also allowed to use an annual or lifetime cap on coverage. This meant that people with chronic conditions that required expensive treatment could run out of insurance quickly. This often left them with large and unmanageable medical bills.

Many states in the country allowed insurance companies to do this and did not provide coverage for pre existing conditions. These states used exclusion periods and elimination riders so they could avoid paying for people with pre existing conditions' health coverage. These regulations mainly applied to the individual health insurance market, not the group plans that many people join through their employer. In fact, many Americans did not even realize the individual market was different until they lost their jobs and their group coverage. A loss of group coverage meant paying the entire premium without an employer subsidy. This made it difficult to find affordable health insurance and many were priced out of affording healthcare because of a pre existing condition.

Pre Existing Conditions

Every HMO had their own list of pre existing conditions that could possibly trigger denial or higher premiums. Insurance companies also employed hundreds of underwriters whose only job was to make decisions about whether or not an applicant was suitable for coverage. If they felt an applicant would be a risk, they mailed out a rejection letter.

During the health care reform debate, Congress led an investigation into this practice. It uncovered that more than 400 medical conditions or diagnoses were used to justify a denial of coverage. Some of the conditions on the list included:

- Cancer
- Diabetes
- Hepatitis
- Mental Disorders
- Pregnancy
- And many more

This investigation only surveyed four large insurers and covered a three year period from 2007 to 2009. These four companies alone denied health coverage to 651,000 individuals because of pre existing conditions. This translates to one in seven people who applied for health insurance. The investigation also found that the number of denials increased year after year.

The Present and the Future of Healthcare

At this moment, the ACA is still in effect. This act includes provisions that prevent this sort discrimination. An HMO cannot charge more or refuse to cover an individual with a pre-existing condition. However, thanks to Trumpcare, health care could return to its pre-Obamacare regulations. The AHCA would once again give states the power to decide whether or not health insurance must be provided to individuals with pre existing conditions. It is likely that states who denied coverage to people with this type of condition before the Affordable Care Act would likely do it again.

Additionally, there is speculation that even more ailments would be included on the already long list of pre existing conditions. In addition to pregnancy, cancer, and other conditions, the new healthcare bill could leave an HMO open to denying coverage for ailments like acne, asthma, and depression. There is a good chance that even more people would be unable to find affordable health care if the AHCA does pass into law.

The best thing you can do right now is to find the best affordable health insurance for your needs. Visit First Quote Health to see health care quotes for your area and learn more about finding affordable health insurance.

DELTA DENTAL

NortheastDeltaDental.com

February 5, 2019
The Honorable Tom Sherman, Chair
Senate Health and Human Services Committee
107 North Main St.
Concord, NH 03301

RE: Written testimony to SB4

I am Alexandra Sosnowski, a staff attorney at Northeast Delta Dental.

This testimony is offered as a technical amendment to proposed Senate Bill 4. Specifically, the new paragraph under RSA 420-G:4-d, II regarding Essential Health Benefits. This section would require health carriers to offer the Affordable Care Act's (ACA) ten essential health benefits to individuals and small employers in the state and allows the commissioner to define the essential health benefits if the ACA no longer provides for the benefits. One of the ten Essential Health Benefits under the ACA is the pediatric dental benefit.

This technical amendment is intended to mirror the current federal ACA and New Hampshire Department of Insurance guidance regarding the pediatric dental benefit. Current federal provisions of the ACA, allow a health carrier to meet the pediatric dental benefit in conjunction with a stand-alone dental plan. Specifically, for health coverage sold through an Exchange, a health plan may be certified as a qualified health plan if the plan does not cover pediatric dental services if there is a certified stand-alone dental plan covering the those services is available on the Exchange. 42 U.S.C. § 18022(b)(4)(F).

Additionally, through federal rulemaking, the Department of Health and Human Services provides that a health carrier meets its obligation of offering the pediatric dental benefit outside an Exchange, if it obtains reasonable assurance that such individual has obtained the pediatric dental benefit. The New Hampshire Department of Insurance has further defined "reasonable assurance" through Department Bulletin INS. NO. 13-039-AB.

Northeast Delta Dental offers federally compliant stand-alone dental plans, which include the pediatric dental benefit on the Exchange. We cover nearly 3,000 people through our plans on Healthcare.gov. Additionally, we offer stand-alone dental plans off the federal exchange, covering more than 13,000 people, including individuals and families.

The purpose of this bill is to ensure New Hampshire consumers receive the ten essential health benefits should the federal government cease to define them. This proposed amendment ensures this bill mirrors the current federal law and state guidance

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regarding the pediatric dental benefit. It clarifies that carriers and consumers can continue to choose to meet the pediatric dental benefit through a stand-alone dental plan.

We have reached out to the Department of Insurance regarding our proposed language. I have copies of the proposed language and the Insurance Department's bulletin for reference. I am happy to answer any questions.

Thank you for your time and consideration.

Alexandra Sosnowski, Esq.
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State Pharmaceutical Assistance Programs

6/1/2016

Updated 2014; material added January 2016

Prescription drug assistance has been a substantial and growing state interest for a number of years, generally in response to residents who lack insurance coverage for medicines or who were not eligible for other government programs. In fact, the first states to authorize and fund direct subsidy programs did so in 1975. Between 2000 and 2006 at least 26 states authorized and/or started pharmaceutical assistance programs, many intended to aid low-income elderly or persons with disabilities who do not qualify for Medicaid. By 2009, a total of at least 42 states had established or authorized some type of program to provide pharmaceutical coverage or assistance; several of those are not currently operational. The subsidy programs, often termed "SPAPs," utilize state funds to pay for a portion of the costs, usually for a defined population that meets enrollment criteria. In addition, an increasing number of states use discounts or bulk purchasing approaches that do not spend state funds for the drug purchases, listed as "Discount Programs" below. Since the passage of the federal Affordable Care Act (ACA), state legislatures have been less active on SPAP issues.

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Contact

- Health department

CHANGING NUMBERS AND FEATURES:

- 38 states enacted laws over the past 30 years to create SPAP programs; others were created by executive branch action only.
- For 2015-16, 22 states had 40 state subsidy programs certified by CMS/HHS as supplementing Medicare or as "SPAPs" as of for the purpose of determining whether the state-administerd programs were exempt or excluded from calculations of "Medicaid Best Price." This calculation does not constitute federal regulation of these SPAPs.
- 22 operational programs provide for a direct subsidy using state funds; in the past five years a high point of 36 states' laws (plus DC) authorized such subsidies. Iowa has a temporary program that may close when funds are exhausted.
- 27 states created or authorized programs that offer a discount only (no subsidy) for eligible or enrolled residents; of these about 16 are in operation. The latest are in Florida and Iowa, starting in 2008. Some of these states also have a separate subsidy program.
- Several programs ceased operation: North Carolina ended its subsidy program in 2011; South Carolina closed its subsidy program in 2010; Arizona closed its subsidy program 2009. Five others closed in January 2006, replaced by Medicare Part D plans. These include Florida, Kansas, Michigan, Minnesota and North Carolina, plus discount plans in Arkansas and South Carolina. Recent but no-longer-operational programs are listed below., with details in an offline NCSL Rx Archive Appendix for comparative and historical reference.

This report contains four sections:
Rx Summary Chart | Federal reform law | State Subsidy Programs (Table 1) | State Discount Programs (Table 2)

Federal Health Reform: Pharmaceutical Assistance Features

The Affordable Care Act (ACA) law enacted in 2010 includes the following provision:

Closing the Medicare prescription drug "donut hole." Sec. 1101. [updated October 2015]

For 2015 the ACA provides a 55 percent discount for enrollee purchases of brand name pharmaceuticals once they reach the Medicare prescription drug "donut hole" and a separate 35 percent discount on generic drugs.

By comparison, in 2011-2012, the ACA provided a 50 percent discount for enrollee purchases of brand name pharmaceuticals once they reach the Medicare prescription drug "donut hole".

For calendar year 2010 the law provided a $250 rebate for all Medicare Part D enrollees who enter the donut hole in 2010.

The Medicare "coverage gap" or "donut hole" in 2013-2015 started at $2,970 and continues up to $6,733.75 measured on a calendar year basis, with a maximum out-of-pocket per person of $4,750.). In 2016, the coverage gap moves upward: once the enrollee and the Part D insurance plan have spent $3,310 on covered drugs.

The Effect on Certain States: Although Medicare itself is a federal-only program, about 20 states administer an optional subsidy program that wraps-around or adds to the federal benefit. As of 2011, the following 14 states already authorize covering parts or all of this donut hole: **Connecticut, Delaware, Illinois, Maine, Maryland, Massachusetts, Nevada, New Jersey, New York, Pennsylvania, Rhode Island, Vermont and Wisconsin.** The federal $250 annual subsidy increase in 2010 had a small, incremental effect in these states, lowering the state subsidy expenditure for certain individuals. Overall state budget impact in 2011 and beyond will require calculations based on level of use by current state program enrollees, plus estimates of any new enrollees.

Previous years history: The Medicare Pharmaceutical Benefit: The federal law establishing Medicare prescription drug benefits, often termed "Part D," became fully operational on January 1, 2006. The Part D program, based on a network of private insurers, has had a sweeping impact on most of the state "SPAP" programs and the people they serve. Most states that had been paying for nearly 100 percent of drug subsidies chose to shift some or all of their programs to provide a supplemental or "wrap around" benefit, so that Medicare-eligible enrollees would receive "primary" coverage through a Part D Prescription Drug Plan, regulated and funded under federal law. These states converted their efforts to "secondary, wrap around coverage," most often paying for some or all of the required enrollee share of:

- **monthly premiums**
- **co-insurance or co-payments** (up to 25% of purchase price)
- **annual deductibles**
- **the "coverage gap" or "donut hole"** for 2016 [link to explanation]), starts at $3,310 and continues up to $6,733.75, with a maximum out-of-pocket of $4,750) The enrollees pay 45% of brand-name drugs and 58% of generics.
- > 2016 Part D Donut hole calculator and plan choices

ARCHIVE STATISTICS:

The Part D "base beneficiary premium" for 2011 was $32.34 (an increase from $30.36 in 2009) according to the Centers for Medicare and Medicaid Services. The national average monthly bid amount for 2011 is $87.05 (an increase from $84.33 in 2009). Medicare Part D beneficiaries remain in the Donut Hole until their true out of pocket costs exceeds $4,550. The $4,550 does not include the portion of your prescription expenses paid by the insurance carrier or your monthly premiums. 2015 Enrollment in Medicare Part D prescription plans will be open from October 1, 2014 to December 7, 2011.

NOTE: The actual Part D premiums paid by individual beneficiaries equal the base beneficiary premium adjusted by a number of factors. In practice, premiums vary significantly from one Part D plan to another and seldom equal the base beneficiary premium. [CMS Memorandum, 8/14/2008]

The commercial Part D Prescription Drug Plans (PDPs) are allowed considerable variation in their Medicare enrollee charges, so states' roles and contributions also may vary.

State Pharmaceutical Assistance Programs Excluded from Medicaid Best Price - The Medicaid statue allows manufacturers participating in the Medicaid Drug Rebate Program to exclude prices to State pharmaceutical assistance programs (SPAPs) from their Medicaid Best Price calculations. This allows these state-only programs to obtain highly favorable prices without affecting the Medicaid price itself or the private sector market. The Centers for Medicare & Medicaid Services (CMS) has compiled a list of programs that meet the criteria to be considered SPAPs, titled Medicaid SPAP Best Price List. published in 2014 and valid for 2015. Please note that this list only includes states that submitted a description of their programs to CMS for review based on the established criteria in CMS' Manufacturer Release No. 68 [PDF]. *[Accessed 10/10/2015]*

Medicare Savings Program (MSPs) -As described by HHS/CMS , "There are programs that help millions of people with Medicare save money each year. States have programs for people with limited income and resources that pay some or all of Medicare's premiums and may pay Medicare deductibles and coinsurance. 50-state table posted by

Medicare.gov." *[accessed 10/10/15]*

State Discount Programs

Beginning in 1999, a gradually growing number of states established prescription drug discount programs, sometimes termed "Rx Buying Clubs" or Discount Cards. These state-sponsored efforts differ from the "SPAPs" or subsidy plans in at least two ways: Discount programs do not use state or federal funds to actually pay for pharmaceuticals. Instead they generally rely on the large-volume purchasing power of the state, to negotiate a sizable discount on a wide selection of prescription products, brand and generics. A majority of such programs have contracted with a management firm such as a pharmaceutical benefit manager (PBM) to handle the negotiations over price. The consumer still pays the resulting discounted price at the pharmacy counter, and the state is not involved in the individual transactions. Unlike most subsidized SPAP programs, there is no comparable federal program or federal regulation affecting these discount plans. Drugs purchased in this way do not count as part of Medicare or Part D calculations. In the past three years, a growing number of states have emphasized serving residents under age 65, the population segment not eligible for Medicare or Part D. In Table 2 below, this report describes about 19 operational state discount programs and another 10 that are not currently operational.

Special, Limited Eligibility SPAPs

Under the legal authority of the federal Medicare law, the definition of SPAP allows certain limited-function state programs to be treated as "Qualified SPAPs." Usually these program only serve individuals with a single diagnosed medical condition, and they often provide benefits beyond just pharmaceuticals. Examples include: California Genetically Handicapped Persons Program, Colorado Ryan White Aids Drug Assistance Program, Idaho IDAGAP Aids Drug Assistance Program, Texas Kidney Health Care Program, and Virginia HIV/Aids SPAP. These single-disease health programs are mentioned or listed as "special" in this report but may not be tallied equally with the major, open-enrollment pharmaceutical assistance programs.

LEGISLATIVE HISTORY:

2011 Highlights: North Carolina's NCRx subsidy program ended June 2011.

2010 Highlights: The South Carolina Gap Assistance Prescription Program for Seniors closed, due to lack of state funds, on July 1, 2010. The Oklahoma Prescription Drug Discount Program ended September 2010. The Hawai'i Rx Plus discount card program for prescription drug medications was discontinued on August 1, 2010.

2009 Highlights: The West Virginia Rx subsidy program became operational. The Arizona subsidy program closed effective March 1, 2009 due to funding issues. Iowa launched a temporary subsidy program in the fall, using court settlement funds; it may close when funds are exhausted. Colorado Senate Bill 132 repealed Colorado Cares Rx discount program on February 23, 2009.

2008 Highlights: Colorado Cares Rx became operational February. Florida's discount program began in January. WisconsinCare began a Medicare wrap around benefit in January.

2007 Highlights: Colorado enacted a discount program for uninsured residents in January. Delaware extended their subsidy "DPAP" program, allowing applicants to obtain prescription drug coverage through the state while the applicant pursues Medicare Part D enrollment. Florida launched Florida Discount Drug Card effective January 1, 2008. Maine enacted additional Part D state consumer protections for seniors. Maryland now requires a person to enroll in a specific prescription drug plan or Medicare Advantage Plan in order to get state wrap around benefits. Washington reaffirmed a Part D wrap around program begun in mid-2006 and re-launched an expanded discount plan in mid-March. The Wisconsin SeniorCare program, by special act of Congress in May 2007, is allowed to continue using its Pharmacy+ waiver for federal matching funds instead of transferring enrollees into Part D plans. See NCSL's 2007 Prescription Drug Legislation report.

2006 Highlights: Arizona created a benefit for Medicare dual-eligibles to cover 100% of the patient co-payment. California is providing coverage for drugs not included on the Medicare full-benefit dual eligible beneficiary's prescription drug plan's formulary and separately enacted a discount program for residents of any age up to 300% FPL or with Rx expenses at least 10 percent of annual income. Illinois expanded SPAP coverage to residents with HIV/AIDS. New Jersey and Pennsylvania enacted comprehensive wrap around features for their state subsidy programs. South Carolina redesigned their subsidy program to focus on Medicare gap coverage for expenses over $2,250 annually. Washington launched a first-time subsidy program covering the prescription drug co-payments for over 100,000 dual-eligible low-income elderly and disabled individuals. North Carolina re-created a limited subsidy wrap around program, covering premiums up to $216 /year. Nevada added eligibility for persons with disabilities. Kansas launched a discount plan for residents not eligible for Medicare or other funded assistance. Tennessee created CoverRX, a prescription drug plan that targets uninsured and poor residents, effective January 2, 2007.

As of December, 2009, 30+ states, including Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Hawaii, Illinois, Indiana, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Vermont, Virginia and Washington - had enacted laws or resolutions responding to or adjusting to the Medicare Rx law provisions.

The 2015 Federal Poverty Guidelines, often termed the federal poverty level (FPL), were released Jan. 23, 2015. The guideline for an individual is $11,770. For a married couple or 2-person household the 2014 figure is $15,930. Higher figures apply for Alaska and Hawaii.

SUMMARY OF STATE PHARMACEUTICAL ASSISTANCE PROGRAMS

KEY: = Operational | = Not Operational
Dates indicate earliest enacted law. Click on Rx button for details

ARCHIVE NOTICE: Most descriptions published below have not been updated since 2012 and should be used for reference or comparative purposes only.

State	CMS Approved SPAP-2015*	Subsidy Program	State Medicare Wrap Around	Discount Program	Notes
Alabama		n/a			
Alaska		2004	2006		
Arizona		2001	2006	2003	see 2007 change
Arkansas		2001		2005	subsidy ended 2/09
California	(2)	Limited Eligibility	1975	00 06	
Colorado		Limited Eligibility	2009	2007	discount program repealed 2/23/2009
Connecticut	(2)	1986	2005	2000	
Delaware	(4)	2000	2005		description updated 2015
Florida		2000-05	2005	2000, 2008	program ended 12/31/2005
Georgia					
Hawaii		2005	2005	2002	
Idaho		Limited Elgibility	2006		
Illinois		1985	2005	2005	
Indiana		2000	2005		
Iowa		Limited	2009		restarted 6/08

		Eligibility			
Kansas		2000		2006	program ended 12/31/2005
Kentucky		2005	2005		
Maine		1975, 05	2006	2000	
Maryland	(4)	1979	2005	2001,06	
Massachusetts		1996, 02	2005, '06	1999, 05	
Michigan		1988-05			ended 12/31/05
Minnesota	(2)	1997-05			ended 12/31/05
Mississippi		n/a			
Missouri		1999	2005		
Montana		2005	2005	2005	
Nebraska					
Nevada	(3)	1999	2005		
New Hampshire		2006		2000	
New Jersey	(4)	1975	2005		
New Mexico		2003		2002, '05	
New York		1987	2005		
North Carolina		1999	2006		subsidy program NCRx was mandated to end June 2011
Ohio				2002	
Oklahoma				2005	program ended September 2010
Oregon		Limited Eligibility		2003,06	
Pennsylvania	(4)	1984	2006		
Rhode Island		1985	2006	2004	
South Carolina		2006 - 10	2005	2003	subsidy program ended July 1, 2010
South Dakota				2003	program repealed 9/1/2004
Tennessee		2006		2006	
Texas	(2)	Limited Eligibility	2005		
Utah					
Vermont		1989	2005	2000	
Virginia		Limited Eligibility	2007		
Washington		06-07		2007	ended 6/30/07
West Virginia		2009	2009	2000	
Wisconsin	(4)	2001	2007		
Wyoming		1988			
DISTRICT / TERRITORIES					
District of Columbia				2004	
Virgin Islands			2005		

* State Pharmaceutical Assistance Programs are state-only entities, but CMS has compiled a 2014 "CMS list of programs that meet the criteria to be considered SPAPs." The limited consequence of this status is that pharmaceutical manufacturers are exempted from including the SPAPdiscounts from their "Medicaid Best Price" calculations.

MAP 1: Snapshot of State Rx Subsidy Programs (SPAPs), 2011

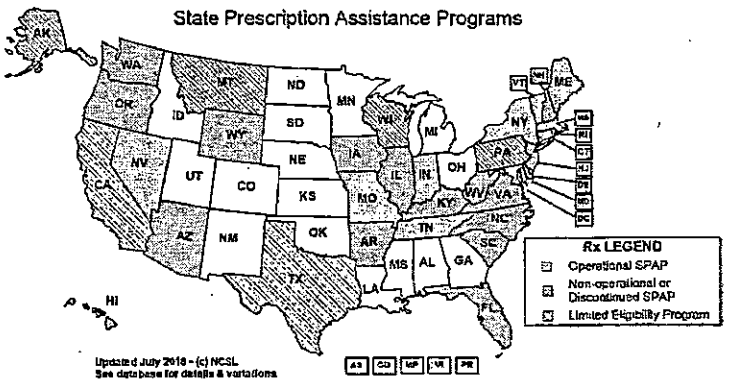


Table #1: **State Subsidy Programs** - provides brief details on each of the individual state programs, including citations and web links to state laws where available, year of creation, basic eligibility requirements and contact telephone numbers within each state for further details. Also see further explanations and notes in Recent Major State Actions, below.
Table #2: **State Discount Programs** - includes state-negotiated price reductions, discount cards and multi-agency purchase arrangements affecting segments of the public. Note that several states have more than one program.

Information is added to these charts when bills are passed. Further details for many states are included below under "Recent Major Actions".
Also see NCSL's other research reports:

- **Pharmaceuticals Overview** - recent activities and list of NCSL publications.
- **Recent Medicaid Prescription Drug Laws, 2001-14** - describes state Medicaid-only laws, not included in this report.

State Subsidy Programs - TABLE 1

ALASKA	The Senior Benefits Program
Alaska was one of six states to create a first-time pharmaceutical subsidy program after the enactment of the Medicare Part D benefit. As such, it was intended primarily as a supplemental, wrap around benefit, aimed only at residents aged 65 and over, with incomes up to 175% of Alaska's special FPL. The law authorized the state to pay premiums and deductibles toward Part D plan costs or toward equivalent insurance premiums. The program was revised, effective August 1, 2007, to provide cash benefits instead of a Medicare contribution.	
Eligibility, Fees	**The Senior Benefits Program started Aug. 1, 2007, serving residents up to age 65. The new cash benefit program for Alaska enrollees offers three different benefit levels based on annual income – See table under Benefits, below. The program no longer directly pays Medicare or insurance premiums. Enrollees receive a cash benefit, which many use for pharmaceutical coverage, but may now use for other needed purchases.**
Disabilities coverage	No coverage for residents under age 65.
Benefits	Senior Benefits Program Gross Annual Income Limit Effective 3/1/2011

Household:	$250 monthly payment	$175 monthly payment	$125 monthly payment
Individual	$10,200 ($850 per month)	$13,600 ($1,134 per month)	$23,800 ($1,984 per month)
Married Couple	$13,785 ($1,149 per month)	$18,380 ($1,532 per month)	$32,165 ($2,680 per month)

	Note: From 1/1/06 to 7/31/07 the SeniorCare Prescription Drug Assistance program covered annual premiums and deductible for Medicare Part D or comparable Prescription Drug Insurance; average value: $736. Income limits: $20,913 for an individual and $28,053 for a 2-person household. *(based on 2005 FPL, as of 1/1/06)*
Medicare wrap around	Yes; all state benefits are provided in coordination with federal Medicare. Qualified SPAP; payments count toward TrOOP. (as of July 1, 2007). The Senior Benefits Program funds spend on Rx should also qualify, but the program itself may not be considered qualified.
Est. # of beneficiaries	**7,112 enrolled in the Cash Assistance program ($120/month subsidy) as of 7/1/06. 122 enrolled in Prescription Drug Assistance program as of 7/1/06.**
State laws	Subsidy law initially enacted in 2004; Wrap around enacted in HB 106, as Chapter 89, signed August 8, 2005. 2007: SB 4 Extends the Senior Care cash assistance program, but repealed the existing stand-alone Rx wrap around benefit. Signed into law as 1st Special Session, Chapter 1, 8/2/07
Special features & issues	Parts of the SeniorCare program sunset in June 2007 unless extended by the legislature. Annual funding is subject to available funds and legislative appropriations. The separate Senior Care Prescription Drug Benefit Program ended July 2007.
Other Rx programs	SeniorCare Cash Assistance can be used for Medicare co-pays, non-covered Rx products, or non-health needs such as housing or food.
Contact & online information	Alaska Department of Health and Social Services: (907) 465-3030; Fax: (907) 465-3068 Senior Benefits Office: 1-888-352-4150 or (907) 352-4150; Fax: 907-357-2561 Web: http://seniorbenefits.alaska.gov/ Application: http://dpaweb.hss.state.ak.us/e-forms/pdf/gen152.pdf

Sources: NCSL summary of law Updated: 6/2011

ARIZONA	Medicare Co-payment Program - No longer operational, as of February 1, 2009 – See Archive

ARKANSAS	Not operational – See Archive

CALIFORNIA	Genetically Handicapped Persons Program
This limited eligibility health program serves only persons diagnosed as genetically handicapped.	
Medicare wrap around	No; It was approved by CMS as a "Qualified SPAP"in 2006, but is no longer qualified as of February 2009.
Contact & online information:	Web: http://www.dhcs.ca.gov/services/ghpp/Pages/default.aspx

Sources: CMS list of Qualified SPAPs, 2/17/2009 Updated: 3/2011

COLORADO	Colorado Ryan White Title II ADAP
This limited eligibility health program serves only persons diagnosed with HIV/AIDs.	
Benefits	The Ryan White Title II ADAP provides only pharmaceuticals used to treat HIV/AIDs
Medicare wrap around	Yes; all state benefits are provided in coordination with federal Medicare. Qualified SPAP; payments count toward TrOOP. added by CMS only as of February 2009
Contact & online information:	Web: http://www.careacttarget.org/community/StateProfiles/Colorado.pdf

Sources: CMS list of Qualified SPAPs, 2/17/2009 Updated: 3/10/2010

CONNECTICUT	ConnPACE (Connecticut Pharmaceutical Assistance Contract to the Elderly and the Disabled)
Connecticut's long-time subsidy program, ConnPACE, provides wrap around and coordinated benefits between ConnPACE and Medicare Part D, including allowing the state to apply on behalf of current state subsidy enrollees. All enrollees eligible for Medicare must join Part D, with the state covering all premiums, all but $30 of the deductible, and costs above the Part D gap.	ConnPACE Logo
Eligibility, Fees	**State residents 65 and older or disabled age 18-64. For single people, the income limit is $25,100. For married couples, the income limit is $33,800. Must have "no other plan of insurance or assistance" except Medicare Part D. An annual inflation adjustment is tied to Social Security income, to the nearest $100. A $45 annual registration fee is required.**
Disabilities coverage	Yes; ages 18-64 are eligible, including coverage during the 2-year waiting period for federal Medicare eligibility.
Benefits	As of January 2010, the state pays 100% of the Part D premiums (average $370 year) for members enrolled in a "benchmark" Part D plan, plus

	all out-of-pocket coinsurance and deductible above the standard ConnPACE $45 annual fee and during the "donut hole" for co-pay costs that exceed $16.25 per prescription. There is no yearly dollar limit on the amount of prescriptions covered. Effective January 2010, ConnPACE requires dispensing of generic medications when available and 'prior authorization' of brand-name medications in all Connecticut prescription drug assistance programs.
Medicare wrap around	Yes; state benefits are provided in coordination with federal Medicare. Qualified SPAP; payments count toward TrOOP. Authorizes automatic application for low income subsidy benefit and state-initiated enrollment in Part D plans, with the state selecting a Part D plan designated by the Commissioner if a recipient has not done so.
Est. # of beneficiaries	34,057 enrolled (29,665 elderly + 4,392 disabled), 9,919 in Medicare Savings Group and 4,122 in low income subsidy group, as of June 2009.
State laws	1986: Program established by CGL sec 17b-491 et seq. 2005: Public Act 05-280, signed June 27, 2005.
Special features & issues	For the first half of fiscal year 2009, the ConnPACE Program subsidized the cost of 232,421 prescriptions totaling $14,512,019 for an average of 34,514 ConnPACE clients. Approximately thirty percent of prescription drugs paid for during this period were for generic products. In addition to the prescription benefit, the ConnPACE Program subsidized Medicare Part D premiums in the amount of $4.8 million for an average of 33,560 clients with Medicare Part D, which is an increase from last reporting period. Enrollment numbers for the ConnPACE program have continued to decline by approximately 2% this reporting period. Between July 1, 2008 and December 31, 2008, total expenses in the following categories were: Subsidy: $17,239,768; Fees: $396,693; Rebates: $1,414,163; Premium Payments: $4,225,225; Net Expenditure: $19,654,137. Total paid claims in this period were: 230,459; average cost per claim: $74.80; and average prescription claim per client per month: $1.09. For the fiscal year July1, 2006-June 30, 2007, there was an average of 42,431 clients that received subsidized costs of $34,365,040 for 990,023 paid prescription claims through the ConnPACE Program, as well as Medicare Part D premium payments totaling $8,248,657. For the six-month period of Jan-Jun 2007, the ConnPACE Program subsidized the cost of 521,660 prescriptions totaling $14,635,235 for an average of 40,702 clients. 44 percent of prescription drugs paid for during this period were for generic products. In addition to the prescription benefit, the ConnPACE Program subsidized Medicare Part D premiums in the amount of $3.9 million for an average of 41,000 clients per month. For comparison, in FY 2006. ConnPACE paid for 995,943 prescriptions costing $95,951,969 annually. As of January 1, 2010, the Program no longer covers products that are not on a Part D Plan's formulary. The state payment rate "may be made at (A) the lowest price established" by a PDP for a preferred drug in the same class, with the beneficiary responsible for any higher balance; (B) the ConnPACE price if lower than the PDP price. Provides that the applicant or recipient "shall appoint the (state) commissioner" for the purpose of appeals and denials.
Other Rx programs	California had a large discount pharmaceutical program serving Medicare enrollees, 2000-2006. A new CA discount plan is scheduled to go into effect in February 2008. See Rx Archive; also CA Children's Services program was certified as a CMS Qualified SPAP.
Contact & online information	Connecticut Department of Social Services, Pharmacy Unit, Medical Care Administration toll-free information: 1-(800) 423-5026; (860) 832-9265; consumers: (860) 269-2029 Web: http://www.connpace.com/ ConnPACE Semi-Annual Report to the Governor (July to December 2010) [12 pages PDF]

Sources: NCSL summary of laws; 11/15/2006; ConnPACE Report (June 2007) Updated:3/2010

DELAWARE	1.) Prescription Drug Assistance Program (DPAP) 2.) Chronic Renal Disease Program (CRDP)

Delaware's Rx subsidy program has established a wrap around benefit for Medicare enrollees, to cover premiums, deductibles and drugs purchased in the coverage gap over $2,400, up to a maximum of $2,500 in state funds per calendar year.

Program Details

Program Name	Delaware Prescription Assistance Program (PDAP)
Phone	(800) 996-9969 EXT: 2
Who is eligible	▪ You must be a resident of Delaware. ▪ You can't be eligible for Medicaid or have other insurance that provides drug coverage, excluding Medicare Part D. ▪ If you are under age 65, you must be eligible for Social Security Disability (SSDI) benefits. ▪ If you are elderly or receive SSDI benefits and have income over 200% of the Federal Poverty Level, you may still be eligible if you have drug costs that are over 40% of your yearly income. ▪ If you are eligible for Medicare, you must show proof of enrollment in a Medicare Prescription Drug Plan (Part D) – and in Social Security's Extra Help Program if you are eligible – within 90 days from the date your DPAP benefits begin. ▪ You are not eligible for prescription assistance if your prescription costs are covered by full Medicaid benefits or by a health insurance plan other than a Medicare Part D plan.
Where to apply	P.O. Box 950, New Castle, DE 19720
Link to state website	Delaware Prescription Assistance Program (PDAP) - Opens in a new windowNew Window icon
Important Notes	▪ The Delaware Prescription Assistance Program will provide each eligible individual with up to $3000 per year toward medically necessary prescription drugs. ▪ The program does not pay for diabetic drugs or supplies for Medicare recipients. ▪ Medicare currently provides this coverage for both insulin and non-insulin dependent patients. PDAP does not offer or pay for mail order drugs. ▪ Clients must make a co-payment of 25% of the cost of the prescription, or a minimum of $5. The co-pay is collected by the dispensing pharmacy. ▪ The pharmacy submits a claim to DPAP and is reimbursed directly

Program Name	Delaware Chronic Renal Disease Program
Phone	(302) 424-7180 (800) 464-4357
Who is	▪ Must be a Delaware resident.

eligible	▪ Medically, the individual must be diagnosed with ESRD, be on dialysis, or have had a renal transplant. ▪ Financially, the individual, and spouse if applicable, must have income below 300% of the Federal Poverty Level. Resources are not counted. ▪ Applicants with a legally married spouse will be considered as a household of two unless the couple is separated and maintains two separate residences for at least 12 months prior to application. ▪ Applicants who have Medicare A or B must apply for Medicare Part D Prescription Drug Coverage and if eligible, for Social Security's Extra Help Program, unless they have other insurance that provides equivalent prescription benefits
Where to apply	11-13 North Church Ave Milford, DE 19963
Link to state website	Delaware Chronic Renal Disease Program - Opens in a new windowNew Window icon
Important Notes	**Services Covered:** Prescription and Over-the-Counter medication; nutritional supplements; Medicare Part D costs (premium, deductible, co-pay, and coverage gap); transportation (to dialysis unit, transplant hospital, related medical appointments). There is no individual funding cap. **Non-covered services:** The CRDP will not pay for insurance premiums (other than Medicare Part D), hospitalizations, ancillary services, medical supplies or dialysis treatments. To start the referral process, the applicant must complete a CRDP application. You should have an application mailed or faxed to you. Contact the Delaware Help Line at 1-800-464-4357 and ask to be transferred to the Chronic Renal Disease Program, or you may call 1-302-424-7180. Once the application has been received by the CRDP office, you will be contacted to schedule an appointment for determining your eligibility for assistance from the Chronic Renal Disease Program.
Contact & online information	The Division of Social Services; Phone: 255-9500 or 1-800-372-2022; FAX: (302) 255-4454 Email Web: http://www.dhss.delaware.gov/dhss/dmma/dpap.html The Division of Medicaid and Medical Assistance; Phone # 1-800-372-2022 or (302) 255-9500; Fax #: (302) 255-4454- http://dhss.delaware.gov/dhss/dmma/crdprog.html

Sources: NCSL Research; Medicare at https://www.medicare.gov/pharmaceutical-assistance-program/state-programs.aspx **Updated December 2015**

FLORIDA	Florida Comprehensive Health Association - No longer operational, as of 2008 – See Archive

HAWAII	State Pharmacy Assistance Program - Not operational – See Archive

IDAHO	IDAGAP: Idaho AIDS Drug Assistance Program
The Idaho HIV State Prescription Assistance Program, IDAGAP, pays an eligible client's Medicare Part D Prescription Drug Plan co-pays and out-of-pocket responsibilities during the cover period of each plan for all medications covered under the plan.	
Eligibility	**Must be an Idaho resident. Must be HIV positive. Must be eligible for Medicare. Must be enrolled in Medicare Part D Prescription Drug Plan. Must have income between 151% to 200% (2011 FPL; $16,443.90 to $21,780) of Federal Poverty Level (clients who have incomes 150% FPL or below may qualify for an exceptic 334-6527). Must be participating in an Idaho HIV Medical Case Management Program.**
Disabilities coverage	Coverage only for people with HIV.
Benefits	IDAGAP works with all Idaho Medicare Part D Plans. IDAGAP uses the formulary of the Medicare Part D plans. Any drug covered by a member's Medicare Drug plan will also be covered I will pay co-pay and coverage gap amounts until such time as individual reaches the Catastrophic Coverage Portion of the Part D Plan. IDAGAP will not pay premiums or deductibles. IDAGAP assistance will cease when the Catastrophic Coverage Portion of Part D Plan is reached. Medicare Part D excludible drugs are not c
Medicare wrap around	**Yes**
Contact & online information	**Idaho Department of Health and Welfare** APSPortal@dhw.idaho.gov **Idaho HIV State Prescription Assistance Program (online description)** **http://www.healthandwelfare.idaho.gov/Health/FamilyPlanningSTDHIV/HIVCareandTreatment/tabid/391**

Updated: 6/2011

ILLINOIS	1) Illinois Cares Rx Plus (formerly SeniorCare) 2) Illinois Cares Rx Basic (formerly Circuitbreaker)
A 2005 state law updated three existing state pharmacy assistance programs and created the "No Senior or Person with Disabilities Left Behind" plan as a Medicare wrap around that allows the state to pay premiums, deductibles and gap coverage for up to 241,000 seniors and persons with disabilities. The state also continues coverage programs for non-Medicare adults.	
Eligibility	**Illinois Cares Rx Plus is available to residents age 65 or older, with income up to $27,066 for individuals or $36,560 for a married couple. Illinois Cares Illinois Cares Rx Basic is available up to $27,610 for individual, up to $36,635 for a couple, or up to $45,657 for a qualified household of three. Medicare eligibility is not a requirement.**
Disabilities coverage	Yes; up to age 64 are eligible, including coverage during the 2-year waiting period for federal Medicare eligibility.
Benefits	A senior with annual income above 150% of federal poverty level (2011; $16,335) with $5,000 in drug expenses could receive 100% of the standard Part D premium and deductible costs, including the 25% co-insurance and gap coverage, totaling about $3,000 in state-paid costs. Coverage includes some drugs that are excluded from federal Medicare coverage such as benzodiazepines. While in the coverage gap members are responsible for 20% of the cost of each drug plus co-pay of $2.50 generic, $6.30 preferred brand, $15 non-preferred brand, and $15 for specialty drugs.
Medicare wrap around	Yes; most state benefits are provided in coordination with federal Medicare. Qualified SPAP; payments count toward TrOOP.
Est. # of beneficiaries	247,592 enrollees as of 6/30/06.
State laws	2005: SB 973, signed 6/29/05; effective 1/1/06. IL also had a Pharmacy Plus Medicaid 1115 waiver for residents under 200% FPL.
Special features & issues	State law authorizes auto-assignment; 2005 state enrollees will be automatically enrolled in wrap around features, with one application for all programs; the state will use its preferred drug list where applicable. The state's Pharmacy Plus 1115 waiver presents special conditions for some enrollees under 200% of FPL (2011; $21,780). IL has two qualified SPAPs for TrOOP calculations. Enrollees with incomes between 200% and 225% of FPL (2011; $21,780 and $24,502.50) are covered only for drugs for treatment of 11 conditions including: Alzheimer's, arthritis, cancer, diabetes, glaucoma, cardiovascular disease, lung and smoking-related diseases, osteoporosis, Parkinson's or multiple sclerosis. All Illinois Cares Rx clients enrolled in a PDP must follow their PDP's formulary. "Illinois Cares Rx will not cover Part D covered drugs just

	because they are not on the client's PDP's formulary." People with Original Medicare must apply for Low Income Subsidy ("Extra Help") and must enroll in one of two Medicare prescription drug plans coordinating with Illinois Cares Rx: PacifiCare Saver Plan or the AARP Medicare Rx of United HealthCare Insurance Company. Governor's Administrative Initiatives: (as of January 2008) with SB 5 stalled in the Senate, the Governor has used his executive authority to expand health coverage. The Governor has said the following: "Unfortunately, the Illinois General Assembly failed to act on expanding access to healthcare this session. In the face of that inaction, I am using my executive authority to expand healthcare to over 500,000 more Illinoisans." As a result, in the summer of 2007, Gov. Blagojevich announced that he planned to use his executive authority to implement five initiatives, some of which were part of Illinois Covered (SB5). Included is Assist Primary Care, Rx, Hospital: This program would provide a medical home, prescription drugs and hospital reimbursements for those without access under 100% of the Federal Poverty Level. The Governor has initiated "All Kids Bridge" program and an expansion of "Family Care," despite having no statutory authorization, and despite the disapproval of the Joint Committee on Administrative Rules of proposed rules attempting to implement the Family Care expansion. A lawsuit is pending challenging the Governor's authority, but the program has been enrolling families in the meantime. (1/08)
Other Rx programs	**Discount Program: Illinois Rx Buying Club** Member Services. Tel. Toll-free 866-215-3463; (TTY) 866-215-3479 http://www.illinoisrxbuyingclub.com/ **Illinois Covered *Assist*:** A state program focused on access to primary care and disease management for those who are very low-income—under 100% of the federal poverty level (FPL) (for 2011 a single person who makes less than $10,890 annually, or a couple making less than $14,710 annually)—and who do not have health insurance or access to current Medicaid programs. *Assist* will provide access to a medical home through a community health center, a prescription drug benefit, and reimburse hospitals for non-elective in-patient services for *Assist* beneficiaries.
Contact & online information	Telephone 217 524-0084; toll-free in IL: 800 624-2459 http://www.illinoiscaresrx.com/ ; http://www.cbrx.il.gov/ Applications: http://www.cbrx.il.gov/aging/1rx/cbrx/cbrx_forms.htm

Source: State web site, conversation with IL House. Updated: 1/22/2008; 5/2009; 6/2011

INDIANA	HoosierRx
The Hoosier Rx program, founded in 2000, continues in 2007. The current structure provides up to $1,200 per year for seniors age 65 and over with annual incomes up to 150 percent of federal poverty guidelines. The program now offers wrap around benefits for Medicare PDP monthly premiums for plans working with HoosierRx .	HOOSIER Rx
Eligibility	**Must be a resident, age 65 and older, have Medicare Part A and/or Part B, and have a yearly income up to, $16,485 or less for a single person, or $22,095 or less for a married couple living together. (Approximately 151% FPL for 2011) Participants must enroll in one of the Medicare Prescription Drug Plans working with HoosierRx. Participants must apply with the Social Security Administration for extra help from Medicare. HoosierRx can assist those that get partial extra help from Medicare and those denied for Medicare's extra help due to resources.**
Disabilities coverage	Persons with disabilities under age 65 are not eligible for state benefits, as of 11/05.
Benefits	HoosierRx will help low-income seniors make up the difference between their out-of-pocket costs and the Medicare coverage. For individuals with partial Medicare extra help, HoosierRx "can help pay the monthly Part D premium, up to $70 per month," that is not covered by Medicare, within one of the plans that are working with HoosierRx. For individuals with no Medicare extra help, HoosierRx will pay the monthly premium of one of the nine plans working with HoosierRx: AARP/United Healthcare, CIGNA Healthcare, Coventry AdvantraRx, First Health, Humana, MemberHealth, Prescription Pathway, SilverScript and WellCare. [2008 list]
Medicare wrap around	Yes; all state benefits are provided in coordination with federal Medicare. Qualified SPAP; payments count toward TrOOP.
Est. # of beneficiaries	2,300 enrollees as of 7/2007 (no non-Medicare, no full dual-eligibles).
State laws	HB 1251; HB 1325 (2005), also IN Admin. Code, Title 405, Art. 6
Special features & issues	HB 1325 seeks coverage for Medicare deductibles, premiums and drug costs not covered by the federal benefit or federal PDP plans. HoosierRx currently does not require the use of prior authorization, preferred drug lists or mandatory generics. The 2005 law authorizes future coverage up to 200 percent of federal poverty if recommended and approved. HoosierRx has restructured the program and, as of 7/1/06, there is no more wrap around benefit ($250 for co-pays and premium). HoosierRx will now pay a higher premium amount for enrollees instead of using the wrap around benefit. Funding: Money from the Tobacco Settlement Fund has been allotted for this program, it does not receive Indiana General Fund dollars. State legislators will have to approve a budget that includes money allotted to this program for its continuation. *[2/08]*
Other Rx programs	"Rx for Indiana" is a separate "collaborative effort by Gov. Mitch Daniels, local and statewide organizations and the pharmaceutical industry" and is not a subsidy program, but rather a clearinghouse that pulls together all federal, state and private companies that offer discounted drugs and services. Rx for Indiana helps people of all ages find and apply for assistance through pharmaceutical manufacturers for help with brand name drugs. Each company program has different benefits and covers different drugs, providing free or discounted prescription drugs to eligible patients. As of 7/11/06, the Rx for Indiana telephone hotline logged 76,649 calls and the website logged 99,148 hits. 141,592 patients initially qualified for assistance and approximately 81% were eventually matched to a program.
Contact & online information	Hoosier Rx Program (toll free) at 1-866-267-4679 Senior Health Insurance Information Program counselors (toll-free) at 1-800-452-4800. Subsidy program http://www.in .gov/fssa/ompp/2699.htm *[2/08]* Clearinghouse: http://www.rxforindiana.org/

Sources: Hoosier Rx website (3/4/2008); interview with Governor's office 12/29/2005; HB 1325; HB 1251; IAC Title 405, Art. 6; e-mail and telephone correspondence with Brian Smith, PhRMA. Updated: 7/17/2007, 3/4/2008.

IOWA	Iowa Medication Voucher Program
The Iowa Medication Voucher Program is designed to help lower-income Iowans has been created with funds paid by two pharmaceutical benefit manager companies for alleged consumer fraud violations. Coverage is for hypertension/high blood pressure, diabetes, elevated cholesterol, depression and pregnancy prenatal care medications.	
Eligibility	**Must be an Iowa resident, uninsured, underinsured and in financial need. Eligible residents need to obtain a voucher, present it with a prescription to a participating Iowa pharmacy. A valid prescription good for 90 days must be presented to any participating Iowa pharmacy located in 94 Iowa counties. The consumer will be asked to pay the $3 co-pay; the remaining cost will be paid by the program.**
Disabilities coverage	Yes.
Benefits	The Attorney General's Office awarded $420,000 in settlement funds to the Iowa Prescription Drug Corporation to create the new Iowa Medication Voucher Program. The program will help eligible lower-income Iowans pay for medications for hypertension/high blood pressure, diabetes, elevated cholesterol, depression and pregnancy prenatal care. The program will fund up to 52,000 prescriptions.

Medicare wrap around	No; Not a qualified SPAP; payments do not count toward TrOOP.
Special features & issues	"This program will use $420,000 paid by the companies to provide thousands of lower-income Iowans with a 90-day supply of certain medications for an out-of-pocket cost of just $3 per prescription," Miller said. "The program will pay the remaining cost of the drugs."
Other Rx programs	Yes, discount program. The Iowa Prescription Drug Corporation provides coordination among programs; see http://www.iowapdc.org.
Contact & online information	To obtain a voucher, Iowans can inquire at their local safety net provider including community health centers, free clinics, family planning clinics and rural health clinics. They may also contact their county board of health. Enroll Information is available on the Iowa Prescription Drug Corporation web site at http://www.iowapdc.org/Voucher%20Program.htm. The web link provides a county coordinator or "point of contact" for each county, as well as participating pharmacies and the list of medications available.

Sources: state Rx web site; also http://www.reducedrugprices.org/read.asp?news=4311 Updated: 10/3/2009

KENTUCKY	Kentucky Pharmaceutical Assistance Program - Not yet operational – See Archive

MAINE	Low Cost Drugs for the Elderly and Disabled Program
Maine has run one or more senior pharmacy assistance programs since 1975. With the availability of Medicare Part D as of 2006, the state offered wrap around benefits for Medicare eligibles, including coverage for premiums, one-half of the deductible and 80% of the coverage gap.	
Eligibility	**For subsidized benefits: Maine residents age 62 and older, or persons with disabilities age 19-61, with annual income of 185% ($20,146 for 2011). Income at or less than 185% FPL (income limit is 25% higher if at least 40% of yearly income is spent on prescription drugs). 185% of 2011 FPL for 1 person is $20,146 and $ 27,213.50 for a 2 person household annually.**
Disabilities coverage	Persons with disabilities under age 65 are eligible for state benefits, including coverage during the 2-year waiting period for federal Medicare eligibility.
Benefits	Wrap around benefits apply to dual eligibles & three levels based on income. Some pharmaceuticals excluded by Medicare will continue to be covered for everyone, as covered in 2005. The state will pay 1/2 of the copay up to $10 - $15 for all dual eligibles. For those in assisted living, the state will pay 100% of all copays. The program has eliminated its asset limit, which will qualify an estimated 9,000 new residents. Those residents for whom the state pays Part B Medicare premiums, the state also will now cover Part D premiums. Copays are covered 50% with a cap of $10; also will cover 100% premium; 50% of deductible; and 80% of the coverage gap (doughnut hole) after a member spends $1000 on eligible prescription drugs, for the 14 categories of treatments specified in state law. Enrollees pay 20% of the coverage gap (over $2,250).
Medicare wrap around	Yes; all state benefits are provided in coordination with federal Medicare. Qualified SPAP; payments count toward TrOOP.
Est. # of beneficiaries	86,000 (47,876 are Dual Eligible; 38,133 are non-Dual or non-Medicare) 7/2007
State laws	2005: LB 1325, signed by governor as Chapter 401, 6/17/2005; State agency given emergency regulatory authority
Special features & issues	The Department of Human Services has emergency regulatory authority to make further adjustments in benefits and eligibility. In April '06, a Supplemental Budget was enacted with broad bipartisan support. It includes $10.7 million to ensure that seniors who received prescription drug benefits under MaineCare or the state's Drugs for the Elderly program would not lose benefits or have to pay more because they were switched to the federal Medicare Part D program. The budget provides extensive ongoing wraparound benefit for Medicare Part D enrollees including both Medicaid dual eligibles and participants in the state elderly low-cost drug program members who are transitioning to Medicare Part D. Also provides for the state purchase of a higher than benchmark plan when a person needs a drug that is not on their plan's formulary and they have an initial denial of an exception for coverage; eliminates all co-payments for persons in all levels of private non-medical institutions (boarding and group homes); and eliminates all co-pays on generics. MSP program-asset test converted 9,000 enrollees.
Other Rx programs	Yes, Maine Rx Plus Discount Plan, see below
Contact & online information	Tel.: 207 287-2674; toll-free: 888 600-2466 Enroll http://www.maine.gov/dhhs/beas/medbook.htm

Sources: Chapter 401 of 2005; Interview with Jude Walsh, Maine Special Asst for RX, 6/2007. Updated: 6/1/2007; 5/2009; 6/2011

MARYLAND	Maryland Senior Prescription Drug Assistance Program (SPDAP) Primary Care Program
Maryland has provided some state Rx assistance since 1979. A 2005 law integrated previous state programs by providing Medicare Part D beneficiaries who meet program requirements with a state subsidy authorized for a portion of their Medicare Part D premiums, deductibles, coinsurance payments, and/or copayments and gap coverage. For 2008 the benefit covers up to $25 of the monthly premiums.	
Eligibility	**Resident for 6 months; at or below 300% FPL ($32,670 for individual, based on 2011 rate) and enrolled in Medicare; but must not be qualified for full federal "extra help" LIS benefit. 2005 members grandfathered in as of 12/31/05.**
Disabilities coverage	Persons with disabilities under age 65 are eligible for state benefits, including coverage during the 2-year waiting period for federal Medicare eligibility.
Benefits	Successful applicants can receive up to $25 per month ($300 annually) towards the cost of their monthly Medicare Rx or Medicare Advantage Prescription Drug premium. Gap coverage: those eligible can receive a subsidy of up to $1,200 per year for 2010, available through 22 selected companies (Gap coverage plan list. 2011) SPDAP will pay 95% of the entire drug costs for members while in the coverage gap (if enrolled in a plan that has agreed to offer the coverage gap subsidy).
Medicare wrap around	Yes; all state benefits are provided in coordination with federal Medicare. Qualified SPAP; payments count toward TrOOP.
Est. # of beneficiaries	35,500 enrollees, as of 7/1/06
State laws	2005: HB 324 & SB 282, enacted into law May 2005. Authorizes a state subsidy for a portion of their Medicare Part D premiums, deductibles, coinsurance payments, and/or copayments.
Special features & issues	1) The MD discount and subsidy programs of 2005 were folded into the new Primary Care Program. The new Primary Care Program was authorized under Maryland's revised 1115 waiver renewed earlier this year. People enrolled now get prescription drugs and more replacing need for a separate drug program. Maryland also has an Rx discount plan, changed as of 1/1/06 to serve non-Medicare residents, mostly under age 65. 2) The Maryland Pharmacy Program (MPP) Provides services for the following programs: Medicaid, HealthChoice receive most mental drugs; all other drugs are provided by HealthChoice Managed Care Organizations (MCOs); Primary Adult Care (PAC); Family Planning receive only contraceptives and Medicare Part D fully dual eligible Medicare beneficiaries receive most drugs excluded from Medicare Coverage. 3) SPDAP will attempt to coordinate with an individuals' selected Medicare Rx or Medicare Advantage plan for the direct subsidy of the monthly premium, so that enrollees are only billed by the Medicare plan for any premium which exceeds the state's monthly subsidy of $25. During the 2006 session, the Maryland Legislature passed HB 702, which prohibits the subsidy required under the Senior Prescription Drug Assistance Program from exceeding a specified amount in specified fiscal years. The bill also authorizes a subsidy for copayments and deductibles.

Other Rx programs	Yes, see MD Discount plan below
Contact & online information	To request an application, call the Maryland Pharmacy Program toll-free, 1-800-226-2142 SPDAP program: http://www.marylandspdap.com/ The Maryland Medicaid Pharmacy Program (MPP): www.dhmh.state.md.us/mma/mpap/ Enroll Application and income: download application Maryland SPDAP, c/o Pool Administrators, 100 Great Meadow Rd, Suite 705, Wethersfield, CT 06109

Updated: 2/21/2008; 3/18/2010; 6/2011
Sources: Text of MD 2005 law; Maryland web site 3/18/2010.

MASSACHUSETTS	Prescription Advantage
Massachusetts is one of two states which had a sliding-scale subsidized prescription insurance plan, with no income limit for seniors but with a low-income limit for persons with disabilities. The recently authorized wrap around begun in 2006 makes Medicare Part D the required primary coverage, with state help for deductible, copayment and coverage gap payments. The state was the first to gain approval in 2005 for automatic enrollment in Part D on a random basis.	
Eligibility	Open to all non-Medicaid seniors age 65 and older of all incomes, and low income persons with disabilities (see below). No asset test. For persons with Medicare, income limit is up to 500% FPL (2011; $54,450); without Medicare, there is no income limit. Prescription Advantage will continue to offer prescription drug insurance coverage for people not eligible for Medicare.
Disabilities coverage	Persons with disabilities under age 65 with a special maximum income of 188% FPL (2011; $20,473.20) and not more than 40 work hours per month are eligible for state benefits, including coverage during the 2-year waiting period for federal Medicare eligibility.
Benefits	The state will help pay deductible, copayment and coverage gap payments, with at least six categories of income levels receiving sliding scale financial benefits. Program will pay all Part D copayments after annual out-of-pocket spending reaches $1625 to $3250. The details are not specified in statute. See the full 2011 copayment schedule online. Examples: > Full duals (under 135% FPL; 2011, $14,701.50) will not receive state help. > Between 135%-188% FPL (2011; $14,701.50 - $20,473.20): state pays premiums up to $363.24 annually and copays above $7 generic or $18 brand-name. Out-of pocket expenses capped at $1,300 to $1,440. > Between 188%-225% FPL (2011; $20,473.20 - $24,502.50): State may pay premium share up to $360 annually and copays (only above the "donut hole)" above $12 generic or $30 brand-name. Out of pocket expenses capped at $1,800 annually. (Member Category S3) > Between 225% FPL-300% FPL (2011; $24,502.50 - $32,670): State pays only copays above $12 generic or $30 brand-name. Out of pocket expenses capped at $2,150 annually. > Between 300%-500% FPL (2011; $32,670 - $54,450): State may provide gap coverage after a cap of $2,870.
Medicare wrap around	Yes; all state benefits are provided in coordination with federal Medicare. Qualified SPAP; payments count toward TrOOP. • How Prescription Advantage Works with the Medicare Prescription Drug Coverage (Part D) for 2015 *[Updated 12/2015]*
Est. # of beneficiaries	Total enrollment in Prescription Advantage is 68,364 as of 7/2007. Estimated 70,229 eligible for Medicare; 774 are non-Medicare.
State laws	MGL Ch. 19A, §39 H 4200, §27 signed into law by governor as Chapter 45 of 2005 on 6/30/05. Chapter 175 of 2005 signed into law by governor on 12/30/05 H 5000 of 2006 signed into law by governor on 7/8/06 2015 Regulations: 651 CMR 15.00: Prescription Drug Insurance Plan (PDF)
Special features & issues	Important Note: effective January 1, 2010, Reductions to the current fiscal year budget for Prescription Advantage require that benefits be changed. Co-payment assistance from Prescription Advantage is only available to members enrolled in a Medicare Part D drug plan or creditable coverage plan. On August 29, 2005, CMS formally approved the Massachusetts plan to automatically enroll state members into lower cost drug plans, with 5 plans initially approved for this process. Members in "Medicare Advantage" plans (Tufts, Fallon, Harvard Pilgrim and Blue Cross) will not be automatically enrolled. Prescription Advantage will pay for benzodiazepines (excluded from Medicare coverage) but will not cover other drugs excluded from Medicare coverage, such as barbiturates and over-the-counter drugs. The multi-level sliding scale benefits may be examined to simplify the structure. The state-only insurance product for the much smaller pool of 3,000 people may be subject to evaluation as well. As of January 1, 2009, enrollees with incomes above 188% FPL have significant increases in the cost of some prescription drug copayments, the result of an $11 million cut in the program announced by the Governor in October '08.
Other Rx programs	MassMedLine is a free, confidential pharmaceutical information clearinghouse available to all Massachusetts residents who are seeking information regarding their medications. Using the toll-free help line, 1-866-633-1617, residents can speak to pharmacists and case managers one-on-one to receive personal assistance with pharmacy related questions or finding programs to help with the cost of medications. The program was created in a law (now MGL Chapter 19A, sec. 4C) passed by Sen. Richard Moore in 2000. Website: http://www.massmedline.com	Spanish language site.
Contact & online information	MA Executive Office of Elder Affairs; 617 727-7750 Prescription Advantage Customer Service - toll-free: 800 243-4636. PRESCRIPTION ADVANTAGE. http://www.mass.gov/elders/healthcare/prescription-advantage/prescription-advantage-overview.html *[link updated 12/2015]* Fact Sheet: http://www.mass.gov/Eelders/docs/prescription_advantage/fact_sheet.pdf

Updated: 7/28/2006, 1/20/2009; 5/2009; 6/2011 Sources: presentation by Beth Waldman, MA Medicaid 6/7/2005; CMS statement 8/1/2006; websites of EOEA 12/2005; e-mail correspondence with Randy Garten, Dir. of Prescription Advantage (Exec. Office of Elder Affairs) 7/28/2006.

MISSOURI	"MoRx"; Missouri Rx Plan (replaced Missouri Senior Rx)
Missouri's 2005 law coordinates state pharmaceutical assistance with MMA. It establishes a newly defined "Missouri RX" subsidy plan for residents with income up to 200% of federal poverty. The Plan "may pay all or some of the deductibles, coinsurance, payments, premiums and copayments" required by Part D; the state may select one or more preferred PDP plans for purposes of the coordination of benefits between the program and the Medicare Part D drug benefit. Beginning 2006, Medicare disabled under 65 were added as eligible.	
Eligibility	Single Missouri residents with an annual gross household income of $21,660 or less and married Missouri residents with an annual gross household income of $29,140 or less. The old Senior Rx Program members and all dual eligibles (eligible for both Medicare and Medicaid) were automatically enrolled into MoRx. There is no cost for this enrollment, nor is there any additional paperwork. To receive the benefits of the MoRx program, its members must be enrolled in a Medicare Prescription Drug Plan. Non-duals must not be enrolled in Medicaid.

Disabilities coverage	As of 2006 persons with disabilities under age 65 are eligible for state benefits, once they fully qualify for Medicare after the federal two-year waiting period.
Benefits	"MoRx pays for 50% of members' out of pocket costs remaining after their Medicare Prescription Drug Plan pays. It pays for 50% of the deductible, 50% of the co-pays before the coverage gap, 50% of the coverage gap, and 50% of the co-pays in the catastrophic coverage."
Medicare wrap around	Yes; all state benefits are provided in coordination with federal Medicare. Qualified SPAP; payments count toward TrOOP.
Est. # of beneficiaries	172,000 as of 7/2007. 148,348 are dual-eligibles transferred from State Medicaid Program in 2006; 13,297 were members of former program called Missouri Senior Rx (auto-enrolled into Missouri Rx Program)
State laws	2005: SB 539 was signed into law by governor on April 26, 2005. The old "Senior Rx Plan" is being phased out as soon as the MMA Part D benefit is "fully implemented" as certified by the state.
Special features & issues	The new Missouri Rx Plan will no longer require an enrollment fee or deductible. It will provide "wrap around" coverage to those who have Medicare A and/or B and are enrolled in a Medicare Rx Prescription Drug plan. Missouri Rx benefits will help pay a percentage of member's out of pocket drug costs remaining after using their Medicare Rx Prescription Drug plan. 2005 enrollees over 150% FPL were expected to transfer to a federal-only benefit plan in 2006, where the costs of benefits will be somewhat similar to their old benefit, with higher premium but 25% copay instead of 40%. On November 1, 2006, Governor Blunt announced expansion to cover residents up to 200% of FPL.
Contact & online information	Missouri Rx, 205 Jefferson Street, Room 1310, Jefferson City, MO 65101 Telephone: 1-800-375-1406 (Toll-free) clinical.services@dss.mo.gov Missouri Rx Plan (MoRx): http://www.morx.mo.gov Application: http://www.morx.mo.gov/pdf/morxapp-en.pdf

Sources: MO legislative and agency web sites, 12/2005; telephone conversation with Jerry Simons, Executive Director of Missouri Rx Plan. Updated: 11/2/2006; 5/2009

MONTANA	1.) Big Sky Rx Program 2.) Montana Aids Drug Assistance Program (ADAP)
The Montana Big Sky Rx program is designed to help qualified Medicare residents pay for Medicare prescription drug premiums, up to $449 annually. The Montana STD/HIV Section administers the AIDS Drug Assistance Program (also known as ADAP) with funding provided by the Ryan White Part B CARE Act which is administered through the federal Health Resources and Services Administration.	
Eligibility	Big Sky Rx: MT Resident, enrolled in Medicare Part D plan, with annual family income less than about $21,780 if single or about $29,420 if married and living together (200% FPL). ADAP: MT Resident, income less than 330% of the federal poverty level (adjusted gross taxable income). Ineligible for any other assistance programs that would pay for such treatments.
Disabilities coverage	Big Sky Rx: As of 2006 persons with disabilities under age 65 are eligible for state benefits, once they fully qualify for Medicare after the federal two-year waiting period. ADAP: Provides anti-retrovirals, protease inhibitors, hydroxyurea and pentamidine to qualified individuals at no cost.
Benefits	Pays up to $37.47 of Medicare Part D premium, for an annual maximum of $449.64.
Medicare wrap around	Yes; all state benefits are provided in coordination with federal Medicare. Qualified SPAP; payments count toward TrOOP.
Est. # of beneficiaries	4,031 as of 7/2007.
State laws	2005: SB 324, signed into law as Chapter 282 of 2005, 5/10/05.
Special features & issues	funded by the tobacco tax revenue. Concerned about growth factor in premiums and other unknowns.
Other Rx programs	Yes, Montana PharmAssist Program, see below
Contact & online information	Brochure: http://www.dphhs.mt.gov/prescriptiondrug/bigskyrxapcover.pdf Application: http://www.dphhs.mt.gov/prescriptiondrug/bigskyrxapplication.pdf Homepage: http://www.bigskyrx.mt.gov/ Montana Aids Program; Phone (406) 444-4744; E-mail: jnielsen@mt.gov http://www.dphhs.mt.gov/PHSD/STD-HIV/std-hiv-consorti.shtml Application: http://www.dphhs.mt.gov/PHSD/STD-HIV/documents/adap-application.pdf

Updated: 7/18/2006; 6/2011
Sources: Website; interview with Bureau Chief; interview with Gayle Shirley, MT Public Information Office 7/18/0206.

NEVADA	1) Nevada Senior Rx 2) Nevada Disability Rx
Nevada's first-in-the-nation state-negotiated Rx insurance subsidy program was one model for the federal Medicare benefit, with its reliance on private insurers. State law enacted in 2005 requires the state to wrap around and coordinate prescription drug services provided by the state with those provided by Medicare, with a goal of maintaining present coverage "to the extent allowed by federal law," as well as maximizing prescription drug coverage and the use of federal funds.	
Eligibility	**Senior Rx is available for residents age 62 or older at the time of application with annual income not more than $25,477 for individual or $33,963 for a married household (effective July 2010).** **Disability Rx is available for residents age 18-61 with annual income not more than $25,477 for individual or $33,963 for a married household (figures current as of May 2009).** **For those eligible for Medicare, Senior Rx and Disability Rx will help pay for Part D PDP premiums and prescription drug costs after Part D coverage limit is reached. For those not eligible for Medicare, there is no monthly premium, no deductible, drug coverage of $10 for generics and $25 for brand, and an annual coverage limit of $5,100. The State provides assistance with Medicare Part D expenses for members who are eligible for Part D and a cost-sharing benefit for members who are not eligible for Part D.**
Disabilities coverage	Persons with disabilities under age 65 are eligible for state benefits, including coverage during the 2-year waiting period for federal Medicare eligibility.

Benefits	The state will pay up to $281.52 annually toward annual Part D premiums (100% of $23.46/month for a basic plan) and will provide gap coverage for 100% of the expenditures over $2250 /per year as long as the medications are on the formulary of the member's Part D plan (a state contribution up to $2,850). Maximum annual state benefit = $5,100.00.
Medicare wrap around	Yes; all state benefits are provided in coordination with federal Medicare. Qualified SPAP; payments count toward TrOOP.
Est. # of beneficiaries	5,756 enrolled in Senior Rx as of 7/2007 526 active enrollees in Disability Rx
State laws	2005: AB 495 and AB 524 enacted and signed June 10, 2005
Special features & issues	The department may waive the eligibility requirements for an individual based on income, disability or extreme financial hardship, certified in a written request. State-only insurance policies remain available for non-Medicare enrollees. For 2006 only there may be a special emergency fund to assist with deductibles. "We want to make sure no one is worse off" said Mike Willden, Director of Health and Human Services. The legislature requested a departmental report by 11/05 regarding the state amount for premium payments. The state program continues to serve a small population of non-Medicare residents (age 62-64 or with certain disabilities) with an insurance policy product. [NOTE: A Notice to members on the NV website states that deductibles and copayments will not be paid.]
Contact & online information	Senior Rx: Toll Free 1-866-303-6323; http://dhhs.nv.gov/SeniorRx.htm Enroll Application: http://dhhs.nv.gov/DisabilityRx/Docs/DisabilityRxApp_Interactive.pdf Disability Rx: Toll Free 1-866-303-6323; http://dhhs.nv.gov/DisabilityRx.htm Enroll Application: http://dhhs.nv.gov/DisabilityRx/Docs/DisabilityRxApp_Interactive.pdf

Updated: 7/21/2006; 5/2007; 5/2009; 6/2011
Sources: Senior Rx website; text of Nevada law; statement by Department 7/21/2006

NEW HAMPSHIRE	**N.H. Pharmaceutical Assistance Program - Not yet operational – See Archive**

NEW JERSEY	**1) PAAD - Pharmaceutical Assistance for the Aged and Disabled** **2) Senior Gold**
New Jersey's two operational pharmacy assistance programs served over 200,000 residents in 2005, and celebrated a 30th anniversary since they enacted their original, first-in-the nation senior program in 1975. Beginning 2006, N.J. requires that Medicare eligibles enroll in a Part D plan, with the state covering cost-sharing, deductibles and coverage gap costs in Medicare Part D, as well as premiums for those eligible for PAAD.	
Eligibility *(Updated for 2017)*	▪ **A New Jersey resident;** ▪ **65 years of age or older or 18 years of age or older and receiving Social Security Title II Disability benefits; and** **PAAD:** ▪ **Annual income for 2017 of less than $26,655 if single or less than $32,680 if married; and** ▪ **Medicare-eligible PAAD beneficiaries are also required to enroll in a Medicare Part D Prescription Drug Plan in New Jersey. PAAD will pay the monthly premium for certain standard basic Part D plans with a monthly premium at or below the regional benchmark or standard basic plans or enhanced plans up to $20 above the benchmark amount that has no deductible.** ▪ These plans will cover medically necessary prescription medications under Medicare Part D. The federal Medicare Plan and/or PAAD will pay any costs above the PAAD copayment of $5 for each covered generic drug or $7 for each covered brand name drug, including premiums. However, if a Medicare Part D plan does not pay for a medication because the drug is not on its formulary, PAAD beneficiaries will have to switch to drug on their Part D plan's formulary, or their doctor will have to request an exception due to medical necessity directly to their Part D plan. Medicare Advantage participants must add a prescription benefit to their coverage, and PAAD will contribute up to the regional benchmark amount towards the prescription portion of their total premium. **Senior Gold:** ▪ **Annual income for 2017 is between $26,655 and $36,655 if you are single or between $32,680 and $42,680 if you are married.** ▪ **All Medicare-eligible Senior Gold beneficiaries are also required to enroll in a Medicare Part D Prescription Drug Plan of their choice. They will be responsible for paying the monthly premium directly to the Medicare Part D plan. They also will be responsible for paying any late enrollment penalty imposed by Medicare for each month they were eligible to enroll in Medicare Part D but did not enroll.**
Disabilities coverage	Persons with disabilities under age 65 are eligible for state benefits, including coverage during the 2-year waiting period for federal Medicare eligibility.
Benefits	NJ will pay all premiums, deductibles and cost-sharing above the $5 or $7 per prescription copayment for PAAD enrollees. A person with $5,000 in annual Rx expenses might receive up to $3,600 in state-funded benefits. Coverage for deductibles, co-insurance, and the coverage gap.
Medicare wrap around	Yes; all state benefits are provided in coordination with federal Medicare. Qualified SPAP; payments count toward TrOOP. Part D prescription "excluded drugs" are covered by PAAD and Senior Gold.
Est. # of beneficiaries	172,807 enrolled in PAAD as of 7/2007 26,237 enrolled in Senior Gold as of 7/2007
State laws	1975 NJ Ch.30: 4D-20 et seq. 2001 S.6; chapter 96 of 2001 2005: S 3000, (signed as Chapter 132, 7/2/05)
Special features & issues	The state PAAD benefit "shall only be available to cover the beneficiary cost share to in-network pharmacies and for deductible and coverage gap costs associated with enrollment in Medicare Part D for beneficiaries of the PAAD and Senior Gold programs, and for Medicare Part D premium costs for PAAD beneficiaries.
Other Rx programs	No other subsidies or discounts; New Jersey has a Prescription Drug Retail Price Registry to help consumers compare the retail prices charged by many pharmacies for the 150 most-frequently prescribed prescription drugs.
Contact & online information	Dept. of Health & Senior Services Telephone: 609-292-7837; Toll-free in NJ: 1-800-367-6543 Enroll PAAD: http://www.nj.gov/humanservices/doas/services/paad/ *[rev. 2017]* Enroll Senior Gold: http://www.nj.gov/humanservices/doas/services/seniorgold/ *[Revised 2017]*

Updated: 10/23/2007, 7/9/2008; 6/2011; eligibility 3/2017
Sources: NJ Department web site; text of S 3000, now Chapter 132 of 2005.

NEW YORK	**Elderly Pharmaceutical Insurance Coverage (EPIC)**

New York's EPIC plan, the nation's largest state subsidy program, has enacted a wrap around plan that will pay for most drug costs not paid by Medicare, including deductibles, co-insurance or copayments, the gap in coverage above $2,250 and products not covered by Medicare. Enrollees remain responsible for state-established copayments up to $20, fees or deductibles (up to $1,200).	
Eligibility	**New York state seniors age 65 or older with annual income up to $35,000 if single or $50,000 if married (equal to approximately 321% and 340% of FPL in 2011). As of July 1, 2007 a new EPIC Law Requires Medicare Part D Enrollment. There is a sliding scale annual fee from $8 to $300 annually for lower income enrollees; a deductible is required for individuals over $20,000 annual income. Seniors who receive full Medicaid benefits are not eligible for EPIC benefits.**
Disabilities coverage	Persons with disabilities under age 65 are not eligible for state benefits.
Benefits	Members of the EPIC Fee Plan receive free Medicare Part D coverage because EPIC will pay the monthly premiums (up to $24.45 a month, the average cost of a basic Medicare drug plan) for any Part D plan. The EPIC Deductible plan is available to single seniors with income between $20,001 and $35,000, and married seniors with income between $26,001 and $50,000. Those enrolled pay full price for their prescriptions until they meet an annual deductible which is also based on income. An enrollee with annual income of 200% of FPL with $5,000 in Rx expenses might receive up to $2,900 in gap coverage and partial copayment assistance. Coverage for deductibles, co-payments/coinsurance, and coverage gap (donut hole) claims for drugs that are covered by the Part D plan.
Medicare wrap around	Yes; all state benefits are provided in coordination with federal Medicare. Qualified SPAP; payments count toward TrOOP. Part D prescription "excluded drugs" are covered by EPIC.
Est. # of beneficiaries	360,000 enrolled as of 6/2007; of the total, 162,000 are enrolled in a Medicare Part D plan. Of those 162,000, there are approx. 62,000 eligible for full Low Income Subsidy (LIS).
State laws	2005: S 3668 signed as Chapter 58 on 4/12/05.; 2006: *A 9554;* sections became law by veto override as Chapter 54, 4/26/06
Special features & issues	EPIC fee will be waived for those with Medicare Low Income Subsidy. EPIC can be combined with other plans to lower costs at the retail counter. For example, if a PDP requires a $25 copay for a $100 product, EPIC will cover the $25 expense and charge the enrollee only $7 as a copay. Co-branding agreements are being sought with all PDPs willing to meet criteria for seamless coordination with EPIC benefits. The state is using "intelligent Random Assignment" for all low income Subsidy members. EPIC is considered "creditable drug coverage" at least equal to Part D, so state enrollees will not face a premium penalty if they do not enroll in Part D by May 2006. The complex financial sliding scales of fees and deductibles in EPIC may present special challenges in calculating costs and benefits among private plans. The legislature's FY 2006-07 budget, A 9554, authorizes continuing Medicaid wraparound coverage for duals until January 14, 2007. Separate from EPIC, the NY Medicaid program, in limited circumstances "will provide an additional Medicaid 'wrap around' benefit for drugs not covered by the PDP in addition to the federally excludable drug categories. This will only occur after the prescriber has requested an exception (the first step in an appeal) with the PDP and has received a denial. To assure that the Medicare prescription benefit has been maximized prior to billing NYS Medicaid, the Medicare Verification System (MVS) was developed." (View description online)
Contact & online information	EPIC Office Telephone: 518 452-6828; Toll-free in NY: 800 332-3742 Guide: Your Guide to New York State EPIC. (2008) Enroll: http://www.health.state.ny.us/health_care/epic/index.htm

Sources: Presentation by Director Julie Nagleri 9/26/2005; NY EPIC web site; NY law text; interview with Scott Franko, EPIC Program 7/21/2006. 6/2011

NORTH CAROLINA	**NC Rx - Slated to end in June 2011** **NC Senior Care Program**
The North Carolina Senior Rx program closed on January 1, 2006, with all enrollees encouraged to join a Part D plan instead. In November 2006, the state launched "NC Rx," to be operational January 1, 2007. The new program offers state subsidized help Part D premiums. **The NC Senior Care Program was certified by CMS (update as of March 13, 2012) to be exempt from Medicaid Best Price as a qualified SPAP.**	
Eligibility	NC resident age 65 or over, enrolled in Medicare Part D plan that participates in NCRx. No other form of drug coverage that is as good or better than Medicare Part D. Not eligible for the full federal "Extra Help" subsidy for Medicare Part D. Income requirements are at or below $15,952 for individuals and $25,497 for married couples. Combined savings, investments and real estate (other than home, car, and $1,500 per person to cover burial expenses) of $22,092 or less for individuals and $33,139 less for married couples.
Disabilities Coverage	Persons with disabilities under age 65 are not eligible for state benefits.
Benefits	A senior may receive up to $18 a month or $216 annually toward premiums.
Medicare Wrap Around	Yes; all state benefits are provided in coordination with federal Medicare. Qualified SPAP; payments count toward TrOOP.
Est. # of Beneficiaries	Enrollment opened mid-November, 2006
State Laws	
Special Features & Issues	New program started January 1, 2007. The program may require further legislative authorization and appropriations in 2007. **NCRx was slated to end in June 2011, for more information see link:** http://www.seniorpharmassist.org/_resources/Threat.pdf
Other Rx Programs	NC HIV SPAP (a "qualified SPAP" meeting CMS criteria (update as of March 13, 2012)
Contact & Online Information	For consumer assistance, call 1-888-425-6279 Web site: www.ncrx.gov

OREGON	**1.) Senior Prescription Drug Assistance Program - Never became operational – See Archive** **2.) CAREAssist: AIDS drug assistance program (ADAP)**
The CAREAssist program (Oregon's AIDS Drug Assistance Program) provides people living with HIV or AIDS with assistance to pay for medical care expenses.	
Eligibility	New enrollees at less than 200% ($1,815 for an individual; $2,452 for a couple, for 2011) FPL (not Medicaid/OHP or VA eligible).
Benefits	CAREAssist pays full Rx, co-pays, deductibles, insurance premiums, lab procedure co-pays, and other service co-pays at an annual capped amount.
Contact and Online Information	CAREAssist Phone (971) 673-0144; 1-800-805-2313 http://www.oregon.gov/OHA/pharmacy/careassist/index.shtml Application: http://dhsresources.hr.state.or.us/WORD_DOCS/DE8406.doc

PENNSYLVANIA	**1.) Pharmaceutical Assistance Contract for the Elderly (PACE)** **2.) PACE Needs Enhancement Tier (PACENET)** **3.) Chronic Renal Disease Program and General Assistance Program**

	4.) Special Pharmaceutical Benefits Program
The Pennsylvania subsidy plan has operated since 1985. PACE Plus Medicare is a new program designed toconvert the state's drug assistance plans into a supplemental program that wi private Medicare Part D prescription drug plans. It gives the state the authority to act as a representative for its PACE and PACENET enrollees in matters relating to Medicare Part D, enrol into Medicare Part D plans, pay Part D premiums, and apply for low-income subsidies on behalf of PACE and PACENET members.	
State law(s)	1985 law 2006: SB 1188, signed as Act 111 on 7/7/06.
Eligibility	Pennsylvania residents age 65 and older, for at least 90 days prior to the date of application, and not enrolled in the Department of Public Welfare's Medicaid prescription benefit. PACE: A single person's annual income up to $14,500; a married couple's combined annual income up to $17,70. PACENET: A single person's annual income can be between $14,500 and $23,500; a married couple's combined total income can be between $17,700 and $31,500. CRDP: Currently on dialysis or received a renal transplant. Must be within 0% - 300% of the Federal Poverty Guidelines. Must be in End Stage Renal Disease. Must be a US Citizen or resident of PA for at least 90 days - or show intent to be a PA resident. SPBP HIV/AIDS: Must be a resident of Pennsylvania, have a gross annual income of less than or equal to 337% of the Federal Poverty Level (FPL), and have a diagnosis of HIV/AIDS program. SPBP Mental Health: Pennsylvania resident, gross income limit up to $35,000 per year for individuals and $35,000 gross income per year for families, plus an allowance of $2,893 for e member. Must have a medical need with a DSM diagnosis of schizophrenia. The prescription must include the DSM diagnosis, the ICD-9-CM diagnosis code number and the physician the certification on the application.
Disabilities coverage	Persons with disabilities under age 65 are not eligible for these state benefits.
Benefits	The Legislature made changes to law in order for PACE to pay premiums; as the wraparound portion of PACE and PACENET. PACE members pay an average of 14% of total drug cos $2,400 per person annually. For the first nine months of 2006, PACE members paid a co-payment of $6 for generic and $9 for brand-name drugs. PACENET members pay a co-paym and $15 for brand-name drugs. The new PACE Plus Medicare program will drop the $40 monthly deductible PACENET enrollees pay in favor of a monthly premium, not to exceed the Part D premium of $32.54. The premium will be treated like a deductible and will be collected by pharmacies. About 15,000 PACENET enrollees who do not normally use drugs may fac this new plan design. Donut Hole: Program will fill in coverage gaps so that members can continue to get prescriptions by only paying the PACE co-pays; no more than $6 for each generic prescription and each brand name prescription for a 30 day supply. SPBP HIV/AIDS: Provides pharmaceutical assistance and specific lab services to low to moderate income individuals living with a diagnosis of HIV/AIDS who are not eligible for pharmacy Medical Assistance (MA) Program. SPBP Mental Health: Provides service to individuals with schizophrenia who do not respond to first-line drug therapies and who are not eligible for pharmaceutical coverage under the MA P
Medicare wrap around	Yes; all state benefits are provided in coordination with federal Medicare. Qualified SPAP; payments count toward TrOOP. Part D prescription "excluded drugs" are covered, only for Be barbiturates, vitamins and weight loss.
Emergency gap coverage - 2006	Executive action allowed state Medicaid to pay the excess copay, the amount individuals are inappropriately charged over the low-income subsidy level. State expects to spend no mon during January and expects to be reimbursed by CMS and the plans for the costs.
Special features	The program allows members to be also enrolled in another prescription or health plan. PACE is "creditable coverage," meaning that enrollees who choose not to enroll in a Part D plan not face a premium penalty later. PA law requires a manufacturer rebate for PACE purchases. For 2006 the program is "intending to collect 'best price' rebates on any claim that PAC the deductible period, coverage cap, or off formulary. On all other claims PACE will not be seeking a rebate." (4/4/06). Enrollment in Part D is optional for new PACE Plus Medicare. Th stand-alone Part D plans for the new auto-assign/auto-enroll process. Auto-assignment began on 7/19/06 and auto-enrollment began on 8/8/06. Enrollments were effective on 9/1/06. In September 2005, Pennsylvania launched the Independent Drug Information Service in 28 counties, including Allegheny, Beaver and Lawrence, aiming to educate doctors about pres by helping them choose the most clinically appropriate medications for their patients. The goal is to improve the prescription process by informing physicians on various drugs, rather th product. The concept was designed by Dr. Jerry Avorn, a professor of medicine at Harvard University. In conjunction with the PACE program, eight specially trained drug information co meeting with doctors at their practices last year. The consultants visit 25 to 30 doctors a month, mainly physicians whose prescribing habits don't mesh with their peers. The doctors are information on various types of drugs and brand-name alternatives are discussed. As of April 2006 there have been 2,300 visits to physicians and about 420 educational sessions.
Requirements & Limits	Medicaid enrollees and public Retired Employees Health Plan (REHP) enrollees are not allowed to enroll in PACE or PACENET.
SPAP legal status	Qualified SPAP approved by CMS; payments count toward enrollee TrOOP, 7/2007
Est. # of beneficiaries	311,000 total 184,049 in PACE as of 7/2007 (an estimated 80,000 eligible for extra help in 2006) 127,681 in PACENET as of 7/2007.
Funding source	PA State Lottery and tobacco settlement funds; also a small part covered by general funds.
future issues	State law on PACE was changed in July 2006 by the legislature's SB 1188 of 2006 (Act 111 of '06). The state discussed choosing to have an "unqualified SPAP" by selecting a plans. State will base premium assistance from average of standard PA plans. It was anticipated that, because of the new PACE Plus Medicare program, the PACE and PACENET pro expanded by 35 percent to cover an additional 120,000 enrollees by 2007.
Contact & information Web site	PA Dept. of Aging 555 Walnut Street, 5th Floor, Harrisburg, PA 17101 Residents toll-free 1-800-225-7223 or (717) 787-7313; FAX: 717-772-2730 Email: aging@state.pa.us PACE: http://www.portal.state.pa.us/portal/server.pt/community/pace___pacenet/17944 http://www.portal.state.pa.us/portal/server.pt/community/pace_plus_medicare/17946 Email Application: http://www.portal.state.pa.us/portal/server.pt/community/pace___pacenet_applications/17945 The Chronic Renal Disease Program - The Pennsylvania Department of Health – Division of Child and Adult Services Phone 1-800-225-7223; Fax (717) 651-3664 http://www.portal.state.pa.us/portal/server.pt/community/chronic_renal_disease/14233 Email Application: http://www.portal.state.pa.us/portal/server.pt/gateway/PTARGS_0_75878_1029449_0_0_18/2011%20CRDP%2C Special Pharmaceutical Benefits Program – Pennsylvania Department of Public Welfare http://www.dpw.state.pa.us/foradults/healthcaremedicalassistance/aidswaiverprogram/specialpharmaceuticalbene ... roc SPBP Customer Service Line 1-800-922-9384

Enroll SPBP HIV/AIDS Application: http://www.dpw.state.pa.us/ucmprd/groups/webcontent/documents/form/s_001352.pdf

Enroll SPBP Mental Health Application: http://www.dpw.state.pa.us/ucmprd/groups/webcontent/documents/form/s_001322.pdf

Updated: 6/2007, 2/2008; 6/2011

Sources: Director Tom Snedden presentation and statements 8/18/05; 4/4/06; 5/8/06; PACE web site, 11/27/05; Theresa Brown, PA Dept of Aging, 12/2005.

RHODE ISLAND	RIPAE - Rhode Island Pharmaceutical Assistance for the Elderly
The currently operational RIPAE subsidy program pays a portion of the cost of prescription drugs for about 16 medical conditions, ranging from 15 to 60% of the price. All other drugs are available at a 15% discount. RIPAE members can receive help in paying for their Part D medications during the plan deductable or coverage gap phases, if applicable.	
Eligibility	Minimum age is 65, or between 55 and 64 if disabled and receiving Social Security Disability Income (SSDI) payments. There are three levels of coverage, based on annual income: 15% discount if over 65 or age 55-64 and disabled with an annual income of $26,280 - $45,991 (individual) and $32,852 - $52,561 (couple); 30% discount for over 65 with an annual income $20,935 - $26,279 (individual) and $26,171 - $32,851 (couple); and 60% discount for over 65 with an annual income up to $20,934 (individual) and up to $26,170(couple). (income limits are effective as of 2010)
Disabilities coverage	Disabled individuals under age 55 are not eligible for state benefits.
Benefits	The details of Part D wrap around and coordination of benefits were not available as of the publication date of this report. The RIPAE program pays "a portion of the cost of prescriptions used to treat Alzheimer's disease, arthritis, diabetes (including insulin and syringes for insulin injections), heart problems, depression, anti-infectives, Parkinson's disease, high blood pressure, cancer, urinary incontinence, circulatory insufficiency, high cholesterol, asthma and chronic respiratory conditions, osteoporosis, glaucoma, and prescription vitamins and mineral supplements for renal patients for eligible Rhode Island residents 65 and older. RIPAE also offers limited coverage for the cost of injectable prescription drugs used to treat multiple sclerosis." RIPAE enrollees can purchase all other FDA-approved "Category B" prescriptions (except for those used to treat cosmetic conditions) at a 15% discount. RIPAE members can receive help in paying for their Part D medications during the plan deductable or coverage gap phases, if applicable.
Medicare wrap around	Yes; all state benefits are provided in coordination with federal Medicare. Qualified SPAP; payments count toward TrOOP.
Est. # of beneficiaries	18,469 enrollees as of 3/2009; Filed claims = 134,000 annually.
State laws	1985, 2003: RI General Laws §42-66.2-5
Special features & issues	Excludes income spent on medical expenses if greater than 3% of total income. Residents between 55 and 64 who are receiving SSDI payments can purchase medications at a 15% discount. There is no state co-payment for these medications. Income limits for SSDI recipients are $41,136 for individuals and $47,012 for a married couple. The details of wrap around and coordination of benefits may require legislative and executive branch action and approval in 2006. Income limits will increase each year to reflect the annual Cost-of-Living Adjustment (COLA) as determined by the Social Security Administration. For 2009 the Governor's budget proposes cutbacks in the program; these changes are not yet enacted. News article: RI: Carcieri's budget includes cut in prescription drug aid for the elderly , 3/19/09.
Other Rx programs	Yes, RI Prescription Drug Discount for the Uninsured, see below
Contact & online information	Dept. of Elderly Affairs (401) 462-3000 Enroll http://adrc.ohhs.ri.gov/paying/Prescription_Assist.php http://www.dea.ri.gov/programs/prescription_assist.php

Updated: 5/1/2009; 6/2011 Sources: RIPAE website; RI Legislative website 5/15/2009

SOUTH CAROLINA	GAPS - Gap Assistance Prescription Program for Seniors - No longer operational, due to lack of state funds, effective July 1, 2010 – See Archive

TENNESSEE	Cover Rx (subsidy)
CoverRx is a statewide pharmaceutical assistance program for adults ages 19-64 lacking pharmacy coverage, providing a sliding scale subsidy for generics for residents with incomes up to 250 percent of federal poverty. Selected brand name products may be available at a discount.	
Eligibility and charges	State residents, ages 19-64 with household income up to 250% FPL (2011; $27,225) [Cover Rx Income Guidelines]. Must be U.S. citizen or qualified legal alien, residing in the state at least six months. Must not have prescription drug coverage, including Medicare, TennCare/Medicaid or employer sponsored drug coverage. There is no enrollment fee or premium; copayments are required for each purchase. Operational as of 1/2/2007. "Due to high demand," CoverRx enrollment was temporarily suspended in February 2007, but reopened in April 2007 for 3,500 on a waiting list and new applicants.
Disabilities coverage	No, only if ages 19-64 and otherwise qualified.
Benefits	Approximately 250 generic drugs are available, with a three-tier copayment based on income. 90-day supply - below 100% FPL (2011; $10,890) is $3; up to 149% FPL (2011; $16,226) is $10; 150% to 250% FPL ($16,335 to $27,225) is $16. 30-day supply - below 100% FPL (2011; $10,890) is $3; up to 149% FPL (2011; $16,226) is $5; 150% to 250% FPL ($16,335 to $27,225) is $8. All other drugs (including available brand names) are available at a flat discount, defined as "lesser of Discount, 'Maximum Allowable Cost' or 'usual and customary' price; no prior authorization program for drugs off formulary . Online [Rx product list; formulary]
Medicare wrap around	No, Medicare Part D eligibles and enrollees are disqualified.
Est. # of beneficiaries	47,140 as of 9/2011
State laws	2006: Signed 6/12/06
Special features & issues	Cover Rx combines features of a discount-only program with features of a subsidy (SPAP) program. It is part of a 5-part health program called "Cover Tennessee." The formulary list is administered by ExpressScripts.
Other Rx programs	Yes, Cover Rx -Discounts, see below
Contact & online information	Cover Tennessee, Dept. of Finance and Administration Toll-Free 1-866-COVERTN Public Information Officer: (615) 532-1921. Online: Cover Rx http://covertn.gov/web/cover_rx.html Enroll Application: http://covertn.gov/web/coverrx_app_english.pdf

Sources: CoverTN web site, accessed 4/12/07; NCSL summary of law Updated: 9/13/2007; 5/2009; 6/2011

TEXAS	1.) Kidney Health Care Program (KHC)

	2.) HIV SPAP
The Kidney Health Care Program is limited to individuals diagnosed with end-stage renal disease; the HIV SPAP Program helps HIV-positive individuals with their out-of-pocket costs associated with Medicare Part D prescription drug plans, including co-payments, deductibles, coinsurance, and during the coverage gap (the "donut hole"). The programs are listed primarily because they are recognized by CMS as "qualified SPAPs."	
Eligibility	KHC: State residency and ESRD must be certified; applicant must be receiving a regular course of chronic renal dialysis treatments or have received a kidney transplant; an application for benefits must be submitted through a Medicare approved hospital, VA facility, or KHC approved facility; an application for ESRD benefits must be filed with Medicare; and KHC-established financial criteria must be met. HIV SPAP: Must be a Texas resident, eligible for the Texas HIV Medication Program and all other THMP eligibility requirements; have an adjusted gross income less than 200% of the federal poverty level ($20,800 for a single person or $28,000 for a married couple in 2008); be eligible for Medicare; enrolled in a Medicare Part D Prescription Drug Plan; and denied the full Low Income Subsidy or approved for the partial subsidy for prescription drug assistance by the Social Security Administration.
Benefits	KHC: Provides assistance to Texas residents with a diagnosis of End-Stage Renal Disease (ESRD) from a licensed physician, receiving regular dialysis treatments or has received a kidney transplant, can NOT get Medicaid medical, drug, or travel benefits, and has an income of less than $60,000 per year. The KHC program services include: prescription drug benefits, coordination of benefits and premium reimbursements for Medicare Part D Prescription Drug Program, co-insurance for immunosuppressive drugs covered under Medicare Part B, limited travel reimbursement and certain medical expenses. KHC will pay for up to four (4) prescriptions per month for Part B and D coverage. The drug must be on the KHC drug list andthe Medicare Part D plan's drug list. HIV SPAP: The SPAP will pay for covered medications up to a maximum annual allowable amount per enrollee. For 2009 the annual allowable amount is $10,995.The SPAP will pay the out-of-pocket costs during the coverage gap (donut hole), for covered medications.
Medicare wrap around	Yes; all state benefits are provided in coordination with federal Medicare. Qualified SPAP; payments count toward TrOOP.
Est. # of beneficiaries	KHC: 18,877 as of 7/2007.
Special features & issues	Beginning on January 1, 2008, KHC will not reimburse enrollees directly for premium payments. The Part D plans will bill KHC for enrollee premiums. See Regulations: 25 TAC §§61.1 – 61.14 of 2005.
Contact & online information	*Kidney Health Care Program, Texas Department of State Health Services* *P.O. Box 149347, Austin, Texas 78714-9347* *Toll-free: 1-800-222-3986;Local: 512-458-7150, ext. 6879; Fax: 512-458-7162.* http://www.dshs.state.tx.us/kidney/ Enroll Application: http://www.dshs.state.tx.us/kidney/forms/default.shtm 2008 requirements: http://www.dshs.state.tx.us/kidney/pdf/2008_KHC-MCRD_Eng.pdf Mental Health: 1100 W 49th, Austin, TX 78756; tel. 512-458-7135 Texas Department of State Health Services – HIV/STD Program Phone: (512) 533-3000; Fax: (512) 371-4672; E-mail: hivstd@dshs.state.tx.us http://www.dshs.state.tx.us/hivstd/meds/spap.shtm Fact Sheet: http://www.dshs.state.tx.us/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=22450 Enroll Application: http://www.dshs.state.tx.us/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=22449

Sources: NCSL summary of program; Kidney program website. Updated: 2/22/2008; 6/2011

VERMONT	VPharm, VHAP-Pharmacy, VScript
VPharm is a recent program that is a hybrid of the previously operating Vermont Rx assistance programs, which first started in 1989. The wrap around features allow the state to pay enrollee out-of-pocket costs; it started January 1, 2006.	
Eligibility	**Residents on Medicare or SSDI with a 2010 annual income up to $22,164 for individuals and up to $29,820 for couples. For those between 150% and 225% FPL (2010; $16,245 to $24,367.5), only maintenance drugs in those classes are covered. For those on Medicaid and those below 150% FPL (2010; $16,245), both maintenance and acute drugs are covered. VPharm also covers most cost-sharing that is not paid by the federal Medicare Part D low-income subsidy.**
Disabilities coverage	Persons with disabilities under age 65 are eligible for state benefits, including coverage during the 2-year waiting period for federal Medicare eligibility. Must be eligible for Medicare Part A or enrolled in Medicare Part B.
Benefits	VPharm assists Vermonters who are enrolled in Medicare Part D with paying for prescription medicines. This includes people age 65 and older as well as people of all ages with disabilities. For Medicare-Medicaid dual eligibles, it covers all non-part D drugs. For pharmaceuticals-only benefit, will cover all costs of premium, copay, coinsurance and doughnut hole. Those above the dual eligible income cutoff pay on a sliding scale: 150-175% FPL (2010; $16,245 - $18,952.50) pay $17 VPharm premium; 175-200% FPL (2010;$18,952.50 - $21,660) pay $23 premium; 200-225% FPL (2010; $21,660 - $24,367.50) pay $50 premium. VPharm pays all other costs. ▪ VHAP-Pharmacy helps Vermonters age 65 and older and people with disabilities who are not enrolled in Medicare pay for eye exams and prescription medicines for short-term and long-term medical problems and includes an affordable monthly premium. ▪ VScript helps Vermonters age 65 and older and people of all ages with disabilities who are not enrolled in Medicare pay for prescription medicines for long-term medical problems. There is also an affordable monthly premium based on your income.
Medicare wrap around	Yes; all state benefits are provided in coordination with federal Medicare. Qualified SPAP; payments count toward TrOOP.
Est. # of beneficiaries	Total = 30,000 (Rx + duals) 14,285 enrolled in VPharm as of 7/2007.
State laws	2005: H 516
Special features & issues	Programs operate within Green Mountain Care, which "is a family of low-cost and free health coverage programs for uninsured Vermonters." VPharm Program started January 1, 2006. Received CMS approval to do auto assignment of duals into a few commercial Part D plans. Covers all costs (other than VPharm premium) for Rx only benefit side. The state has additional pharmaceutical assistance programs for non-Medicare populations. VHAP-Pharmacy, VScript and VScript expanded will continue only for those who are 65 and older or who receive disability benefits from Social Security, but who are not eligible for Medicare. VPharm was created as a wraparound for Part D. *[Source: "State Part D Wrap Around for SPAP Beneficiaries," Report by the Centers for Medicare and Medicaid Services, April 5, 2006.]*
Other Rx programs	Yes. Healthy Vermonters, see below
Contact & online information	Dir. of Health Program Integration Unit (VHAccess) Telephone:800 529-4060 (in state); 800 250-8427 (out of state)

	http://www.greenmountaincare.org/vermont-health-insurance-plans/prescription-assistance Application: http://www.greenmountaincare.org/sites/gmc/files/pdf/pharmacy_programs_application.pdf http://ovha.vermont.gov/for-providers/2plans_that_wrap_part_d.pdf

Sources: VT Legislative website; text of H 516; interview with program & legislative staff, 2/08; 11/20/08 Updated: 12/19/2005; 11/20/2008; 5/2009; 6/2011

VIRGINIA	**Virginia Department of Health SPAP**
The Virginia SPAP pays Medicare Part D costs for people diagnosed with HIV/AIDS who get medicines through the Virginia AIDS Drug Assistance Program (ADAP).	
Eligibility	**Must be Medicare eligible, diagnosed with HIV/AIDS and enrolled in both ADAP and a Medicare Part D plan. Must not be eligible for Medicaid. Yearly family income cannot be 400% (2011; $43,560) of the federal poverty level (FPL).**
Disabilities coverage	No, unless diagnosed with HIV/AIDS and enrolled in both ADAP and a Medicare Part D plan.
Benefits	As of 1/07 the SPAP will help pay for monthly Part D premiums, and "will soon pay all medication copays/coinsurance, deductibles and medication costs during gaps in coverage."
Medicare wrap around	Yes; all state benefits are provided in coordination with federal Medicare. Qualified SPAP; payments count toward TrOOP.
Est. # of beneficiaries	100 enrollees as of 7/2007.
Special features & issues	Current enrollees will be notified when the program will start paying for copays/coinsurance, deductibles and gaps in coverage. "When SPAP starts covering copays, you will be able to use Part D plan to get all your medicines (including medicines you currently receive from ADAP). Participants can use a retail or mail order pharmacy to fill all medicines covered by a Part D pla **Patient Services Incorporated (PSI)** manages the SPAP under a contract with the Virginia Department of Health effective 2008.
Other Rx programs	no.
Contact & online information	Virginia SPAP P.O Box 2448, Richmond, VA 23218; Hotline: (800) 533-4148 FAX: (804) 864-8050 Web: http://www.vdh.state.va.us/Epidemiology/DiseasePrevention/spap.htm *(2/08)* Fact sheet : http://www.vdh.state.va.us/Epidemiology/DiseasePrevention/documents/SPAP%20Fact%20Sheet%20June%202007%20U *(2/08)*

Sources: state web site Updated: 2/2008; 6/2011

WASHINGTON	**Medicare Copayment plan - No longer operational, funded through June 30, 2007** – See Archive

WEST VIRGINIA	West Virginia Rx
West Virginia Rx is a program that provides prescription drugs at no cost to patients who are uninsured, between the ages of 18 and 65.	
Eligibility	**Must be a resident of West Virginia who is uninsured, age 18 to 65 years, with annual income up to 200% of federal poverty (individual $21,780/year; two persons $29,420/year for 2011).** **A $30 enrollment fee is required but may be waived in cases of hardship.**
Disabilities coverage	Yes, if age and income requirements are met.
Benefits	The program provides selected brand-name prescription drugs at no cost. Formulary list online (3/2010)
Medicare wrap around	No, Medicare Part D eligibles and enrollees are disqualified unless they are under age 65 and uninsured.
Est. # of beneficiaries	n/a
Special features & issues	West Virginia Rx is sponsored by the office of West Virginia Governor Joe Manchin, the Heinz Family Philanthropies and the Claude Worthington Benedum Foundation. Two of the state's premier free health care clinics, West Virginia Health Right in Charleston and Beckley Health Right, are administering the project.
Other Rx programs	WV Pharmaceutical Discount Program and Golden Mountaineer Discount Program
Contact & online information	WVRx, 1520 Washington Street, East, Charleston, WV 25311 Phone: 304-414-5935; Web site: http://www.wvrx.org/ Enroll in Rx program www.wvrx.org/LinkClick.aspx?fileticket=bGou172mY2I%3d&tabid=174

Updated: 5/7/2009; 6/2011 Source: WV web site

WISCONSIN	1.) SeniorCare Rx 2.) Chronic Renal Disease Program 3.) Cystic Fibrosis Program 4.) Hemophilia Home Care	Wisconsin SeniorCare
A senior subsidy program serving residents up to 240% of federal poverty. Includes a voluntary Medicare Part D wrap around benefit was negotiated but not agreed to in 2006. SeniorCare Rx does not offer any "donut-hole" coverage for those up to about 240% FPL, but does have sliding scale cost-sharing as income rises. The WI federal "Pharmacy Plus" Medicaid waiver, was extended to December 31, 2009.		
Eligibility	**SeniorCare Rx: Wisconsin residents age 65 or older with a 2011 annual income up to 160% FPL ($17,424, individual; $23,563 couple) for Level 1 benefits; 160% - 200% FPL ($17,425 - $21,780 individual; $23,537 - $29,420 couple) for Level 2a benefits; 200% - 240% ($21,781 - $26,136 individual; $29,421 - $35,304 couple) for Level 2b benefits; and more than 240% FPL ($26,137+ individual; $35,305+ couple) for Level 3 benefits. If over $24,961 per individual (level 3), the enrollee must "spend down" below that amount. There is no asset limit. A $30 annual enrollment fee per person is required. Program participants are subject to certain annual out-of-pocket expense requirements depending on their annual income.** **Chronic Renal Disease Program: Wisconsin residents diagnosed as having end-stage renal disease, paying Medicare part b premiums if eligible for Medicare.**	

	Cystic Fibrosis Program: Wisconsin resident diagnosed by the medical director of a cystic fibrosis treatment center as having cystic fibrosis and be 18 years of age or older. Hemophilia Home Care: Wisconsin resident diagnosed by a comprehensive hemophilia treatment center as having hemophilia. The participant must also enter into a written agreement with a comprehensive hemophilia treatment center for compliance with a maintenance program.
Disabilities coverage	Excludes the disabled, whether or not eligible for Medicare.
Benefits	SeniorCare Rx: An individual whose gross annual income is greater than 160% of the current FPL and less than or equal to 200% of the current FPL (level 2a) will have an annual deductible of $500, meaning participant(s) pay for the first $500 of covered prescription drug costs at participating pharmacies each year. After the $500 deductible is met, covered prescription drugs can be purchased at the co-payment amounts for the remainder of the annual benefit period. The co-payments are $5 for each covered generic prescription drug, and $15 for each covered brand name prescription drug. Chronic Renal Disease Program: Inpatient and outpatient dialysis and transplant treatments. One pre-transplant dental examination, and X-rays. Kidney donor transplant-related medical services. Certain prescription medications. Certain home supplies. Certain laboratory and X-ray services. Cystic Fibrosis Program: Inpatient and outpatient services directly related to the disease. Certain physician services. Certain laboratory and x-ray services. - Certain prescription medications. Certain home supplies. Hemophilia Home Care: Eligible to receive services for blood derivatives and supplies necessary for home infusion. A $10 participant co-pay will be applied to each prescription and blood product covered by the program.
Medicare wrap around	Yes, but only for enrollees above 200% of FPL; these state benefits are provided in coordination with federal Medicare. Qualified SPAP; payments count toward TrOOP.
Est. # of beneficiaries	111,267 enrolled, as of 7/16/06 (includes 79,523 waiver and 31,744 non-waiver enrollees)
State laws	SB 55 (2001) (Sec. 1823, 49.477); WI Stat. § 49.688 (2004); The program has an approved Medicaid 1115 "Pharmacy Plus" waiver, still in effect for 2006 and 2007.
Special features & issues	Individuals with prescription drug coverage under other health plans are eligible to enroll in SeniorCare. If an enrollee already has a health insurance plan, SeniorCare will coordinate benefit coverage with that plan. The Department of Health and Family Services has determined that the prescription drug coverage offered by SeniorCare is "creditable coverage." This means that SeniorCare coverage, on average, is as good as the standard Medicare drug coverage. "Non-risk based lump sum approach. Those in spend down are not eligible for the wraparound benefit; will not cover drugs not already covered by Part D or drugs not included in PDP formulary." *[Source: "State Part D Wrap Around for SPAP Beneficiaries," Report by the Centers for Medicare and Medicaid Services, April 5, 2006.]*
Other Rx programs	Badger Rx gold provides a retail counter discount for any resident that lacks prescription drug insurance coverage if the person enrolls and pays the annual enrollment fee.
Contact & online information	SeniorCare Customer Service Hotline: (800) 657-2038 http://dhfs.wisconsin.gov/seniorcare/ *(updated 6/2010)* Fact Sheet: http://www.dhs.wisconsin.gov/seniorCare/factsheets/p10078.htm; PDF: http://www.dhs.wisconsin.gov/seniorCare/factsheets/pdfs/p-10078.pdf Enroll Application: http://www.dhs.wisconsin.gov/seniorCare/app-instruc-info.htm Wisconsin Chronic Disease Program https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/provider/wcdp/index.htm.spage The help desk can be reached (Toll-free) at 1-866-908-1363 between the hours of 8:30 AM — 4:30 PM Monday through Friday.

Sources: SeniorCare website; e-mail correspondence with WI DHFS; WI Admin. Code. Updated: 6/6/2010; 6/2011

WYOMING	Prescription Assistance Program
Wyoming's state-only coverage continues for those under 100% FPL and not qualified for Medicare. Pharmaceutical coverage of Medicare Part D eligibles was discontinued May 31, 2006.	
Eligibility	**Any resident with annual income up to 100% FPL ($10,890 individual; $14,710, 2 person household) with no other Rx coverage (includes Medicare Part D). Also has a vehicle value limit of $15,000 and cash asset maximum limit of $2,500. No age restriction. Medicare Part D enrollees were disqualified as of June 1, 2006.**
Disabilities coverage	The state will continue to include persons with disabilities with the same income and asset requirement as others.
Benefits	The state program will cover up to three prescriptions per month, requiring enrollee copay of $25 brand, or $10 generic products. Uses state Medicaid preferred drug list: http://www.wyequalitycare.org/
Medicare wrap around	No, Medicare Part D eligibles and enrollees are disqualified unless they are under age 65 and uninsured.
Est. # of beneficiaries	269 enrollees, as of 8/1/06.
State laws	Wyo. Stat §42-4-118
Special features & issues	Also covers prescribed oxygen. Agency officials are "waiting to see what legislature will do with the program, since it currently has a capped enrollment." As of 7/1/06, the program reopened to new enrollment for people earning less than the federal poverty level. The program is not limited by age or disability.
Contact & online information	Prescription Assistance Program Pharmacist Consultant - Telephone 307-777-8699. Enroll http://www.health.wyo.gov/healthcarefin/pharmacy/PDAP.html

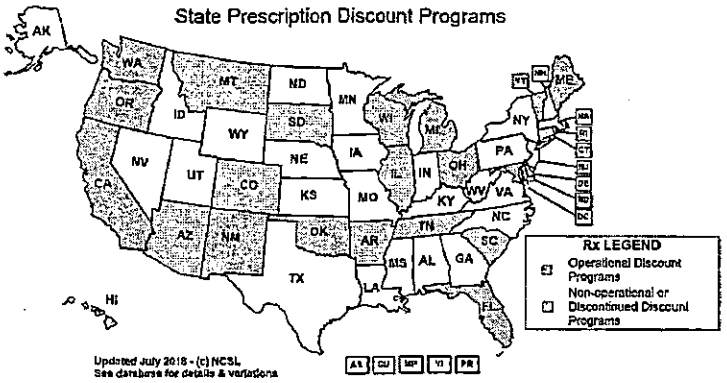
Updated: 12/19/05; 7/31/06; 6/2011

Source: WY Pharmacist Consultant 307-777-8699 alewis@state.wy.us

State Discount Programs - TABLE 2

In almost half the states, programs were once created to provide for a reduced or discounted retail price for eligible participants, but do not provide a state subsidy for the purchase of prescription drugs. In several states, discount programs have been added to or integrated with subsidy programs - see related details in chart one above. In the wake of the Affordable Care Act (ACA, widely called Obamacare), many of these programs have been scaled back or closed.

ARCHIVE STATE TABLE - Maintained as Try the web links or phone contacts listed below. NCSL is not responsible for changes or termination of individual state programs.



Other cost-related programs and proposals, including multi-state projects, inter-agency purchasing, coordination of industry charity programs, evaluating pharmaceutical advertising, and regulating commercial discount cards, are listed separately - see **NCSL Pharmaceutical Reports menu page.**

ARIZONA	CoppeRx Card
The CoppeRx Card program was launched in 2003 as a discount plan aimed at seniors and disabled; in 2005 eligibility was expanded to include all residents.	
Eligibility	All Arizona state residents are eligible. There is no enrollment fee for CoppeRX.
Disabilities coverage	Yes, any state resident is included in the discount program.
Benefits	After expanding the program, participating pharmacies will offer discounted prices negotiated by the state with manufacturers and pharmacies for those who present the card upon picking up any prescriptions.
Medicare wrap around	No; Not a qualified SPAP; payments do not count toward TrOOP.
Est. # of beneficiaries	1,000,057 Arizona residents were enrolled in the program in 2009. Approximately 59,000 people use the card each month.
State laws	Governor Janet Napolitano announced the program in January 2004 http://www.rxamerica.com/media/pdf/az_press_copperx.pdf (hyperlink to news release from Governor office).
Special features & issues	Hundreds of Arizona pharmacies present the card upon picking up any prescription drug medications. It is intended to serve those without prescription drug coverage and to fill gaps that Medicare Prescription plans have.
Other Rx programs	Yes, Medicare Co-Payment Plan
Contact & online information	Program administered by AHCCCS: Tel: 602-417-4000; Every Arizonan is entitled to a free CoppeRX® Card. **Click here** to sign up or call (888) 227-8315. http://azgovernor.gov/governor/copper-card
Sources: AZ website; interview with Governor Health Policy Advisor	Updated: Dec. 2015

ARKANSAS	Arkansas Rx Program - Enacted Law HB 1241; Act 538, signed 3/3/05; Not operational, never implemented – See Archive

CALIFORNIA	1) California Prescription Drug Discount Program for Medicare Recipients (2000-) 2) California Discount Prescription Drug Program - Not yet operational – See Archive
Eligibility	California Prescription Drug Discount Program for Medicare Recipients includes anyone who is eligible for Medicare, seniors over the age of 65 and those under the age of 65 who are disabled. There is a 15 cent processing fee per prescription filled.
Disabilities coverage	Yes, for disabled that otherwise qualify
Benefits	Medicare: Prescription drugs are at the Medi-Cal prescription rates with over 500 pharmacies throughout California. No prior authorization is needed on prescription drugs and virtually all prescriptions are covered.
Medicare wrap around	No; Not a qualified SPAP; payments do not count toward TrOOP.
Est. # of beneficiaries	Program has no enrollment process. No information on number of beneficiaries. (9/2011)
State laws	Medicare enrollee programs: 1999 law SB 393; 2001 law SB 696
Special features & issues	The program was contentious during the legislative and ballot question phase. Funding eliminated August 21, 2007: $6.3 million from the California Discount Prescription Drug Program Fund: The Governor zeroed out the money to implement this program that would negotiate with drug companies to provide discounts to uninsured and underinsured Californians. In his veto statement, he directed the Department to identify ways to start the work, but the program is likely to be delayed. The pricing structure includes these features: "Consider three different benchmarks in negotiations with drug manufacturers: the Medicaid Best Price, the lowest price offered to private payers, and the average manufacturers' price minus 15 percent. For the first three years, gives drug manufacturers the ability to voluntarily negotiate discounts. If after August 1, 2010, manufacturers do not provide discounts at the benchmark levels, the state may, upon federal approval, tie participation in Medi-Cal with participation in this program as long as imposing this linkage does not disrupt care of California's Medi-Cal enrollees and budget neutrality is maintained."
Other Rx programs	1) Genetically Handicapped Persons Program is a single-condition limited eligibility program certified as a "qualified SPAP" by CMS. 2) California Discount Prescription Medication Program (1999-2006) California was one of the first to launch a statewide prescription drug discount program, aimed at the Medicare population. With no income or enrollment requirements, residents just show a Medicare Card to be eligible for a calculated price reduction at the counter, based on the state Medi-Cal (Medicaid) negotiated price. The need for this program reduces substantially once individuals enroll in the federal Medicare Part D drug plans, but those not using Part D or facing a gap in coverage may use this plan.
Contact & online information	Tel: Dept. of Health Services: 916-657-4302 or 916-552-9714 and HICAP: 800-434-0222 http://www.dhcs.ca.gov/individuals/Pages/PresDrgDisPrgmMedRcpts.aspx
Sources: CA websites; conversation with agency 10/07.	Updated: 2/2007; 1/22/2008; 2/22/2008; 9/2011
COLORADO	Colorado Cares Rx - Enacted Law SB 07-001, signed 2/1/2007; Program repealed, February 2009 – See Archive

CONNECTICUT	ConnPACE part "B"- Enacted Law Public Act 00-2; Not operational, never implemented – See Archive

DISTRICT OF COLUMBIA	AccessRx program - Enacted Law 15-569, signed 3/25/2004; Not operational – See Archive

FLORIDA	Florida Discount Drug Card
The Florida Discount Drug Card is designed to lower the cost of prescriptions for Florida residents without drug insurance coverage. Enrollees save an estimated 5 to 40 percent on Rx purchases.	
Eligibility	All Florida residents are eligible. The Florida Discount Drug Card offers additional savings for Florida residents who are: Age 60 to 64, without prescription drug coverage, and do not belong to a Medicare Part D plan; Or, under age 60, without prescription drug coverage and with an annual family income of less than 300% of the federal poverty level. Qualifying incomes include: $32,670 per year for an individual, $44,130 per year for a family of two, and $67,050 per year for a family of four. *Qualifying incomes for families larger than four are available upon request.*
Disabilities coverage	Yes, all who qualify under income and age requirements above.
Benefits	"Savings will vary depending on the quantity, type and brand of the drug purchased. Average savings on 10 commonly used prescription drugs ranged from 5 to 42 percent; "virtually all prescription drugs" may be available. Click here to check Drug Pricing. Member card may Be used at all participating pharmacies: Pharmacy Locator
Medicare wrap around	No; Not a qualified SPAP; payments do not count toward TrOOP.
Est. # of beneficiaries	n/a
State laws	Created by executive agency action, December 2007.
Other Rx programs	No. In 2000 Florida enacted a subsidy program and another discount plan, named Senior Prescription Affordability Act - they were phased out in 2005 and are not operational – see ARCHIVE
Contact & online information	Enroll: Information on Florida Discount Drug Card, call Toll-free: 1-866-341-8894 (TTY Users may call 1-866-763-9630) or e-mail flddcp@envisionrx.com Web: http://www.floridadiscountdrugcard.com Fact Sheet: http://www.floridadiscountdrugcard.com/pdfs/AboutFactSheet.pdf

Sources: Gov. Christ news release; agency web site, 12/27/07; 1/22/08 Updated: 12/27/2007; 6/2011

HAWAII	Hawaii Rx+ Discount Program - Enacted Law 2002 HB 2834; Program discontinued, effective August 1, 2010 – See Archive

ILLINOIS	IL Rx Buying Club
The Rx Buying Club began as a Governor's initiative in 2003 for seniors and disabled. As of 2006 it was expanded by the legislature to allow residents of any age, with incomes up to 300% of federal poverty guidelines, to buy prescriptions at a discount.	
Eligibility	Any in-state resident who has a household income equal to or les than 300% of federal poverty level. A single person household annual income must be equal to or less than $32,670. The income limit is $44,130 for a couple. Annual administrative enrollment fee is $10.00 and non-refundable.
Disabilities coverage	Yes, if otherwise qualified.
Benefits	Senior citizens and person with disabilities can receive discounts on all FDA approved prescription drugs.
Medicare wrap around	No; Not a qualified SPAP; payments do not count toward TrOOP.
Est. # of beneficiaries	77,589 as of September 2011
State laws	*2003 law:* SB 3; 2005: HB 973
Other Rx programs	Also offers Illinois Cares RX Plus, see above
Contact & online information	Illinois Rx Buying Club Member Services: 1-866-215-3463 http://www.illinoisrxbuyingclub.com Enroll: Application: http://www.illinoisrxbuyingclub.com/application.html

Sources: Interview with Drug Advocate for the Governor;NCS; Summary of Law Updated: 8/2007; 5/2009; 9/2011

MAINE	Maine Rx Plus Program
Maine Rx Plus was originally created by a 2000 state law; it became operational in 2004 after a largely favorable ruling by the U.S. Supreme Court. The program offers retail counter savings of 15 percent on name brands and up to 60 percent on generics.	
Eligibility	Most Maine residents without prescription drug coverage will be eligible for the Maine Rx Plus Card. A single person household must have a gross monthly income less than $2,978; a two person household monthly income less than $3,993; a three person household monthly income less than $5,008; a four person household monthly income less than $6,023; and a five person household monthly income less than $7,038.
Disabilities coverage	Yes, if otherwise qualified.
Benefits	All members save up to 15% on name brand drugs and up to 60% on generic drugs. Low Cost Drugs for the Elderly and Disabled also receive cost savings as Maine Rx Plus Members
Medicare wrap around	No; Not a qualified SPAP; payments do not count toward TrOOP.
Est. # of beneficiaries	51,436 as of September 2011
State laws	2003 LD 1634/ SP 560 (signed 6/13/03) U.S. Supreme Court favorable ruling 5/19/03 Operational 4/2004
Special features & issues	This program was initially authorized in 2000 but implementation was delayed by challenges in federal court and ultimately upheld by the U.S, Supreme Court in May 2003.
Other Rx programs	Yes. Also offers a subsidy program, Low-Cost Drugs for the Elderly and Disabled Program
Contact & online information	Enroll: Maine Rx Plus Program. http://www.maine.gov/dhhs/mainerx/index.htm Maine Rx Plus Brochure. http://www.maine.gov/dhhs/mainerx/brochure.pdf

	Maine Rx Plus Fact Sheet. http://www.maine.gov/dhhs/mainerx/fact.pdf Bureau of Medical Services To enroll: 1-866-796-2463 207 287-2674

Sources: Interview with Director of Pharmaceuticals Updated: 7/2007; 5/2009; 9/2011

MARYLAND	Primary Adult Care Program
Beginning in July 2006, the Primary Adult Care Program (PAC) replaced the Maryland Pharmacy Assistance Program. If you were in the Pharmacy Assistance Program you will be in PAC.	
Eligibility	**This program replaced the Maryland Pharmacy Assistance Program, effective July 2006. State residents between the ages of 19 and 65 who do not qualify for Medicare or Medicaid and meet the income requirements. For families with a household of more than one person call 1-800-226-2142 for income guidelines. Your assets can't be more than $6,000. For individuals, call 1-800-226-2142 for income guidelines. Your assets can't be more then $4,000.**
Disabilities coverage	Yes, if otherwise qualified.
Benefits	Free office visits to a Primary Care Provider, also called a PCP. Free office visits to a counselor or psychiatrist for mental health services. Prescription drugs, although you may need to pay a co-pay for some prescriptions. Community-based substance abuse treatment services.
Medicare wrap around	No; Medicare enrollees are disqualified; Not a qualified SPAP; payments do not count toward TrOOP.
State laws	2005: HB 1143 law effective 6/1/05
Special features & issues	The 2005 law allows for qualify residents to be within 175% of federal poverty level; see "eligibility" above for current requirements. Maryland Pharmacy Discount Program
Other Rx programs	Yes, see MD subsidy program above. Maryland Senior Prescription Drug Assistance Program (SPDAP)
Contact & online information	Maryland Pharmacy Assistance 1-800-226-2142 PAC Program Application, P.O.Box 386, Baltimore, MD 21203-0386 www.dhmh.state.md.us/mma/pac/index.htm Click for Application [updated 5/10] http://www.dhmh.state.md.us/mma/pac/pdf/2011/PAC_Broch_03.15.11_FINAL_English.pdf

Sources: NCSL summary of law Updated: 2/2007; 2/2008; 6/2011

MICHIGAN	MI Rx Prescription Savings Program (MiRx)
The Michigan MiRx program provides retail counter discounts to residents of all ages who lack Rx coverage. Estimated average savings are 20 percent per month.	
Eligibility	**No minimum age; must have no prescription drug coverage and must be a state resident. Eligibility is based upon sliding income scale. Income must be at or below Michigan Median Income. Current rate for individual is $31,200; two person household is $42,000. There is no enrollment fee for this program.**
Disabilities coverage	No, intended for people without coverage.
Benefits	Beneficiaries will save approximately 20% on each prescription.
Medicare wrap around	No; Not a qualified SPAP; payments do not count toward TrOOP.
Est. # of beneficiaries	Est. 50,000-200,000-- updated number pending as of 7/07
State laws	*2004 Governor's initiative*
Other Rx programs	No; the previous MI senior subsidy program was terminated December 31, 2005 and replaced by federal Medicare Part D.
Contact & online information	Michigan Dept. of Community Health: http://www.mihealth.org/mirx/index.html 1-866-755-6479 (Online application form) http://www.mihealth.org/mirx/mirx_brochure/mirx_brochure.pdf

Sources: MI RX Website; NCSL summary of law Updated: 8/2007; 6/2011

MONTANA	Prescription Drug Plus Program - Enacted Law SB 324, signed 4/19/05; Not operational, never implemented - See Archive

NEW MEXICO	New Mexico Discount Prescription Drug Program
In 2006, The New Mexico Discount Prescription Drug Program was expanded to all New Mexico residents, also replacing an earlier New Mexico SenioRX program. It provides a retail counter discount averaging 13 percent on brand names and up to 50 percent on generics.	
Eligibility	**All New Mexico state resident are eligible for the program. State residents who already have prescription drug coverage are still eligible for the program and can choose to use whichever program whether it be their prescription drug coverage or the New Mexico Discount Prescription Drug Program that benefits them the most. There is no enrollment fee or premium costs for the program. Once a state resident signs up there is no need to reapply annually, residents are enrolled in the program until they request to cancel.**
Disabilities coverage	Yes, every state resident is eligible and can choose which is more beneficial if they have multiple options on prescription drugs.
Benefits	Enrollees can save up to 50% on generic drugs and an average of 13% on brand name drugs. Over 300 pharmacies participate in the program and accept the discount card.
Medicare wrap around	No; Not a qualified SPAP; payments do not count toward TrOOP.
Est. # of beneficiaries	6,625 enrollees as of 7/25/07
State laws	2005: SB 689, signed as Chapter 160, 4/5/05
Other Rx programs	Not currently. See archive
Contact & online information	Operational, 2006 Administered by the NM Retiree Health Care Authority 1-866-244-0882. New Mexico Retiree Health Care Authority

Sources: NCSL summary of law; Interview with Representative of New Mexico Health Care Authority Updated: 8/2007; 6/2011

OHIO	Ohio Best Rx - Formerly Golden Buckeye Prescription Drug Savings Program
The Golden Buckeye Prescription Drug Savings Program has merged into the Ohio Best RX Program. Seniors with a Golden Buckeye card receive prescription drug discounts through the Ohio Best RX Program. Legislation that enacted the Ohio Best RX program has since been amended to expand eligibility requirements to include all	

state residents, with annual income limits only for those under age 60, set as up to $32,670 for an individual.

Eligibility	State residents over the age of 60 are automatically enrolled regardless of income. State residents under the age of 60 cannot have any insurance coverage to be eligible for the program. In order to be eligible under the age of 60 a state residents must meet the an income requirement which requires them to make equal to or less than 300% of federal poverty guidelines, which equal $32,670 for an individual and $44,130 for a family of two and $67,050 for a family of four. There is no enrollment fee.
Disabilities coverage	Yes, if otherwise qualified; no age limit applies.
Benefits	Average savings to each enrollee is approximately 34% monthly for each participant. Seniors who are also covered by Medicare Part D can still use the card for saving on out of pocket expenses.
Medicare wrap around	No; Not a qualified SPAP; payments do not count toward TrOOP.
State laws	2002: SB 261, §173.08 signed 6/5/02; Summary of 2006 statute amendments
Special features & issues	As of July 2007 the Ohio Best RX Program is administered by the Department of Aging. Amendments to the original program have expanded eligibility from 250% of FPL to 300% of FPL; prior to the amended requirements state residents under the age of 60 had to wait three months before being eligible for the program if they went without health insurance. Now state residents who once had health insurance and no longer do, do not need to wait the three months to be eligible for the program.
Other Rx programs	(Sec. 185.02.) Created the Office of Pharmaceutical Purchasing Coordination in the Department of Administrative Services. [2/2009]
Contact & online information	Operational as of October 2003 Ohio Best RX Program participant help desk: 1-866-923-7879 Ohio Best RX State Program Office: (614) 466-9783 Ohio Best Rx. www.ohiobestrx.org/ Enroll Applications: http://www.ohiobestrx.org/applications.aspx

Sources: Interview with Representative from the Ohio Department of Aging;NCSL summary of law Updated: 7/2007, 2/2008; 5/2009; 6/2011

OKLAHOMA	Oklahoma Prescription Drug Discount Program - Enacted Law SB 547 *Chapter 419, signed 6/6/05;* No longer operational, program ended September 2010 – See Archive

OREGON	Oregon Prescription Drug Program (OPDP)
A 2003 state discount program was significantly expanded by a 2006 binding ballot measure. Beginning January 2007, any state resident lacking prescription drug coverage may enroll, with no age or income limits.	
Eligibility	All Oregonians are eligible to join. There is no enrollment fee and there is no maximum income requirement.
Disabilities coverage	Yes; see eligibility above.
Benefits	Enrolled residents receive a card with an average savings of 50%. Persons enrolled in Medicare Part D prescription coverage are still eligible for this program.
Medicare wrap around	No; Not a qualified SPAP; payments do not count toward TrOOP.
Est. # of beneficiaries	375,420 through August 2011.
State laws	2006 expansion: Ballot Measure 44 approved by voters 11/7/06. Expanded program began 12/8/06
Special features & issues	Effective February 1, 2007, OPDP joined the Washington Prescription Drug Program to form the Northwest Prescription Drug Consortium. The Consortium entered into a contract with The ODS Companies for pharmacy benefit administration.
Other Rx programs	Not in 2007 - see archive.
Contact & online information	Oregon Prescription Drug Program of the Oregon Health Policy and Research Agency contact: Betty Wilton Phone: 503-945-7353 ; Toll-free: 888-411-8737 https://www.odshealthplans.com/SecuredFormsWeb/ODS/drug_card_opdp.jsp on-line description - http://www.oregon.gov/OHPPR/OPDP/index.shtml

Sources: OPDP Website; Interview with Representative; NCSL summary of law Updated: 9/2008; 9/2011

SOUTH CAROLINA	South Carolina Retirees and Individuals pooling together for Savings (SCRIPTS) - Enacted Law H 3586, signed 6/18/03; Not operational, never launched; repealed by H3221 of 2006 – See Archive

SOUTH DAKOTA	Senior citizen prescription drug benefit program - Enacted Law S 216 (2003); Not operational; repealed 9/1/04 – See Archive

TENNESSEE	Cover Rx (discounts)
Cover Rx was enacted into law in 2006 as part of a broader state health coverage package. The prescription drug discount component applies to drugs not on the Covered Drug List. CoverRx was launched in January 2007.	
Eligibility	Any Tennessee resident of at least six months between the ages of 19 to 64, who is a US resident or qualified alien, with an income at or below 250% of poverty level, and with no prescription drug coverage may be eligible. A single person household income level must be under $27,225 and a couple must be under $36,775. Costs to participate vary according to income level. For covered generics, a 30 or 90 day supply for a person below the federal poverty level is $3; a person between FPL and 149% of FPL pays $5 for a 30 day supply and $10 for a 90 day supply; and participants between 150% to 250% of FPL pay $8 per prescription for a 30 day supply or $16 for a 90 day supply.
Disabilities coverage	No, unless otherwise qualified as uninsured or underinsured. See Eligibility above
Benefits	Affordable access to approximately 250 medications, mostly generic. There is a five script limit per month, however, insulin and diabetic supplies do not count against the limit. Drugs not on the covered list or beyond the limit are available for full payment of the discounted price (price varies by drug)
Medicare wrap around	No; Not a qualified SPAP; payments do not count toward TrOOP.
# of beneficiaries	47,140 (as of 7/31/2011)
State laws	Signed 6/12/06. Operational Jan. 2, 2007; CoverRx enrollment was temporarily suspended in February 2007, but reopened in April 2007.
Special features & issues	Cover Rx is part of a 5-part health program called "Cover Tennessee." The formulary list is administered by ExpressScripts.

Other Rx programs	
Contact & online information	Cover TN telephone: 1-866-CoverTN; Enroll Cover Rx: http://www.covertn.gov/web/cover_rx.html Application: http://www.covertn.gov/web/coverrx_app_english.pdf

Sources: Cover Rx Website; NCSL summary of law Updated: 9/13/2007; 5/2009; 9/2011

VERMONT	Healthy Vermonters Discount Program
This 2002 state discount program was aimed at residents over 65; the current program defines eligibility as any age, with income at or below 300 percent of federal poverty.	
Eligibility	**The program is intended for people without prescription drug coverage or those who have commercial plans with an annual limit. For residents of any age with income at or below 300 percent of federal poverty. This translates to monthly income of $2245 for a household of one, $3030 for a household of two, and $3815 for a household of three. If a resident is over the age of 65, or disabled and receiving Medicare or social security benefits and have an income at or below 400% of FPL. A monthly income equal to or less than $2,994 for an individual or $4,004 for a couple.**
Disabilities coverage	Yes, if otherwise qualified for Medicare or social security benefits.
Benefits	Beneficiaries are able to receive discounts equal to those of Medicaid rates.
Medicare wrap around	No; Not a qualified SPAP; payments do not count toward TrOOP.
Est. # of beneficiaries	For SFY 2010, the Healthy Vermonters program had a caseload of 4,753. (9/2011)
State laws	2002: H.31 signed as Act 127; Program was implemented July 2002
Other Rx programs	Yes. VT also offers VPharm as a subsidy, see above.
Contact & online information	Department of PATH, Tel: 802-241-2992 Members: 1-800-250-8427 Healthy Vermonters Discount Program http://www.greenmountaincare.org/vermont-health-insurance-plans/prescription-assistance Enroll Application: http://www.greenmountaincare.org/sites/gmc/files/pdf/pharmacy_programs_application.pdf

Sources: State web site; conversation with PATH agency; NCSL summary of law Updated: 7/2007; 5/2009; 9/2011

WASHINGTON	Washington Prescription Drug Program (WPDP)
In March 2007, the Prescription Drug Program was launched with a goal of offering state-negotiated discounts to all interested residents, regardless of income, age or current insurance coverage.	
Eligibility	**State residents of all ages, all incomes. No restriction based on current insurance coverage. No enrollment fee. Note: Persons with Medicaid or comprehensive employer-based insurance are eligible but will not be able to use a state discount and an insurance payment for the same purchase.**
Disabilities coverage	Yes, no restrictions as above.
Benefits	Stated goal is to negotiate discount prices for "average savings" of 20 -percent on brand-name drugs and 60 percent on generic drugs. Actual discounts depend on agreements with individual manufacturers and distributors. Purchases can be made at participating local pharmacies or by mail-order. Average savings described as $26 per prescription. (10/07)
Medicare wrap around	No; Not a qualified SPAP; payments do not count toward TrOOP.
Est. # of beneficiaries	Approximately 160,000 (9/2011)
State laws	2005 bulk purchasing law, SB 5471, now: RCW 70.14.060 (1):
Special features & issues	The program is the first to use multi-state bulk purchasing as a strategy for obtaining discounts, in partnership with Oregon. The multi-state bulk purchasing partnership with Oregon is called the Northwest Prescription Drug Consortium. Total prescription drug charges: $11,065,041 * Total spent by Card members: $6,418,209 Total number of prescriptions filled: 195,908 Total savings by Card members: $4,646,831; Average savings per prescription: $22 or 41%; Average percentage of generic Rx: 81% The WPDP Discount Card group is saving over $300,000 each month** News: "Governor Gregoire Announces Washingtonians Have Saved Over $1 Million on Prescriptions" 10/25/07.
Other Rx programs	Yes. Washington offers a special-purpose subsidy program: Medicare Copayment Plan, see subsidy above.
Contact & online information	The Prescription Drug Program, Washington State Health Care Authority Ray Hanley, Washington Prescription Drug Program Manager Phone: 360-923-2786 Online Description at http://www.rx.wa.gov/

Sources: **Interview with Washington State Health Care Authority 9/29/08; NCSL summary of 2005 law & 2006 Northwest. Updated: 5/2008; 9/2008; 9/2011

WISCONSIN	Badger Rx Gold
Badger Rx gold provides a retail counter discount for any resident that lacks prescription drug insurance coverage if the person enrolls and pays the annual enrollment fee.	
Eligibility	**Any state resident that does not have health insurance, resident that has health insurance that does not cover prescription medications, the specific medication they need, or the co-payment is too high. There is no minimum age requirement or any other type of screening. Enrollment fees are $25 for an individual or $75 for a family.**
Disabilities coverage	Yes, any state resident if otherwise qualified.
Benefits	Badger Rx Gold saves enrollees 25-40% on prescription medications
Medicare wrap around	No; Not a qualified SPAP; payments do not count toward TrOOP.
Est. # of beneficiaries	7,000 as of March 2006
State laws	2003 Act 33; 2005 expansion to allow businesses to participate.
Other Rx programs	Wisconsin is one of six states in the I-Save-Rx program that provides a portal for purchase of prescription drugs from state-approved Canadian venders.
Contact & online information	Description Online Badger Rx Customer Service: Tel:1-866-809-9382

Sources: Interview with Pharmacy Representative on Legislative Council Updated: 8/2007; 6/2011

NCSL Sources and Archive Resources:

- ***Pharmaceuticals Overview*** *- NCSL web-based menu page features recent news, publications and other facts.*
- ***"Prescription Drugs: Frequently Asked Questions"*** *- 2007 update of a popular tool for state policymakers. 8/31/07. [7 pages, PDF]*
- *Prescription Drug State Legislation, annual editions:* ***2008*** *|* ***2007*** *|* ***2006*** *|* ***2005*** *|* ***2004*** *- tallies of filed bills, including enacted new laws, updated regularly.*
- ***Health Premium Tax Credits*** *- NCSL report, November 2008.*

APPENDIX I: Federal Definition of "SPAP" roles and MMA

"The MMA allows SPAPs to "wrap around" the Medicare benefit to fill gaps in coverage and for State programs that meet the definition of "SPAP," the program's wrap-around payments will count as if they were paid by the beneficiary for purposes of filling the coverage gap and meeting the catastrophic limit. As a result, SPAPs will be able to provide the same or better coverage for beneficiaries who receive coverage through state programs now, at a lower cost per beneficiary for the states because of the availability of the Medicare drug benefit. Coordinating with Medicare frees up significant amount of state funds, allowing for the expansion of the population served by state SPAP programs. In fact, we estimate that the savings that will accrue to States as a result of Medicare Part D displacing SPAP expenditures for low-income beneficiaries will be approximately $600 million per year, or about $3 billion over the five-year period from CY 2006-2010.

A State program may still be considered an SPAP if some or all of its program funding is from private sources (for example, from charities or independent foundations), and payments made by SPAPs will count towards an enrollee's true out-of-pocket costs (TrOOP). This will allow the enrollee to reach the catastrophic coverage faster, at which point the Medicare program pays for at least 80% of the costs."

-Source: ***SPAP Assistance for Low Income Subsidy Eligible Individuals under the Medicare Prescription Drug Benefit,*** Leslie Norwalk, CMS, 2005

- ***Resources on Pharmaceutical costs and access, 2010*** *- NCSL compilation of outside links to academic, government, industry and consumer perspectives - updated regularly.*
- *National Pharmaceutical Council:* ***"Pharmaceutical Benefits Under State Medical Assistance Programs, 2007***
- ***State Pharmacy Assistance Programs: A Chartbook*** *- Commonwealth Fund, 8/04 [84 pages]*
- ***U.S. Office of Pharmacy Affairs: Overview of the 340B Drug Pricing Program*** *- web page, updated 2010*
- ***PhRMA's HelpingPatients.org*** *- Interactive web site integrating information about products from 48 Rx manufacturers.*

Eligibility standards: The figures listed in these charts are based on language in state statutes or other state regulations. They are examples of the scope of individual programs; they are not intended as full descriptions of eligibility requirements for individuals. Please consult state program links and contacts for additional details and conditions.

Federal Poverty Guidelines are issued annually, and are used widely by federal and state programs as a measure of income eligibility. Many state laws and programs, and some federal programs refer to the specific maximum amount as a percentage of the "Federal Poverty Level" abbreviated as FPL. Tables and descriptions in this report use the term "FPL" to describe a percentage amount based on guidelines. **HHS Federal Poverty Guidelines Description, 2012**

Social Security Disability Income (SSDI) federal standards and descriptions of disability are available on-line; see **State Assistance Programs for SSI Recipients, 2010.** The link includes state-specific tables. Many states have adopted the federal definition of disability as a standard for state Rx eligibility.

Compiled by Richard Cauchi, NCSL Health Program, with additional research and input by Karmen Hanson, Steve Landess (Denver office).

Methodology: This report and resource page is updated frequently to reflect latest laws, developments, policy adjustments and recently released statistics. As such, it is not an academic-style survey or "snapshot" comparison of all listed programs. Please also consult the studies listed under "Resources" for alternative information and data compilations.

Testimony on SB 4, Codifying State Level Health Care Consumer Protections for Pre-Existing Conditions and Essential Health Benefits
Senate Health and Human Services Committee, February 5, 2019

My name is Zandra Rice Hawkins and I'm the executive director of Granite State Progress, a multi-issue advocacy organization working on issues of immediate state and local concern.

For the last decade, our organization has worked to ensure access to quality, affordable health care for every Granite Stater, and for the last two years our organization has ran the Covering New Hampshire open enrollment campaign to help Granite Staters sign up for health insurance through the health insurance marketplace.

We are here today in strong support of Senate Bill 4, which would codify state level health care consumer protections for pre-existing conditions and essential health benefits.

Prior to the Affordable Care Act, many families and small business owners faced challenges securing the health care coverage they needed for pre-existing conditions or essential health needs. According to the Kaiser Family Foundation, New Hampshire has an estimated 201,000 non-elderly adults with a pre-existing condition, or roughly 24% of our non-elderly population. That's how many Granite Staters could face difficulty obtaining insurance in the individual market if the consumer protections under the ACA were repealed or overturned in some way.

As we say in the health care advocacy world, almost every person or family will experience a pre-existing condition at some point. Our families need to be able to depend on getting health insurance coverage, and they also need to be able to depend on being able to use it.

That's why we also support the inclusion of the ten essential health benefits, a popular provision in the federal law that includes important health benefits like preventive care, emergency room care, lab services, and mental health and substance use disorder services, including behavioral health treatment.

The Affordable Care Act's requirement that essential health benefits be covered without annual dollar caps has provided patients with more health benefits and less financial burden. While plans before the ACA stated that they covered many of these services, actual coverage was often uneven—patients often faced unexpected dollar limits on services that were technically covered by their plans, forcing them to pay the remainder of costs.

Or worse yet – and we certainly have the health care horror stories to prove it – families or small business owners may have paid into a plan for years, only to later find out that it didn't cover some of the essential health services that their families needed.

OR pre-existing conditions

Ensuring we have state-level health consumer protections around pre-existing conditions, and a set of essential health benefits families can depend on, increases health and financial security for Granite State families. It also provides stability to our health insurance marketplace, which is operating under these requirements already.

We encourage the committee to recommend SB 4 ought to pass. Thank you.

Zandra Rice Hawkins
Executive Director
Granite State Progress
(603) 225-2471
zandra@granitestateprogress.org

The full list of ten essential health benefits include: ambulatory patient services (outpatient services); emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs, rehabilitative and habilitative services (those that help patients acquire, maintain, or improve skills necessary for daily functioning) and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Testimony in Support of SB 4

Tuesday, February 5, 2019

Good afternoon Senate Health and Human Services Committee,

My name is Destinee DiPrima and my family and I have lived in Kensington, New Hampshire for the last 15 years. I am asking you to support SB-4 relative to coverage of pre-existing conditions.

My twin daughters, Madison and Morgan are are 19 and currently attend college out of state. I recently moved to Seabrook, New Hampshire. Morgan was born with three holes in her heart and a rare condition called severe Hemophilia. Her sister is a carrier, as am I. Having a child with a severe chronic illness can be extremely difficult, stressful and expensive. Her medication is called clotting factor and there is no generic options available, however, hemophilia can be managed successfully and to prevent horrible internal bleeds from happening that would otherwise be life threatening if not treated.

Morgan infuses her medication several times per week to prevent this type of bleeding and will infuse again if she develops a bleed due to some type of fall or injury. This can mean several infusions of her medication and this cost on average $50,000 per month. This type of medication is based on body weight and how her body metabolizes it. She is able to self infuse and receives her comprehensive care from a Hemophilia Treatment Center (HTC). The closest HTC is located in Boston's Children's Hospital.

Our insurance currently and has in the past covered her medication under our medical benefit and we use a specialty infusion pharmacy to receive all her medication and infusion supplies monthly. There was a time where Morgan qualified for the Medicaid Katie Beckett waiver as a secondary provider. That was a huge help when our family fell upon desperate times after my husband lost his job and she still required her regular medication. Her complicated medical needs grew even more expensive after she was diagnosed with an Autism Spectrum Disorder and the therapies there after.

Over the last 19 years, our family has faced difficult financial hardships and with the help of patient assistance organizations/organizations and Medicaid, we have been able to access her medication and she was able to receive her medical and therapy treatments.

If we did not have coverage for individuals who experience pre-existing conditions then my daughter would not be alive today. People should not experience barriers to care due to a condition they have no control over.

Thank you for taking the time with me to share our family's story of having a preexisting condition.

Sincerely,

Destinee DiPrima
603-686-0690
diprima.destinee@gmail.com
16 Newbury Street
Seabrook Beach, NH 03874

Testimony in Support of SB 4

Tuesday, February 5, 2019

Thank you to the Chair and other members of the Senate Health and Human Services Committee,

My name is Vanessa Gregoire and I live in Manchester NH with my husband Austin and our two boys Luke and Joseph. I am here asking for you to support SB-4. My personal experience as an LNA has brought me to believe that EVERYONE has some sort of pre-existing condition. Some like myself and my son Joseph, were born with these conditions. I have two uteruses and my son Joseph was born with an extremely rare medical condition which impacts his hearing, growth and communication skills. I do not believe anyone should be penalized for something they can not control. Others develop a pre-existing condition later in life. Asthma and diabetes are extremely common and can be costly to the people and families they affect.

Recently, my husband lost his job and with it our healthcare benefits. We have always had health insurance through his employer and we are now fighting the clock to get coverage before time runs out. We are currently in the process of navigating the online ACA marketplace to find health coverage for our family. If there was a barrier to being able to access healthcare due to our "pre-existing conditions" then we would be in a big mess. Joseph requires additional supports and services and will require them for the rest of his life. We currently have a system in place to ensure he is covered as a child, but when he becomes an adult this policy would generate issues in him receiving the care he needs. My condition requires that I receive a heavier regiment of routine care as I am twice as likely to develop cancer.

A Pre-existing condition is known as a persons' Medical History everywhere else in the world. We shouldn't penalize any person for their medical history. We do not ask to get sick. We do not ask for our diagnosis. We all need health care when we are ill or hurt. Please support SB 4 to ensure all families have access to the health care coverage they need.

Vanessa Gregoire
125 Joseph Street
Manchester NH

Testimony in Support of SB 4

Tuesday, February 5, 2019

Good afternoon members of the Senate Health and Human Services Committee,

My name is Stephen Glynn and I live in Barrington with my wife Yun Cha. I am submitting this written testimony to ask you to support SB4 and make sure that pre-existing conditions are covered without penalty to individuals experiencing a pre-existing condition. I was once a certified master plumber and HVAC technician, I experienced nerve damage in my feet and hands which ultimately resulted in my having to leave work due to disability. I have type 2 diabetes. At one point, I did not have health insurance due to being too young to qualify for Medicare and my work no longer providing healthcare for me. I turned to the ACA Marketplace but before my plan kicked into gear, I was forced to pick and choose which medications I needed over this period of time to live as comfortably as possible. I ended up getting sick due to the side effects of my diabetes.

If we deny coverage for pre-existing conditions, this will ultimately lead to others who may fall into my situation also struggling to make it through until they can eventually find coverage.

In addition to this, my daughter is currently pre-diabetic and works largely in contract positions. If we start to deny pre-existing conditions then her future is also at risk. So please support SB-4.

Stephen Glynn
134 Michael DR
Barrington, NH

SENATE HEALTH AND HUMAN SERVICES TESTIMONY
Re: SB-4

Distinguished Committee Members,

My name is Timothy E. Guidish of Merrimack, NH and I am submitting this testimony on behalf of my 9-year-old son Reid and the 200 other children and adults in New Hampshire that suffer from Cystic Fibrosis.

CF is a life-threatening genetic disease that makes the body produce thick sticky mucus that clogs the lungs and other vital organs. It leads to Respiratory infections and a long list of other problems.

Every day my son must endure 1-2 hours of chest physical therapy and many inhaled medications to clear his lungs. He needs take a handful of pills every time he eats because his pancreas no longer produces the enzymes needed to digest his food.

Currently there is no cure for Cystic Fibrosis, so those with CF fight every day to maintain their health. We must do for Reid what his body cannot do for itself. The good news is, my son is thriving. He's a happy, growing boy, going into the 4th grade, plays baseball and basketball, has many friends and currently 100% lung function

You see the CF community has become very good at battling this disease. The Cystic Fibrosis foundation has established a network of specialized care facilities throughout the country and partnered with many drug companies to develop new, highly effective treatments. There is great hope for those with CF.

My son was born 9 years ago, when the median age of survival was 31 years. It now stands at 41. It would be hard to deny that this pioneering form of venture philanthropy has been a great success. But what good are these advancements if the people who need them are denied access.

Under this administration, the ACA has come under constant attack. And allowing insurers the right to deny coverage to those with pre-existing conditions would be devastating to our community. Without critical access to care and medication needed every day, people with CF will quickly deteriorate. Often times irreversibly.

I feel it is vitally important to protect these coverages and I support any effort to do so. I urge you to pass this important legislation to protect those in our state.

Thank you for your attention to this important issue and your commitment to the health of all New Hampshire residents.

Timothy E Guidish
16 Abbey Rd
Merrimack, NH 03054
603-420-8346

Voting Sheets

Senate Health and Human Services Committee
EXECUTIVE SESSION RECORD
2018-2019 Session

Bill # SB4

Hearing date: March 19, 2019

Executive Session date:_____

Motion of: Amendment 11375 **Vote:** 5-0

Committee Member	Present	Made by	Second	Yes	No
Sen. Sherman, Chair	X	X		X	
Sen. Fuller Clark, Vice Chair	X	X	X	X	
Sen. Chandley	X		X	X	
Sen. Bradley	X			X	
Sen. Gray	X			X	

Motion of: OTP/A **Vote:** 5-0

Committee Member	Present	Made by	Second	Yes	No
Sen. Sherman, Chair	X			X	
Sen. Fuller Clark, Vice Chair	X	X		X	
Sen. Chandley	X		X	X	
Sen. Bradley	X			X	
Sen. Gray	X			X	

Motion of:_____ **Vote:**_____

Committee Member	Present	Made by	Second	Yes	No
Sen. Sherman, Chair					
Sen. Fuller Clark, Vice Chair					
Sen. Chandley					
Sen. Bradley					
Sen. Gray					

Reported out by: Bradley

Notes:

Committee Report

STATE OF NEW HAMPSHIRE

SENATE

REPORT OF THE COMMITTEE

Tuesday, March 19, 2019

THE COMMITTEE ON Health and Human Services

to which was referred **SB 4**

AN ACT relative to the group and individual health insurance market.

Having considered the same, the committee recommends that the Bill

OUGHT TO PASS WITH AMENDMENT

BY A VOTE OF: 5-0

AMENDMENT # 2019-1176s

Senator Jeb Bradley
For the Committee

Doug Marino 271-8631

HEALTH AND HUMAN SERVICES

SB 4, relative to the group and individual health insurance market.
Ought to Pass with Amendment, Vote 5-0.
Senator Jeb Bradley for the committee.

General Court of New Hampshire - Bill Status System

Docket of SB4

Docket Abbreviations

Bill Title: relative to the group and individual health insurance market.

Official Docket of **SB4.**:

Date	Body	Description
1/17/2019	S	**Introduced** 01/03/2019 and Referred to Health and Human Services; **SJ 4**
1/30/2019	S	**Hearing:** 02/05/2019, Room 101, LOB, 02:15 pm; **SC 9**
3/20/2019	S	Committee Report: Ought to Pass with Amendment **#2019-1176s**, 03/27/2019; **SC 15**
3/27/2019	S	Special Order to the beginning of the regular calendar, Without Objection, MA; 03/27/2019; **SJ 10**
3/27/2019	S	Committee Amendment **#2019-1176s**, AA, VV; 03/27/2019; **SJ 10**
3/27/2019	S	**Ought to Pass with Amendment** 2019-1176s, **RC** 22Y-1N, MA; OT3rdg; 03/27/2019; **SJ 10**
4/1/2019	H	Introduced 03/20/2019 and referred to Commerce and Consumer Affairs **HJ 11** P. 72
4/9/2019	H	Public Hearing: 04/23/2019 01:00 pm LOB 302
4/17/2019	H	Full Committee Work Session: 04/25/2019 09:30 am LOB 302
4/17/2019	H	Executive Session: 04/25/2019 01:30 pm LOB 302
4/30/2019	H	Majority Committee Report: Ought to Pass for 05/08/2019 **(Vote 11-8; RC) HC 23** P. 13
4/30/2019	H	Minority Committee Report: Inexpedient to Legislate
5/8/2019	H	**Ought to Pass**: MA **RC** 213-137 05/08/2019 **HJ 15** P. 64
6/10/2019	H	Enrolled Bill Amendment **#2019-2379e**: AA VV 06/06/2019 **HJ 18** P. 41
6/10/2019	S	Enrolled Bill Amendment **#2019-2379e** Adopted, VV, (In recess of 06/06/2019); **SJ 20**
6/18/2019	H	Enrolled 06/13/2019 **HJ 19** P. 18
6/18/2019	S	Enrolled (In recess 06/13/2019); **SJ 21**
7/16/2019	S	Signed by the Governor on 07/12/2019; Chapter 220; Effective 09/10/2019

NH House	NH Senate

Other Referrals

Senate Inventory Checklist for Archives

Bill Number: SB4 Senate Committee: HHS

Please include all documents in the order listed below and indicate the documents which have been included with an "X" beside

X Final docket found on Bill Status

Bill Hearing Documents: {Legislative Aides}

X Bill version as it came to the committee
X All Calendar Notices
X Hearing Sign-up sheet(s)
X Prepared testimony, presentations, & other submissions handed in at the public hearing
X Hearing Report
___ Revised/Amended Fiscal Notes provided by the Senate Clerk's Office

Committee Action Documents: {Legislative Aides}

All amendments considered in committee (including those not adopted):

X - amendment # 02965 ___ - amendment #_____
X - amendment # 11765 ___ - amendment #_____
X Executive Session Sheet
X Committee Report

Floor Action Documents: {Clerk's Office}

All floor amendments considered by the body during session (only if they are offered to the senate):

___ - amendment #_____ ___ - amendment #_____
___ - amendment #_____ ___ - amendment #_____

Post Floor Action: (if applicable) {Clerk's Office}

___ Committee of Conference Report (if signed off by all members. Include any new language proposed by the committee of conference):
X Enrolled Bill Amendment(s) 23795
___ Governor's Veto Message

All available versions of the bill: {Clerk's Office}

X as amended by the senate ___ as amended by the house
X final version

Completed Committee Report File Delivered to the Senate Clerk's Office By:

_____ _____
Committee Aide Date

Senate Clerk's Office AK

May 29, 2019
2019-2379-EBA
05/04

Enrolled Bill Amendment to SB 4

The Committee on Enrolled Bills to which was referred SB 4

AN ACT relative to the group and individual health insurance market.

Having considered the same, report the same with the following amendment, and the recommendation that the bill as amended ought to pass.

FOR THE COMMITTEE

Explanation to Enrolled Bill Amendment to SB 4

This enrolled bill amendment makes a technical correction.

Enrolled Bill Amendment to SB 4

Amend RSA 420-G:3, I(b) as inserted by section 13 of the bill by replacing line 3 with the following:

health coverage as defined in RSA 420-G:7[~~, III~~].