LEGISLATIVE COMMITTEE MINUTES

SB486

Bill as Introduced

SB 486-FN - AS INTRODUCED

2020 SESSION

20-2959
01/04

SENATE BILL ***486-FN***

AN ACT relative to insurance plans that cover maternity benefits.

SPONSORS: Sen. Rosenwald, Dist 13; Sen. Fuller Clark, Dist 21; Sen. Hennessey, Dist 5; Sen. Soucy, Dist 18; Sen. Sherman, Dist 24; Sen. Cavanaugh, Dist 16; Rep. Campion, Graf. 12; Rep. M. Smith, Straf. 6; Rep. Ebel, Merr. 5; Rep. Butler, Carr. 7

COMMITTEE: Commerce

ANALYSIS

This bill requires insurance plans which cover maternity benefits to provide coverage for emergency or elective abortion services.

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Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

20-2959
01/04

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Twenty

AN ACT relative to insurance plans that cover maternity benefits.

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

1 Name of Act. This act shall be known as the Women's Reproductive Health Parity Act of 2020.

2 New Section; Insurance Plans That Cover Maternity Benefits. Amend RSA 417-D by inserting after section 2-b the following new section:

417-D:2-c Insurance Plans That Cover Maternity Benefits. Every insurer subject to this chapter that provides individual or group coverage for maternity services shall provide coverage for emergency or elective abortion services for persons who are residents of this state. A health plan that provides coverage in accordance with this section may contain provisons for maximum benefits and coinsurance and reasonable limitations, deductibles, and exclusions. All contracts under this section shall be deemed to be renewed no later than the next yearly anniversary of the contract date.

II. If the commissioner determines that enforcement of any policy described under paragraph I may adversely affect the allocation of federal funds to New Hampshire, the commissioner may grant an exemption to the requirements of this section only to the minimum extent necessary to ensure the continued receipt of federal funds.

3 Effective Date. This act shall take effect January 1, 2021.

LBAO
20-2959
12/18/19

SB 486-FN- FISCAL NOTE
AS INTRODUCED

AN ACT relative to insurance plans that cover maternity benefits.

FISCAL IMPACT: **[X] State** **[X] County** **[X] Local** **[ ] None**

	Estimated Increase / (Decrease)			
STATE:	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**
Appropriation	$0	$0	$0	$0
Revenue	$0	Indeterminable	Indeterminable	Indeterminable
Expenditures	$0	Indeterminable Increase	Indeterminable Increase	Indeterminable Increase
Funding Source:	[X] General	[ ] Education	[ ] Highway	[ ] Other

COUNTY:

Revenue	$0	$0	$0	$0
Expenditures	$0	Indeterminable	Indeterminable	Indeterminable

LOCAL:

Revenue	$0	$0	$0	$0
Expenditures	$0	Indeterminable	Indeterminable	Indeterminable

METHODOLOGY:

This bill requires insurance plans which cover maternity benefits to provide coverage for emergency or elective abortion services.

The Insurance Department indicates, to the extent these services are not currently covered, this bill would lead to an expansion of covered services. This may place inflationary pressure on claims, which may lead to either increased premiums or coverage buy downs. This could impact premium tax revenue collected by the State. The Department notes that federal law requires the cost of State coverage mandates for policies sold through the insurance exchange to be borne by the State.

The Department of Administrative Services indicates there would be no impact on the State Health Benefit Plan for Employees and Retirees (the Plan). The Department states, because the plan is a governmental self-insured plan, it is not subject to managed care law and the bill would have no impact on the Plan.

The Department of Health and Human Services indicates this bill would have no impact to the Department. The Department assumes the bill would apply to commercial carriers and not to the Medicaid program.

AGENCIES CONTACTED:

Departments of Insurance, Administrative Services and Health and Human Services

Amendments

Sen. Birdsell, Dist 19
March 9, 2020
2020-1135s
01/04

Floor Amendment to SB 486-FN

Amend the title of the bill by replacing it with the following:

AN ACT relative to insurance plans that cover maternity benefits and establishing the born alive protection act.

Amend the bill by inserting after section 2 the following and renumbering the original section 3 to read as 5:

3 Statement of Finding. The general court hereby finds that it is the purpose of the state of New Hampshire to assert a compelling state interest in protecting the life of any infant born alive as a legal person for all purposes under the laws of the state of New Hampshire, and entitled to all the protections of such laws, including the right to medically appropriate and reasonable care and treatment.

4 New Chapter; Born Alive Infant Protection Act. Amend RSA by inserting after chapter 132-A the following new chapter:

CHAPTER 132-B

BORN ALIVE INFANT PROTECTION ACT

132-B:1 Title. This chapter may be known and cited as the Born Alive Infant Protection Act.

132-B:2 Definitions. In this chapter:

I. "Abortion" has the same meaning as RSA 132:32, I.

II. "Born alive" means the complete expulsion or extraction from the mother of a human infant, at any stage of development, who, after such expulsion or extraction, breathes, has a beating heart, or has definite movement of voluntary muscles, regardless of whether the umbilical cord has been cut and regardless of whether the expulsion or extraction occurs as a result of natural or induced labor, Cesarean section, induced abortion, or other method.

III. "Health care provider" means any individual who may be asked to participate in any way in a health care service or procedure, including but not limited to, the following: a physician, physician's assistant, nurse, APRN, nurse's aide, medical assistant, hospital employee, medical facility employee, or reproductive health care facility employee.

IV. "Medical facility" means any public or private hospital, clinic, center, medical school, medical training institute, health care facility, physician's office, infirmary, dispensary, ambulatory

surgical treatment center, or other institution or location wherein medical care or treatment is provided to any person.

V. "Reproductive health care facility" has the same meaning as RSA 132:37, I.

132-B:3 Born Alive Infant Protection.

I. Any born alive infant, including one born in the course of an abortion, shall be treated as a legal person under the laws of this state, with the same rights to medically appropriate and reasonable care and treatment.

II. Any health care provider present at the time the infant is born shall take all medically appropriate and reasonable actions to the preserve the life and health of the born alive infant.

132-B:4 Mandatory Reporting. Any health care provider, medical facility, reproductive health care facility, or employee or volunteer of a medical facility or reproductive health care facility that has knowledge of a failure to comply with the provisions of this chapter shall immediately report the failure to an appropriate law enforcement agency.

132-B:5 Criminal Penalties. Any health care provider who intentionally or knowingly violates this chapter shall be guilty of a class A felony.

2020-1135s

AMENDED ANALYSIS

This bill requires insurance plans which cover maternity benefits to provide coverage for emergency or elective abortion services.

This bill also establishes the born alive infant protection act which provides that a person shall not deny or deprive an infant of nourishment with the intent to cause or alter the death of an infant during an abortion.

Committee Minutes

SENATE CALENDAR NOTICE
Commerce

Sen Kevin Cavanaugh, Chair
Sen Jon Morgan, Vice Chair
Sen Donna Soucy, Member
Sen Chuck Morse, Member
Sen Harold French, Member

Date: February 13, 2020

HEARINGS

Tuesday	02/18/2020
(Day)	(Date)

Commerce	State House 100	1:00 p.m.
(Name of Committee)	(Place)	(Time)

1:00 p.m.	**SB 452**	making certain technical changes to the insurance laws.
1:15 p.m.	**SB 578**	changing the requirement a member of the sponsoring charitable organization to be present during certain games of chance.
1:30 p.m.	**SB 512**	relative to transportation of beverages and wine.
1:45 p.m.	**SB 623-FN**	requiring insurance coverage for PFAS and PFC blood tests.
2:00 p.m.	**SB 579**	relative to e-delivery of insurance documents and commercial lines renewal notices.
2:15 p.m.	**SB 486-FN**	relative to insurance plans that cover maternity benefits.

EXECUTIVE SESSION MAY FOLLOW

Sponsors:

SB 452

Sen. French	Sen. Morgan	Rep. Bartlett	Rep. Potucek

SB 578

Sen. Sherman	Sen. D'Allesandro	Rep. Leishman

SB 512

Sen. French	Sen. Reagan	Sen. Giuda	Sen. Cavanaugh
Rep. Hunt			

SB 623-FN

Sen. Chandley	Sen. Fuller Clark	Sen. Watters	Sen. Feltes
Sen. Rosenwald	Sen. Cavanaugh	Sen. Sherman	Sen. Hennessey
Sen. Soucy	Rep. W. Thomas	Rep. Rung	Rep. Stack
Rep. Murphy			

SB 579

Sen. Rosenwald	Sen. Morgan	Rep. Muscatel	Rep. Indruk

SB 486-FN

Sen. Rosenwald	Sen. Fuller Clark	Sen. Hennessey	Sen. Soucy
Sen. Sherman	Sen. Cavanaugh	Rep. Campion	Rep. M. Smith
Rep. Ebel	Rep. Butler		

Aaron Jones 271-1403

Kevin Cavanaugh
Chairman

Senate Commerce Committee

Aaron Jones 271-1403

SB 486-FN, relative to insurance plans that cover maternity benefits.

Hearing Date: February 18, 2020

Time Opened: 2:34 p.m. **Time Closed:** 3:27 p.m.

Members of the Committee Present: Senators Cavanaugh, Morgan, Soucy and French

Members of the Committee Absent : Senator Morse

Bill Analysis: This bill requires insurance plans which cover maternity benefits to provide coverage for emergency or elective abortion services.

Sponsors:

Sen. Rosenwald	Sen. Fuller Clark	Sen. Hennessey
Sen. Soucy	Sen. Sherman	Sen. Cavanaugh
Rep. Campion	Rep. M. Smith	Rep. Ebel
Rep. Butler		

Who supports the bill: Senator Cindy Rosenwald, Senator Martha Fuller Clark, Senator Martha Hennessey, Senator Dan Feltes, Representative Polly Campion, Sabrina Dunlap (Planned Parenthood), Kristine Stoddard (Bi-State Primary Care Association), Jake Berry (New Futures), Jeanne Hruska (ACLU-NH), Doug Marino, Patrice Rasche, Helmut Koch, Laurie Koch, Alyssa Antman, James Castigan, Caroline Cascey, Shawn Spinney, Amelia Keone, Stephen Rasche, Morgan Wilson, Jennifer Frizzell (NH Women's Foundation), Ellen Reilly, Louise Spencer, Heather Stockwell

Who opposes the bill: Representative Dick Hinch, Representative Mark Pearson, Representative Walter Stapleton, Representative Linda Gould, Representative Glenn Cordelli, Representative Alicia Lekas, Representative J.C. Allard, Bob Dunn (Roman Catholic Bishop of Manchester), Claire Stapleton, Alvin See, Ellen Kolb (Cornerstone Action), Shannon McGinley (Cornerstone Action), Thomas Walton (Aeroplas Corp.), Daniel Hogan, Thomas Hogan (Knights of Columbus #15669), Rev. Roger Boucher (Magdalen College), Clara Wilder

Who is neutral on the bill: No one

Summary of testimony presented in support:

Senator Cindy Rosenwald

- This bill would only apply to plans regulated by the NHID or those through the individual marketplace. It wouldn't apply to Medicaid or any federally regulated insurance plans.
- This bill would protect NH patients by ensuring that if a plan offers maternity benefits, then they must provide elective or emergency abortion services.
- This bill was introduced in response to two federal rules created by DHHS.
    - First, carriers are required to send consumers two separate bills each month. One bill is solely dedicated to abortion services received. This would place an administrative burden on insurance carriers.
    - Second, marketplace plans are required to offer duplicate plans that don't cover abortion, except under extreme circumstances. Again, this would create an administrative burden.
- This bill would protect thousands of NH residents from losing insurance coverage. It would maintain access and create stability from ever-changing federal rules.
- Currently, the only plan in NH that doesn't offer abortion services is within the marketplace. Therefore, this bill wouldn't affect or place additional requirements on existing plans offered by employers.
- **Senator French** asked if Senator Rosenwald said that most commercial insurance plans cover abortion procedures within the state.
    - **Senator Rosenwald** responded yes. She reiterated that self-funded plans and Medicaid are not required to cover abortion procedures.

Serena Dunlap, VP of Public Affairs, Planned Parenthood

- Abortion has been a safe and legally protected medical service provided for over 50 years; therefore, NH shouldn't restrict or interfere with access now.
- It's important that women retain the ability to make the best medical decisions for themselves.
- As Senator Rosenwald stated, this bill would create stability within the insurance market and ensure that decision-making is in the hands of consumers.
- Reiterating Senator Rosenwald, this bill is in response to federal rules implemented in June 2019 by DHHS. Those rules were implemented despite over 75,000 complaints. DHHS acknowledged that these new rules would result in significant losses of coverage.

- Abortion coverage is important because pregnancies can be unplanned or medically complicated. In fact, a pregnancy might be the costliest medical procedure in a woman's life.
- This bill would help to financially protect families who must make a difficult decision. Since each person and pregnancy is different, no one-size fits all approach can work.
- **Senator French** asked if an abortion costs $500.
    - **Ms. Dunlap** responded yes, but that's only the average cost early on in a pregnancy. As times goes by, costs are likely to go up.
- **Senator French** asked if the cost of giving birth was roughly $20,000.
    - **Ms. Dunlap** stated that's the average cost; however, each pregnancy can be different resulting in different costs.
- **Senator Cavanaugh** inquired if the Supreme Court's ruling in the Hobby Lobby case would effect this bill.
    - **Ms. Dunlap** replied no because that case had a narrow ruling pertaining to federal law. As a result, the ruling is not applicable to state law.
- **Senator Cavanaugh** asked if this bill would apply to every business in NH.
    - **Ms. Dunlap** said that requirements would be placed on insurance carriers, not employers. Large employers who are self-funded would be excluded because they're governed by federal ERISA laws. Again, this bill would only apply to plans in the marketplace and those regulated by the NHID.
- **Senator Cavanaugh** followed up by asking if this bill would increase costs to small businesses.
    - **Ms. Dunlap** stated that she didn't believe so because requirements would be placed on insurance carriers. Also, this bill protects the status quo.
- **Senator French** asked why the state would mandate coverage if most commercial carriers cover abortion services.
    - **Ms. Dunlap** replied that the concern is instability and the adverse effects created by the recent federal rule changes. This bill simply protects comprehensive coverage and provides stability for consumers.

Kristine Stoddard, Director of NH Public Policy, Bi-State Primary Care Association

- In 2018, roughly 20% of uninsured patients went without medical care due to costs. Those patients were disproportionately low-income women.

- In response to Senator French's question, even though the average cost of an abortion is $500, about 40% of adults don't have at least $400 to pay for any out-of-pocket expenses.
- Reiterating previous speakers, Ms. Stoddard noted that most insurance carriers within NH already cover abortion services.

Jennifer Frizzell, Director of Policy, NH Women's Foundation

- Research from a turn-away study found that access to abortion services promotes long-term economic security for women. If a woman has an unintended pregnancy, and they're unable to receive an abortion, they're much more likely to face economic disruptions. Under those circumstances, women are 4 times more likely to be below the federal poverty level and 3 times more likely to be unemployed.
- The study also found that providing access to abortion services can have a generational impact. If a woman has access, both the first and second generation have lower rates of poverty and public assistance as well as higher rates of graduation.
- The ACA required states to establish benchmarks for insurance plans, including the benefits and services they must provide. In 2012, the state established a benchmark that elective or medically necessary abortion services must be offered.
- From an actuarial perspective, offering abortion coverage in 2012 provided a $1.14 savings per member per month.

Jake Berry, VP of Policy, New Futures

- Mr. Berry stated that every woman deserves equal and comprehensive access to reproductive coverage.
- Further, cost and insurance coverage shouldn't prohibit women from choosing to receive abortion services or not.

Jeanne Hruska, ALCU-NH

- As determined by Supreme Court rulings, abortion is only meaningful if an individual has financial access to it.
- Ms. Hruska stated that medical issues and decisions should be left up to patients and their doctors, not by their employer. It's discriminatory to assert that an employer's right or religious freedom should be able to dictate another person's health decisions.
- Currently, there are 6 states that have enacted a similar law.
- Ms. Hruska agreed with Ms. Dunlap that the Hobby Lobby case doesn't impact state law or state court decisions. In fact, she didn't believe this law would face litigation.

- **Senator French** asked why the state should mandate coverage if most commercial insurers already cover these services.
    - **Ms. Hruska** responded that this bill would provide clarity and uniformity because federal rules are currently influx.
- **Senator French** followed up by asking if Ms. Hruska could provide the influx data to him.
    - **Ms. Hruska** said she would.

Summary of testimony presented in opposition:

Ellen Kolb, Cornerstone Action

- This bill is not about parity or money, it's about religious liberty.
- If passed, NH would be entangled in litigation for years. For example, the Supreme Court ruled in favor of Hobby Lobby against an ACA provision. Also, California is currently facing litigation for violating the Weldon Amendment.
- In this bill, there's a provision allowing the commissioner to decide on a case-by-case basis if federal funds are at risk. She stated that religious liberties shouldn't rest on a case-by-case basis.
- She concluded that everything should be done to protect First Amendment religious and conscience rights of citizens throughout NH.

Bob Dunn, Director of Public Policy, Diocese of Manchester

- The Diocese opposes this measure for three reasons:
    - First, unlike maternity benefits, abortion is not healthcare. Mr. Dunn stated that abortion treats a fetus as a disease that needs to be cured.
    - Second, if passed, this bill would impact the conscience rights of employers and individuals who are morally opposed to abortion. Since abortion services would be required, consumers would have to make the decision whether to purchase insurance entirely. Conscience rights are inalienable rights that are set forth under Part 1, Article 4 of the NH Constitution.
    - Finally, this bill would violate the Weldon Amendment. As Ms. Kolb noted, the Civil Rights division of HHS has already sued California for mandating all health plans cover abortion services. The provision giving the commissioner discretion demonstrates that there's a level of doubt that this bill will not face litigation.
- Mr. Dunn stated that all life should be treated with dignity.
- **Senator French** asked if the Diocese offers commercial health insurance to its employees and if abortion procedures are covered.

- **Mr. Dunn** stated that the Diocese does offer commercial health insurance, but it doesn't cover abortion procedures under its plan.

Shannon Grimley

- She stated that she found the notion that women need access to an abortion to get ahead in society as archaic and discriminatory.

Thomas Walton, CEO of Aeroplas Corp.

- NH is tied with MA for the lowest fertility rate in the country. Mr. Walton stated that NH needs more children, which would help with the work shortage crisis.
- Mr. Walton stated that NH is under the control of Planned Parenthood. As a result, he has been thinking about relocating his business.

Daniel Hogan

- Mr. Hogan stated that people don't care that pre-born babies are being killed. He stated that there's a lack of understanding or caring.

Thomas Hogan, Knights of Columbus #15669

- Mr. Hogan stated that his student organization is opposed to this bill.
- He also stated that the committee should take into consideration religious freedom when making their decision.

Neutral Information Presented: None

AJ
Date Hearing Report completed: February 25, 2020

Speakers

Senate Commerce Committee
SIGN-IN SHEET

Date: 02/18/2020 **Time:** 2:15 p.m.

SB 486-FN An ACT relative to insurance plans that cover maternity benefits

	Name/Representing *(please print neatly)*		Support	Oppose	Speaking?	Yes	No
V	Prime!!! Sen. Cindy Rosenwald	Dist. #13	☑	☐		☑	☐
V	Rep Polly Campion	Gr #12	☑	☐		☐	☑
V	Rep Dick Hinch	Hills #21	☐	☒		☐	☒
V	Rep Mark Pearson	Rock 34	☐	☑		☐	☐
V	Rep Walter Stapleton	Sul/Nan Dists	☐	☑		☐	☑
V	Claire L. Stapleton	Claremont Nat'l 90 Veterans Pk R	☐	☑		☐	☑
V	Rep Linda Harrold	Dist 7/Hills	☐	☒		☐	☒
V	Rep Glenn Cordelli	Carroll 4	☐	☑		☐	☑
V	Senator Fuller Clark	SD #21	☒	☐		☐	☒
V	Senator Hennessey	SD #5	☒	☐		☐	☒
V	Alvin See	Self	☐	☑		☐	☑
1	Sabrina Dunlap	Planned Parenthood Bi-State Primary Care Association	☒	☐		☑	☐
2	Kristine Stoddard		☑	☐		☑	☐
V	Dan Feltes	SD #15	☒	☐		☐	☒
V	Ellen Kolb	Cornerstone Action	☐	☒		☐	☐
V	Jake Berry	New Futures	☑	☐		☑	☐
V	Jeanne Hruska	ACLU-NH	☒	☐		☒	☐
V	"Doug" Marino	Self	☒	☐		☐	☐
V	Rep Alicia Lekas	Hills 37	☐	☒		☐	☐

Senate Commerce Committee
SIGN-IN SHEET

Date: 02/18/2020 **Time:** 2:15 p.m.

SB 486-FN An ACT relative to insurance plans that cover maternity benefits

Name/Representing *(please print neatly)*		Support	Oppose	Speaking?	Yes	No
Rep. J.C. Alland	House Ed Comm	☐	☒		☐	☒
Bob Dunn	Roman Catholic Bishop of Manchester	☐	☒		☐	☒
Shannon McGinley	Cornerstone Action / self	☐	☒		☒	☒
BATRICE RASCHE	Self	☒	☐		☐	☒
Helmut Koch	COKE Self	☒	☐		☐	☒
Laurie Koch	Self	☒	☐		☐	☒
Alyssa Antman	AUTMAN Self	☒	☐		☐	☒
James Corrigan	Self	☒	☐		☐	☒
Caroline Casey	self	☒	☐		☐	☒
Shaun Spinney	Self	☒	☐		☐	☐
Amelia Keene	self	☒	☐		☐	☒
Thomas Walton	AEROPLAS Corp	☐	☒		☒	☐
Daniel Hogan	Self	☐	☒		☒	☐
STEPHEN RASCHE	SELF	☒	☐		☐	☐
Morgan Wilson	self	☒	☐		☐	☒
Thomas Hogan	Knights of Columbus #15669	☐	☒		☒	☒
Rev. ROGER BOUCHER,	MAGDALEN COLLEGE	☐	☒		☐	☒
Jennifer Frizzell	NH Womens Foundation	☒	☐		☒	☐
Elm Mills	Self	☒	☐		☐	☒

Senate Commerce Committee
SIGN-IN SHEET

Date: 02/18/2020 **Time:** 2:15 p.m.

SB 486-FN An ACT relative to insurance plans that cover maternity benefits

Name/Representing ***(please print neatly)***

Name/Representing	Support	Oppose	Speaking?	Yes	No
Clara Wilder	☐	☒	Speaking?	☐	☒
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Senate Commerce Committee
SIGN-IN SHEET

Date: 02/18/2020 **Time:** 2:15 p.m.

SB 486-FN An ACT relative to insurance plans that cover maternity benefits

Name/Representing ***(please print neatly)***

Name/Representing	Support	Oppose	Speaking?	Yes	No
Louise Spencer Concord Self	☒	☐	Speaking?	☐	☒
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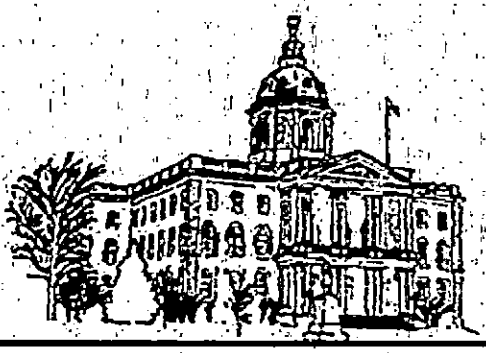
Testimony

Planned Parenthood of Northern New England



Planned Parenthood Act. No matter what.
Planned Parenthood New Hampshire Action Fund

SB 486: **Relative to insurance plans that cover maternity benefits.**
Committee: **Senate Commerce**
Date: **February 18, 2020**
Position: **Support**

SB 486 helps protect access to reproductive health care by ensuring coverage of abortion services.

This bill would ensure that commercial insurance policies and policies on the Affordable Care Act exchange in New Hampshire cover abortion care if they also cover maternity care. This is a matter of basic equity and fairness.

Abortion has been a safe and legally protected medical procedure for nearly 50 years, since the US Supreme Court decided in *Roe v. Wade* that people have a constitutional right to make decisions about their own reproductive health. New Hampshire has a long history of protecting the right to abortion and a deep respect for patients' right to make their own health care decisions. The government's role is to protect this right and not restrict or interfere with it. SB 486 removes barriers to reproductive health care and ensures that insurance companies cover abortion.

While a number of private insurance providers and insurance providers on the ACA Exchanges cover abortion care in New Hampshire, some plans do not. No abortion coverage requirements exist for insurance providers, and decisions regarding coverage can be arbitrary. SB 486 would be a step toward eliminating this disparity, especially in the instances of health endangerment and pregnancy complications.

This bill protects the Granite Staters against the Trump administration's proposed rule changes to the ACA.

This bill will also help mitigate the impact of two rules proposed by the Trump administration that would make it more difficult for commercial plans to cover abortion:

The first rule, which recently became final and will go into effect in June, imposes additional cumbersome billing requirements for insurance companies on the Marketplace that cover abortion. This arbitrary rule will make it **more difficult** for plans to offer coverage for abortion and would make it **easier for them to exclude** abortion. It is feared that some plans will drop coverage of abortion altogether and consumers could lose coverage by inadvertently missing a payment. SB 486 would help mitigate the harm resulting from this rule, by making it clear that coverage of abortion is required in NH.

The other rule requires that ACA Marketplace plans that offer abortion coverage outside the limited cases of rape, incest or life endangerment, also offer health plans that do not include abortion coverage. This rule would impose increased costs and administrative burdens on insurance companies, and insurers could drop abortion coverage to avoid the hassle and costs. Importantly, this rule does not apply to states with laws requiring abortion coverage. Without the Reproductive Health Parity Act, the new rule could result in major losses of coverage for people in NH.

SB 486 creates stability for insurers.
Requiring coverage of abortion care is consistent with several laws recently passed that protect New Hampshire residents from further erosion of the ACA and that help provide stability for insurers in New Hampshire, including access to no-cost contraception and ensuring coverage of essential health benefits. In addition, the state law now requires coverage of in vitro fertilization (IVF). Like the laws requiring contraception and essential health benefits coverage, this bill would help protect New Hampshire residents from any potential changes to the Affordable Care Act.

SB 486 recognizes the importance of coverage.
Now, more than ever, states can play a crucial role in safeguarding women's health by covering abortion in private insurance plans. The very purpose of health insurance is to ensure that individuals can manage the expenses associated with unexpected medical and health events. Pregnancies can be unplanned, or unexpectedly become medically complicated. For women in either situation, the status of their pregnancy may be the most unexpected health event they experience in their lives. Affording an abortion can be challenging for many women, and without insurance coverage, some women could be denied access to necessary reproductive health services.

SB 486 would help protect access to abortion in the Granite State, and we urge you to vote "ought to pass" on this bill.
For more information or questions, please contact Kayla Montgomery, kayla.montgomery@ppnne.org

###

Planned Parenthood of Northern New England (PPNNE) *is the largest provider of reproductive and sexual health care for women, men and young people across the State of New Hampshire. We serve New Hampshire residents through 6 health centers in Claremont, Derry, Exeter, Keene, Manchester and White River Junction, VT. In 2018, we saw nearly 14,000 patients at these sites.*

Planned Parenthood New Hampshire Action Fund (PPNHAF) *is an independent, nonpartisan, not-for-profit organization formed as the advocacy and political arm of Planned Parenthood of Northern New England in New Hampshire. The Action Fund engages in educational and electoral activity, including voter education, grassroots organizing, and legislative advocacy. The Action Fund makes independent expenditures on behalf of or in opposition to targeted candidates for public office. PPNHAF maintains a separate, segregated political committee and fund to make direct campaign contributions to endorsed candidates (the PAC).*

Dear Senate Commerce Committee members,

My name is Kelly, and I live in Concord. A few years ago, I was pregnant with my second child, a boy. We had a 2-year-old daughter and were excited for her to have a sibling. I had an ultrasound at Dartmouth Hitchcock at 19 weeks. When the doctor came in, he sat down and showed me my ultrasound results, and I knew something was wrong. This part is fuzzy in my memory, because I was in a state of shock. He said that my baby had severe hydrocephalus, that the fluids on his brain were way over what was normal.

My husband and I had many questions as we considered what to do next. We thought about what our child's quality of life would be like, if he even survived being born. We had to consider how this would affect our 2-year-old daughter. We didn't want to have to turn her life upside down if we didn't have to. We considered both of our feelings and how it would affect us to have a child that would inevitably have multiple, possibly many brain surgeries (that might not even work, could cause an infection, etc.) I didn't want our child to suffer. Less important, but still a consideration were our finances. I was a teacher in a childcare center and my husband worked at a nursing home. We already lived week to week. How enormous would the cost of our child's medical care be, and for how long? How on earth could we afford thousands and thousands in medical bills when we were barely making it as it was? What about medical insurance for him? What about transportation? Would we have to move to be closer to the hospital, since this condition was so rare? The questions went on and on. We went back and forth about what would ultimately be best for him.

We had to make the most difficult choice a parent can make. We thought about what would be the best, kindest thing to do for our child. We decided to terminate because it would be the most kind decision to do for our son, our daughter, us. If we had had any hope that our child could lead a decent life, our decision would have been different. There were no guarantees, and I didn't want to take a chance on the unknown. I was 20 weeks pregnant.

Terminating for medical reasons was the most difficult, heart wrenching decision I've ever had to make in my life. I knew in that moment how lucky I was to have safe medical care and the ability to choose what would be done to me. When it was over, I hurt like any other parent would after losing a child.

I was fortunate to have most of my procedure covered by my insurance company. I can't imagine what it would be to face the most heartbreaking day of my life and then be slapped with a bill that could be thousands of dollars.

SB 486 would financially protect people like me, who are loving, caring, and must make choices that nobody would ever want to make. Each person is different, each pregnancy is different, and there is no one size fits all solution. It is critically important for women to focus on the decision that is right for her life, her baby's life, her family's life, and not have to worry about her insurance coverage. I urge you to support SB 486.

Thank you.

February 2020

Overview:
The Reproductive Health Parity Act (SB 486) ensures that all commercial insurers in New Hampshire cover abortion services, including plans on the ACA Marketplace. Current law allows insurance companies to influence personal and private medical decisions by withholding coverage of abortion care under insurance plans. This bill will require insurance companies to cover abortion services if the plan also provides prenatal care. This is a matter of basic equity and fairness.

Protection from proposed changes by the Trump Administration
This bill will also help mitigate the impact of two rules proposed by the Trump administration that would make it more difficult for commercial plans to cover abortion:

One rule, which recently became final and will go into effect in June of 2020, imposes additional billing requirements for insurance companies on the Marketplace that cover abortion -- an onerous task for both insurers and consumers. This rule will make it **more difficult** for plans to offer coverage for abortion and would make it **easier for them to exclude** abortion. It is feared that some plans will drop coverage of abortion altogether to avoid the administrative burdens.

The other rule requires that ACA Marketplace plans that offer abortion coverage outside the limited cases of rape, incest or life endangerment, also offer health plans that do not include abortion coverage. This rule would impose increased costs and administrative burdens on insurance companies, and insurers could drop abortion coverage to avoid the hassle and costs. Importantly, this rule does not apply to states with laws requiring abortion coverage. Without this proactive legislation, the new rule could result in major losses of coverage for people in New Hampshire.

Ensuring Coverage
In addition to the proposed rules, there are currently several plans available on the Marketplace that do not cover abortion services, and the absence of abortion coverage can result in sizable out-of-pocket costs for patients. For women facing an unintended pregnancy, or changed circumstances during a planned pregnancy, access to timely, affordable and respectful abortion care is a critical component of reproductive health care.

Stability for Insurers
Requiring coverage of abortion care is consistent with the passage of several laws that protect NH residents from further erosion of the ACA and that help provide stability for insurers in New Hampshire, including access to no-cost contraception and ensuring coverage of essential health benefits. In addition, the state now has a law requiring coverage of in vitro fertilization (IVF). Like the contraception and essential health benefits coverage, this bill would help protect New Hampshire residents from any potential changes to the Affordable Care Act.

The lack of consistent coverage for abortion services is rooted in entrenched inequities in the areas of health insurance coverage, health care, and medically accurate sex education, as well as other health-promoting resources. This bill will be a first step in addressing these inequities and disparities in reproductive health.

A broad coalition of health care advocates and organizations have signed on in support of this bill. Passage of this legislation will help protect access to abortion care in New Hampshire and create stability for insurers. The undersigned urge the passage of SB 486.

Planned Parenthood
Act. No matter what.
Planned Parenthood
New Hampshire Action Fund

newfutures

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AMERICAN CIVIL LIBERTIES UNION
of NEW HAMPSHIRE

new hampshire
WOMEN'S FOUNDATION

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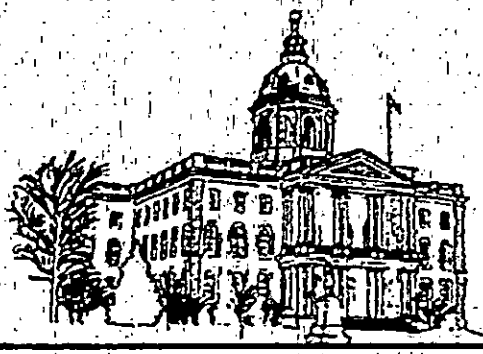
ACOG
The American College of
Obstetricians and Gynecologists

Planned Parenthood of Northern New England



Planned Parenthood Act. No matter what.
Planned Parenthood New Hampshire Action Fund

Reporters & Editors,

On Tuesday, Feb. 18 at 2:15 pm, the New Hampshire Senate Commerce Committee is scheduled to hear SB 486, the Reproductive Health Parity Act. Sponsored by Sen. Cindy Rosenwald, this critical legislation will require private insurance and plans on the Health Insurance Marketplace to cover abortion care if the plans also cover prenatal care. A pregnant person should be able to make their own decisions about whether to end a pregnancy without insurance companies withholding coverage.

This bill also protects Granite Staters from instability in federal laws and regulations, including two rule changes to the Affordable Care Act that would create additional barriers to care. The Reproductive Health Parity Act is a necessary measure to ensure that these rules don't result in major losses of insurance coverage for Granite Staters *(see background for more details on these federal rules)*.

The Reproductive Health Parity Act builds on the progress the Granite State has made in recent years to protect patients from changes happening at the federal level. Last year, the New Hampshire Legislature enshrined the essential health benefits for the Affordable Care Act into state law and passed a law that requires New Hampshire insurers to cover infertility diagnosis and treatment, and in 2018 the state legislature passed a law that requires insurance to cover no-cost contraception.

Background on Trump Administration Insurance Rules:

- The Reproductive Health Parity Act will protect Granite Staters against new Trump administration rules designed to make it more difficult for health insurance plans to cover abortion.
- These two new Trump administration rules make it more important than ever that New Hampshire patients have the right to access abortion services through their health insurance. **Currently in New Hampshire, insurance companies can choose not to cover abortion services**, making Granite Staters vulnerable to these attacks on their health care.
- The first rule, which is set to go into effect in June, requires insurers to separately bill consumers, sending one bill for coverage of abortion care and another for all other health care, forcing the consumers to pay in two separate transactions.

- This new payment requirement goes against industry practice, which allows for a single bill to consumers and a single payment, and will cause unnecessary confusion and frustration for enrollees around payments.
- Plans on the ACA exchange must already segregate funds that are used to cover abortion services.
- This unnecessary administrative burden pushed onto consumers is expected to cause confusion and potentially result in losses of coverage. By the Trump administration's own account, more than 3 million consumers would be subject to these onerous restrictions and could potentially lose coverage.

- The second rule, which has not yet been finalized, will require that ACA Marketplace plans that offer abortion coverage (outside the limited cases of rape, incest or life endangerment) also offer health plans that do not include abortion coverage.
  - This rule would impose increased costs and administrative burdens on insurance companies, and insurers will likely drop abortion coverage to avoid the hassle and costs.
  - Importantly, this rule does not apply to states with laws requiring abortion coverage, so it would not apply to New Hampshire if the Reproductive Health Parity Act is state law.

Let me know if you have any questions!

Derek

Guttmacher Policy Review

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Restrictions on Private Insurance Coverage of Abortion: A Danger to Abortion Access and Better Health Coverage

By Adam Sonfield

HIGHLIGHTS

- *Antiabortion conservatives have long sought to eliminate private insurance coverage of abortion, and their main tactic in Congress has been to push for barring health plans from covering abortion if any part of the plan is paid for with federal dollars.*
- *Abortion coverage is already severely restricted and difficult to obtain in many parts of the United States, and further federal restrictions will make things worse for patients who need abortion care.*
- *The obsession with banning abortion coverage threatens broader efforts to expand and improve U.S. health insurance coverage and to make it more affordable.*

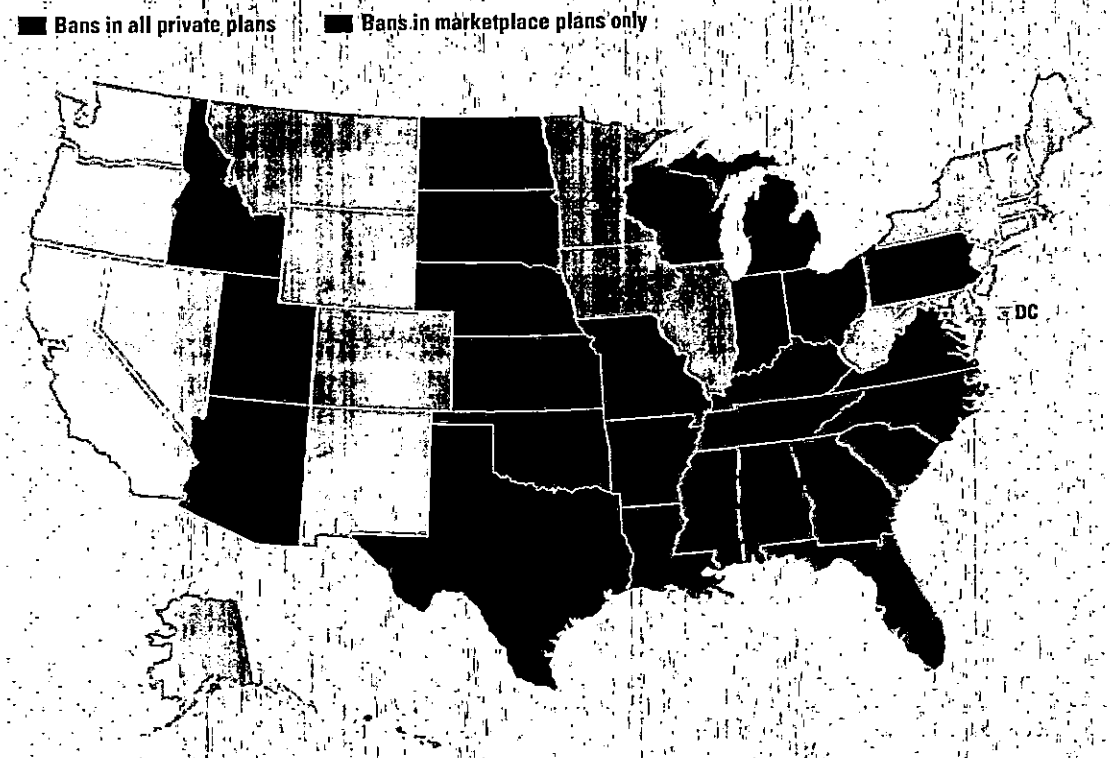
One long-term goal of antiabortion conservatives has been to eliminate abortion coverage in all private insurance plans, just as they have eliminated abortion coverage under Medicaid in most parts of the United States already. In a number of the most conservative states, antiabortion policymakers have pursued their goal directly. Eleven states have outright bans on abortion coverage in all private insurance plans regulated by the state, and many additional states have bans for segments of the insurance market, such as in Affordable Care Act (ACA) marketplace plans or plans for public employees (see figure 1).[1]

At the federal level, antiabortion policymakers have used federal funding as a pretext for proposed restrictions. First, they argue that antiabortion taxpayers should not have to violate their religious or moral convictions by helping to fund insurance plans that cover abortion. Second, they insist that no compromise policy can satisfy taxpayers' concerns. For example, they claim that the ACA's current policy—under which federal dollars cannot pay for abortion coverage, but segregated funds from enrollees' premium payments can—indirectly allows federal dollars to fund abortion by "freeing up" other resources.

Conservatives' dogged commitment to their goal of eliminating private insurance coverage of abortion is a clear threat to the ability of millions of people to access and afford abortion care. Moreover, antiabortion conservatives have turned their demand into a roadblock to efforts that might lower overall premiums and deductibles, improve consumers' choice of health plans, or otherwise improve on the ACA and expand health insurance coverage in the United States.

Social conservatives view federal funding as leverage for eliminating private insurance coverage of abortion. For more than 40 years, antiabortion conservatives have used the specter of federal funding for abortion to justify the Hyde Amendment, which bans federal funding for abortion under Medicaid, except in cases of life endangerment, rape or incest. It has been an effective tactic: No state can afford to give up federal Medicaid funds, so abortion is not covered in most states' Medicaid programs. It is only because the federal government cannot prevent states from funding abortion coverage separately with state dollars that Medicaid enrollees in 16 states have abortion coverage available.[2]

① Half the states have banned abortion coverage in at least some private insurance plans



Source: Guttmacher Institute. *Note:* Some states make exceptions in cases of life endangerment, rape or incest.

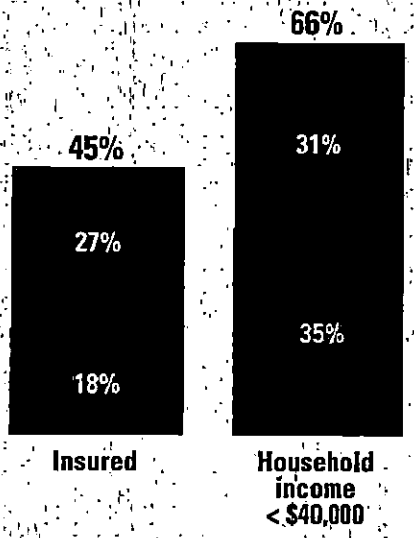
Antiabortion conservatives see their past success in restricting abortion coverage under Medicaid and other federal programs as a template for imposing restrictions on private insurance coverage as well. The ACA provided them with an opening, because it established substantial new federal subsidies for many private insurance plans, which plans and consumers cannot afford to turn down. Individual states would not be in a position to preserve abortion coverage if a federal restriction on private insurance plans were enacted, because there would not be any state program or money involved. Rather, a state would need to set up a new program purely for abortion coverage for otherwise privately insured people—an extreme step away from the status quo, where many states are neutral on the question of abortion coverage in private insurance.

That use of federal money is not really the issue is made clear by the antiabortion movement's rejection of the ACA's current policy, which allows insurance plans to cover abortion but requires them to wall off federal dollars from private dollars to ensure that no federal money pays for abortion coverage or services. Only a small number of antiabortion lawmakers agreed to that policy as a compromise to get the ACA enacted. Those members of Congress were swiftly rejected by the broader antiabortion movement, which falsely argued at that time and ever since that the ACA was a massive federal subsidy for abortion.

Antiabortion conservatives have fought relentlessly for a different policy: to bar any health insurance plan that receives even a dime of federal money from covering abortion. They pushed for this restriction throughout the debate over ACA enactment, in subsequent stand-alone legislation, during the effort to "repeal and replace" the ACA in 2017, and in debating new federal investment to lower insurance premiums and expand consumer options. The specific language proposed has varied, and most recently, congressional conservatives have argued that they "merely" want to

❷ Without abortion coverage, many people would struggle to pay for the unexpected cost of the procedure

Abortion at 10 weeks: approximately $500



Sources: Guttmacher Institute and Kaiser Family Foundation.

apply the Hyde Amendment language to private insurance plans. However, the bottom line is that the antiabortion movement would not propose or accept any language that would fail to accomplish the goal it has consistently pursued.

New coverage restrictions would make it harder or even impossible for people to buy abortion coverage. To be clear, private coverage of abortion is already highly restricted in the United States because of a slew of state-level restrictions and the burdensome requirements for segregated funding written into the ACA. Even when abortion coverage is permitted by law, it is often unavailable: For example, analyses of ACA marketplace plans by the Guttmacher Institute and the Kaiser Family Foundation have found that in states that allow abortion coverage, consumers in many counties and some entire states have no plan choices that actually include that coverage.[3,4]

Antiabortion policymakers are seeking to make this situation worse with new restrictions. For example, if they succeed in barring the use of federal funds (such as federal subsidies to help enrollees afford premiums and cost sharing) for ACA marketplace plans that cover abortion, that would effectively eliminate abortion coverage in marketplace plans altogether because those federal subsidies are too important for consumers to pass up. If Congress were to place that type of ban on federal funds that go to all individual market plans and to employer-based plans (such as many "reinsurance" proposals, which would protect insurance plans against unexpected costs and thereby lower premiums), it would effectively eliminate abortion coverage more broadly. Antiabortion policymakers plan to keep adding restrictions to as many parts of the health insurance market as possible, until there are no insurance plans left that can cover abortion or are willing to do so.

New federal restrictions on plans that cover abortion would be particularly harmful in the four states—California, New York, Oregon and Washington—that have worked to protect abortion rights and access by requiring private insurance plans they regulate to cover abortion.[5] A federal restriction would place these states in an untenable position: The state might be forced to reverse or stop enforcing its abortion coverage requirement, or else state residents and health plans might find themselves unable to receive federal subsidies—a situation that would negate Congress's attempts to make private insurance coverage more affordable.

Barriers to abortion coverage harm patients. Whether health insurance covers abortion has direct financial implications for patients, particularly those with lower incomes.[6] About four in 10 privately insured abortion patients use their insurance to pay for the procedure.[7] An abortion at 10 weeks' gestation typically costs around $500, and the cost is considerably higher for abortions later in pregnancy.[8] Many patients may be unable to pay such an amount out of pocket: According to another Kaiser survey, about one-third of lower income people would be unable to pay for an unexpected $500 medical bill, and roughly another third would have to borrow money or charge the expense on a credit card and pay it back over time (see figure 2).[9]

For the six in 10 privately insured abortion patients who pay out of pocket, it is unclear what specific hurdles they face. Some patients may have health insurance plans that do not cover abortion, or they may not know whether their plan covers the procedure. Others have high deductibles that must be met before their plan covers any expenses. In some cases, a patient's health plan may not include her abortion provider in its network. And given the stigma that surrounds abortion, some patients may opt not to use their insurance coverage because they worry that their insurer, employer, spouse or parent might find out about the abortion. Abortion coverage restrictions contribute directly or indirectly to most of these barriers.

To cover the out-of-pocket cost for the procedure if they do not have abortion coverage—plus the costs for things like travel, lodging, child care and time off from work—many low-income patients put off paying utility bills or rent, or buying food for themselves and their children.[10] Others receive financial help from family members, clinics or charities, or sell their personal belongings.[7,10] Moreover, taking time to find the money for an abortion can lead to delays in obtaining care, which in turn can lead to additional costs and delays. As a pregnancy progresses, the cost of an abortion increases, the number of providers who offer abortion services decreases,[8] and more legal restrictions on abortion might apply.[11]

In other cases, not having abortion coverage can mean not being able to obtain abortion care at all, and the result is an unplanned and often unwanted birth. The reasons people give for seeking an abortion are informative: Most abortion patients say they cannot afford a child or another child, and that having a baby would interfere with their work, school or ability to care for their other children.[12] These sorts of fears have been substantiated by recent research from the University of California, San Francisco. For example, researchers found that women denied an abortion (because they were past the facility's gestational limit for the procedure) were more likely than those who obtained an abortion to be unemployed, receiving public assistance and living below the federal poverty level for years afterwards—despite having similar economic circumstances a year before seeking the abortion.[13]

The idea of separately sold abortion "riders" is unfeasible and deceptive. In many of their proposals to restrict private insurance coverage of abortion, antiabortion policymakers and advocates have put forward the idea—sometimes through specific legislative language and sometimes only implied—that enrollees would still be able to use their own money to purchase separate insurance policies ("riders") that only cover abortion. They claim this option would mitigate any harm to enrollees' rights and health.

That idea is unworkable and unreasonable, both in theory and in practice. In essence, it would require that people prepay for an abortion. Yet abortion is a health care service that few people anticipate needing; for example, people do not anticipate an unwanted pregnancy or a severe pregnancy complication. In addition, a requirement that abortion coverage can be offered solely through a rider sends a signal—an intentional one—that abortion is not "real" health care.

In practice, the pre-ACA history of maternity care riders offers a clear lesson that riders do not work. They were rarely offered, and exceedingly expensive when available, because insurance companies assumed that anyone buying coverage for a single service expected to make use of that coverage in the coming year and that would lead to costs for the insurer.[14,15] For abortion, riders have been technically allowed under the law in almost all of the states that otherwise ban abortion coverage, but a 2018 report found that they were "practically nonexistent": They simply did not exist in the individual insurance market in those states, and were available for small businesses from just a single insurance company in a single state.[16]

Conservatives' arguments about taxpayer rights and indirect subsidies are unworkable and hypocritical. Antiabortion conservatives are also dishonest in making their core arguments for coverage restrictions. An abortion coverage restriction is not some sort of religious exemption for antiabortion taxpayers. Rather, it gives those taxpayers a veto power over insurance coverage that other people can receive. And if the idea of a taxpayer's veto took root, it would make governing impossible. Antiwar taxpayers would be able

to veto funding for the U.S. military. Corporate taxpayers would be able to veto policies that give advantages to their competitors. Anti-tax activists would be able to veto taxes entirely.

Similarly, the argument that spending government money "frees up" private dollars to be used elsewhere (a concept referred to as "fungibility") is one that only ever seems to be applied to reproductive health care.[17] The U.S. government has a long tradition of involving private-sector organizations in achieving its goals in areas like public health, social welfare and global development, and fungibility is rarely, if ever, raised as a problem. For example, many billions of federal and state dollars go to religious organizations and charities every year, and by the logic of fungibility, all of that money would free up private funding to proselytize or engage in other religious activities. If that were true, then any government funding to a religious organization would be a violation of the U.S. Constitution's Establishment Clause, since it would indirectly subsidize religion.

Antiabortion politics threaten progress on expanding and improving health insurance coverage overall. Despite occasional protests to the contrary, few conservative policymakers have demonstrated serious interest in expanding health insurance coverage or taking steps to make it more affordable for everyone. It is obvious that many policymakers only care now because they fear the political consequences of rising premiums and fewer coverage options under their watch. In that context, it should be equally obvious that conservative policymakers' attempts to impose new abortion coverage restrictions in any proposal to make broader insurance coverage more affordable is an example of bad-faith negotiation. An abortion coverage restriction is a "poison pill," designed to shift the blame to others for conservatives' failure to compromise and to act constructively. And if conservative policymakers ever waver, antiabortion advocates will force them to toe the ideological line, because advocates see the ongoing fight over health insurance affordability as an opportunity to advance their long-term goal of eliminating abortion coverage.

The consequences of this standoff for the United States are severe: It means that abortion politics will perpetually interfere with any proposal in Congress to expand health insurance options, reduce insurance premiums and deductibles, or do anything else that involves spending federal dollars to make private insurance coverage work better. Similarly, antiabortion conservatives will make abortion coverage a front-line obstacle to more ambitious proposals, such as a "public option" for people in any income bracket to buy into Medicare or Medicaid, or a plan to set up single-payer insurance coverage.

Policymakers and advocates working to make health coverage better for more people in the United States cannot allow antiabortion forces—who will never accept compromise—to get in the way of progress. At the same time, policymakers and advocates must continue to press for repeal of the Hyde Amendment and other abortion coverage restrictions, and work toward requiring that all public and private insurance plans cover abortion—like any other vital health care service—so that it is affordable and accessible for everyone who needs it. ■

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February 18, 2020

Senator Cavanaugh, Chairman
Senate Commerce
State House, Room 100
107 N. Main Street
Concord, New Hampshire 03301

RE: SB 486-FN relative to insurance plans that cover maternity benefits

Dear Chairman Cavanaugh and Members of the Senate Commerce Committee:

Thank you for the opportunity to provide testimony in support of SB 486, which requires insurance plans that include maternity benefits also provide coverage for abortion services. Bi-State Primary Care Association respectfully requests the Committee vote SB 486 "ought to pass."

Bi-State Primary Care Association is a non-profit organization that works to expand access to primary and preventive care for all New Hampshire residents. We also represent New Hampshire's 14 community health centers, which have 56 locations across the state. Community health centers are non-profit organizations that provide integrated oral health, substance use disorder treatment, behavioral health, and primary care services, including obstetrics, gynecology, and prenatal and perinatal services. In 2019, New Hampshire's health centers provided over 490,000 visits to nearly 122,000 patients, most of whom live below 200% of the federal poverty level or $25,520 for an individual.[1,2] Community health centers serve patients regardless of their ability to pay or insurance status. Bi-State supports the expansion of health care services, including the expansion of health insurance coverage for reproductive health care services.

Whether a person has access to health insurance coverage affects access to care: "[o]ne in five uninsured adults in 2018 went without needed medical care due to cost."[3] According to a Kaiser Family Foundation issue brief published in June 2019, abortion coverage restrictions disproportionately affect poor and low-income women.[4] The woman bears the entire out-of-pocket cost for an abortion if she does not have abortion coverage: The median cost of an

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[3] Tolbert, Jennifer, Kendal Orgera, et al, *Key Facts About the Uninsured Population*, Kaiser Family Foundation, 1 (Dec. 13, 2019).

[4] Salganicoff, Laurie Sobel and Amrutha Ramaswamy, *Coverage for Abortion Services in Medicaid, Marketplace Plans, and Private Plans*, Kaiser Family Foundation, 7 (June 2019).

abortion at 10 weeks gestation is $500, and the median cost of an abortion at 20 weeks is $1195.[5] When 40% of adults in the United States do not have enough savings to pay for a $400 emergency expense, it is not hard to imagine how difficult it is to find the funds for a medical procedure that costs $500.[6]

Currently, insurance companies in New Hampshire can choose whether or not to cover abortion services. Senate Bill 486 would require health insurance plans (private insurance and insurance purchased through the Health Insurance Marketplace) that include maternity coverage to include coverage for abortions. New Hampshire has a long history of ensuring access to health insurance coverage. In the last two years alone, this body passed legislation to require coverage of fertility treatment, pediatric autoimmune neuropsychiatric disorders, required insurance coverage for prescription contraceptives, and codified the Affordable Care Act in state statute. In a similar vein, SB 486 will protect a patient's access to abortion coverage in New Hampshire.

Senate Bill 486 reduces barriers to health care services for Granite Staters. Every person, regardless of income, deserves access to timely, affordable, and respectful reproductive services, including abortion care. Bi-State's mission is to promote access to effective and affordable primary care and preventive services for all. Bi-State fully supports SB 486 because it increases access to health insurance coverage for reproductive health care and reduces barriers to health care services. We respectfully request the Committee recommend SB 486 "ought to pass."

Please feel free to contact me if you have any questions or concerns.

Sincerely,

Kristine E. Stoddard, Esq.
Director of NH Public Policy
603-228-2830, ext. 113
kstoddard@bistatepca.org

[5] *Id.* at 1.

[6] *See* Salganicoff at 1.

new hampshire
WOMEN'S FOUNDATION

To: Chairman Cavanaugh and the Senate Commerce Committee
Re: Testimony in Support of Senate Bill 486
Date: February 18, 2020
Position: OUGHT TO PASS

Background

The New Hampshire Women's Foundation invests in equality and opportunity for women and girls through research, education, advocacy and philanthropy. Along with our predecessor organizations the NH Commission of the Status of Women, The NH Women's Lobby and the NH Women's Policy Institute we have been a consistent and leading voice in New Hampshire for the advancement and the protection of the rights of women and girls for more than 50 years.

We strongly support access to safe, legal abortion for women and teens and we align behind public policies that not only protect the right to abortion, but also those policies that remove geographic or financial barriers and thus ensure that right can be exercised.

While the most important implication of SB 486 is to fulfill an individual's ability to make decisions about their reproductive life, improvements in abortion access will also effect economic outcomes for women and their families, including educational attainment and labor market participation. Deciding whether and when to have a child is THE most consequential decision relative to a woman's lifetime economic well-being, so it is important that all choices, including abortion, are available to those who face unintended pregnancy. Women who are denied abortion for financial reasons go on to experience economic hardship and economic insecurity lasting for years

SB 486 will promote greater economic security for New Hampshire women and families in three keys areas:

1) **Lowering Fertility** – Delayed childbearing and reduced fertility allow women to invest more heavily in their human capital, including increased schooling and job training which contribute to greater economic security.

2) **Increasing Educational Attainment** – women who have access to abortion have higher rates of high school and college graduation.[1]
3) **Labor Force Participation** – It takes 4-years on average for a woman to return full-time to the workforce after childbirth when denied access to abortion.

The Impact of Abortion Access under SB 486 will have a Two-Generation Effect[2]

Abortion Access not only has economic benefits for the pregnant woman, but also benefits other children (born previous or subsequent) in the household: lower rates of poverty and receipt of public assistance, and increase in high school graduation and college attendance. Moreover, these children were less likely to be single parents or access public assistance as adults.

Conclusion

Abortion access is a critical tool for women to further their education, strengthen their economic security and improve their ability to parent existing children.

The New Hampshire Women's Foundation encourages your support for this bill and is committed to work further with legislators, insurance companies and women's health leaders toward enactment. We thank you for the opportunity to provide testimony and urge you to support this proposal.

Respectfully Submitted

Jennifer Frizzell
Director of Policy
jennifer@nhwomensfoundation.org
603.340.1593

[1] Angrist and Evans, "Schooling and Labor Market Consequences of the post-1970's State Abortion Reforms" In *Research in Labor Economics,* 2000, pp75-113

[2] ANSIRH, *2019 Introduction to the Turnaway Study.* UCSF www.anshirh.org

ISSUE BRIEF, AUGUST 2018

Socioeconomic outcomes of women who receive and women who are denied wanted abortions

Key Points:

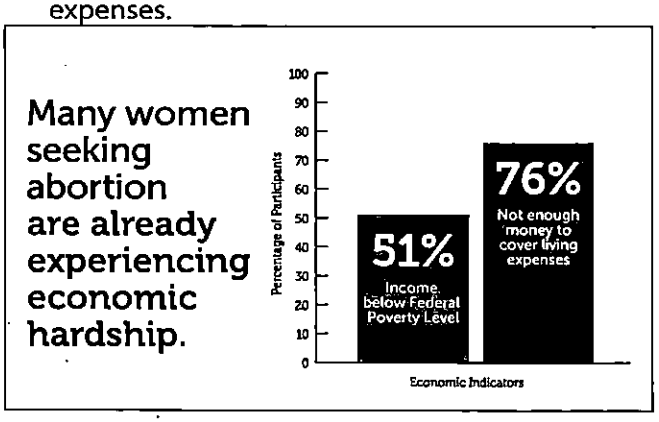
- **Many women are already experiencing economic hardships at the time they seek an abortion. In fact, not having enough money to care for a child or another child is the most common reason for seeking an abortion.**
- **Consistent with their concerns, we find that being denied a wanted abortion results in economic insecurity for women and their families, and an almost four-fold increase in odds that a woman's household income is below the Federal Poverty Level compared to those who receive an abortion.**

Background

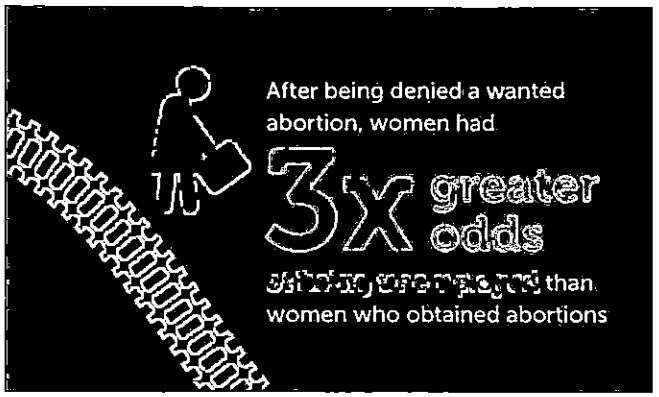
- Not having enough money to care for a child or support another child is the most common reason women give for wanting to terminate an unwanted pregnancy. [1,2,3]
- The data in this brief come from the Turnaway Study, the first study in the US to examine women's outcomes for years after receiving or being denied abortion. The study was designed to assess the consequences for women of having an abortion versus being denied a wanted abortion. Women were recruited from 30 abortion facilities across the country. Some of the women in the study received a wanted abortion and some were denied because they were past the gestational age limit. For more information about the Turnaway Study, visit www.ANSIRH.org.
- To measure the relationship between abortion and socioeconomic outcomes, researchers interviewed women about their household size, employment, receipt of public assistance, and financial security every six months for five years after seeking an abortion.

Findings

- Many women were already experiencing economic hardships at the time they sought an abortion – half had incomes below the Federal Poverty Level and three-quarters reported not having enough money to pay for basic living expenses.



- Six months after being denied an abortion, women had more than three times greater odds of being unemployed than women who were able to access an abortion.
- Women who were denied a wanted abortion were more likely to be enrolled in public safety net programs like Temporary Assistance for Needy Families (TANF), food assistance (SNAP), and Women, Infants, and Children (WIC) compared to women who received abortions.



- Over time, women denied abortions were more likely to be raising children alone – without family members or male partners – compared to women who received an abortion.
- Giving birth, instead of being able to access a wanted abortion, resulted in an almost four-fold increase in odds that a woman's household income was below the Federal Poverty Level, and a greater likelihood of reporting not being able to cover basic living needs.

Conclusions

- Women are justified in being concerned about the financial consequences of carrying an unwanted pregnancy to term.
- Because the responsibility of raising a child born after being denied an abortion falls disproportionately on women, restricting abortion access threatens women's economic security.
- TANF, SNAP, WIC, and Medicaid play an important role in supporting women and their families, but they are not sufficient in keeping women from falling below the Federal Poverty Level.
- Increasing access to, and funding for, public assistance programs could help ensure all women can obtain the support they need regardless of the outcome of their pregnancies.
- Denial of abortion leads to economic hardships for women. Laws that limit women's access to abortion will result in more women carrying unwanted pregnancies to term, with subsequent harm to their economic wellbeing and the financial security of their families.

For more information about this and other ANSIRH research, please visit www.ansirh.org.

References

1. Biggs, M., et al. (2013). "Understanding why women seek abortions in the US." BMC Women's Health 13(1): 29.
2. Finer, L., et al. (2005). "Reasons U.S. women have abortions: quantitative and qualitative perspectives." Perspect Sex Reprod Health 37(3): 110-118.
3. Kirkman, M., et al. (2009). "Reasons women give for abortion: a review of the literature." Arch Womens Ment Health 12(6): 356-378.

This issue brief summarizes findings from the following publication:
Foster DG, Biggs MA, Ralph L, Gerdts C, Roberts S, Glymour MM. "Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions in the United States." Am J Public Health. 2018 Mar;108(3):407-413.

Cornerstone

TO: Senate Commerce Committee

FROM: Shannon McGinley, volunteer executive director, Cornerstone Action
smcginley@nhcornerstone.org, (603) 228-4794

RE: SB 486-FN, abortion-insurance mandate

DATE: 18 February 2020

Cornerstone Action urges you to vote "inexpedient to legislate" on SB 486-FN. This bill is not about health care or parity. It's about coercing people into helping to pay for others' abortions, even when that violates sincerely-held religious beliefs. This is poor public policy that is wrong for New Hampshire.

- The plain language of SB 486-FN applies to insurers, as defined in RSA 417-D:1, II. In practice, however, anyone involved in providing health insurance for others - i.e. employers - would be helping to provide abortions.
- SB 486-FN and it is sure to entangle our state in litigation as a violation of religious liberty and conscience rights, and it could also subject the state to a loss of federal funding under the Weldon Amendment. The provision beginning on line 10 of the bill, authorizing the commissioner to grant minimal exemptions as needed to keep federal dollars flowing, does not allay our concern. Those exemptions would likely be on a case-by-case basis in order to meet the minimum requirements of the Weldon Amendment. That would be unsatisfactory. Religious liberty is a fundamental right under both the U.S. and New Hampshire Constitutions. It should not rest on a commissioner's case-by-case exemptions in order to be respected, nor should it rely on federal rules that can change from one Administration to the next.
- SB 486-FN seeks to force employers to be involved in employees' abortion decisions, if the employer offers health insurance as an employee benefit. Nothing in the bill acknowledges that an employer or insurer could have religious or conscientious objections to abortion. The bill is clear that it would apply to all insurance policies that

cover maternity benefits. No exceptions are listed. We believe that the lack of exceptions is a feature of the bill rather than an oversight by the sponsors.

- SB 486-FN is a politically motivated attempt to use insurance regulations to sidestep longstanding statutory and administrative restrictions on public funding of abortion. Its supporters want to extract from you what they cannot get any other way: expanded abortion funding.

For these reasons, SB 486-FN deserves an "inexpedient to legislate" recommendation.

HHS.org announcement re Weldon Amendment as applied to California law:
https://www.hhs.gov/about/news/2020/01/24/hhs-issues-notice-of-violation-to-california-for-its-abortion-coverage-mandate.html

"Washington forces church to choose: Fund abortions or break the law" (about pending litigation against Washington's abortion-insurance-mandate law):
https://www.adflegal.org/detailspages/press-release-details/washington-forces-church-to-choose-fund-abortions-or-break-the-law

February 18, 2020

The Honorable Kevin Cavanaugh, Chairman
Senate Commerce Committee
State House Room 100
Concord, NH 03301

Re: New Futures' support of SB 486

Dear Chairman Cavanaugh and Members of the Committee:

New Futures appreciates the opportunity to testify in support of SB 486, the Reproductive Health Parity Act. 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. It is with this mission in mind that New Futures offers the following testimony.

First, this bill will help improve access to a full range of reproductive health services and improve the overall health and wellness of Granite Staters. More coverage of services, including abortion care, will help close gaps in coverage that currently exist between those who have insurance coverage for all reproductive health services and those who have plans that do not. This is a straightforward policy to remove a barrier to access, reduce inequities in coverage, and help Granite State women plan their futures and care for their families.

This is not the first time this legislature has sought to protect choice in the reproductive health care space or has enacted legislation to protect New Hampshire residents from changes to the Affordable Care Act (ACA). Through past legislation, our state already protects access to contraception, essential health benefits, and in vitro fertilization (IVF). Like the previously mentioned protections passed by this body, this bill would help protect Granite Staters from further changes to the ACA.

Half of all states have banned abortion coverage in at least some private insurance plan; Fifteen states ban coverage in the Marketplace and eleven ban coverage in all private insurance. New Hampshire has a prime opportunity to protect crucial access to reproductive health care by joining seven other states in protecting patients from discriminatory bans on abortion coverage. These states are Maine, Illinois, New York, Oregon, Connecticut, Washington, and California.

Insurance companies should not be deciding whether women can or cannot access abortion. The proposed legislation corrects this inequity and provides a safeguard against health care discrimination. Everyone deserves reproductive health care coverage that meets their needs, including abortion, without shame or stigma, regardless of one's gender, sexual orientation, or economic status.

For these reasons, New Futures urges the Committee to vote ought to pass on SB 486.

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

Respectfully submitted,

Holly A. Stevens, Esq.
Health Policy Coordinator

ACLU New Hampshire

Statement by Jeanne Hruska, ACLU-NH Political Director
Senate Health and Human Services Committee
Senate Bill 486
February 18, 2020

I submit this testimony on behalf of the American Civil Liberties Union of New Hampshire (ACLU)—a non-partisan, non-profit organization working to protect civil liberties throughout New Hampshire for over fifty years. I appreciate the opportunity to testify in support of SB486 and in support of continuing this legislature's work to provide stability to Granite Staters when it comes to health insurance coverage.

The constitutional right to abortion is meaningless without access. The U.S. Supreme Court recognized a pregnant person's right to abortion in *Roe v. Wade*, and reaffirmed it in *Planned Parenthood v. Casey*. To exercise that right, however, a woman needs access to abortion services.

There are currently several private insurance plans available on the market that do not cover abortion services. This can result in patients with sizeable out of pocket costs or unable to access abortion services. Depending on federal rules, which are in flux, this could even include an abortion sought to preserve the life of the mother.

When an insurance plan covers reproductive healthcare, it should cover all the options that can result from a pregnancy. This includes births, miscarriages, stillbirths, and abortion. Too many medical decisions are made already in part on how or if insurance will cover certain services. That should not be the case with pregnancy. SB486 would ensure basic equity and fairness in insurance coverage by making sure that people who decide to obtain an abortion are treated no differently by their insurance plan than those who decide to continue with a pregnancy.

Employers are not asked to opine on medical services covered by their employees' insurance plans. In providing health insurance plans that cover a broad range of health care services, employers are not taking a position on these services. In no other realm would we even consider employers being able to pick and choose what services an employee can access. For example, we would not tolerate an employer denying coverage for blood transfusions for religious purposes, because the health and well-being of employees is the relevant issue here. We should not tolerate cherry picking with reproductive health either.

Arguments about freedom of religion in this context are actually arguments in support of discrimination. Allowing employers the right to deny coverage of certain services is a license to discriminate and deny employees access to a right provided under the constitution. It represents a chilling return to the days when women's sexuality was treated as immoral, perpetuating harmful stereotypes that have long been used to discriminate against women and deny access to medical services.

The decisions that I make in the privacy of my doctor's office do not impact my employer's rights. However, my employer picking and choosing my medical care can directly interfere with not just the quality of my medical care, but my constitutional rights as well.

For these reasons, the ACLU-NH respectfully urges the members of this committee to vote *ought to pass* on SB486.

DIOCESE OF MANCHESTER

February 18, 2020

Senator Kevin Cavanaugh, Chair
and Members of the Senate Commerce Committee
State House
Concord, NH 03301

Re: SB 486 (Mandatory Insurance Coverage for Abortions)

Dear Senator Cavanaugh and Members of the Committee:

As Director of Public Policy for the Roman Catholic Diocese of Manchester, and on behalf of Bishop Peter Libasci, I want to respectfully register **our opposition to SB 486.**

It goes without saying that abortion is the issue that most sharply divides the body politic in this country today. As has been said, some look at the images of a child in the womb and see one of us. Others look at those same images and do *not* see one of us. Or they see one of us and yet they believe that there are reasons why the law should allow the taking of that life.

As you know, over the years this Diocese has actively advocated on many public issues where the fundamental principles of life and human dignity were at stake. We have for instance opposed the death penalty, supported stronger protections for victims of human trafficking, and taken positions on behalf of immigrants. We strongly oppose this bill for exactly the same reasons.

I would like to briefly discuss three of the specific grounds for our objection to SB 486.

First, the bill wrongly equates abortion with health care.

SB 486 seeks to equate abortion services with maternity services. As I assume no one would deny, maternity care is life-affirming and life-giving. It is thus health care in the truest sense. Abortion, on the other hand, treats pregnancy as if it were a disease to be cured. It indisputably involves the intentional ending of a life. Killing is not health care.

Moreover, because New Hampshire law contains almost no restrictions on when or why abortions can be performed, this bill would have the effect of mandating insurance coverage for any abortions done (for example) for purposes of sex selection, or because of a finding of Down syndrome or genetic abnormalities. Abortions done for purely eugenics-based purposes would mandatorily be in the orbit of coverage under SB 486.

Second, and closely related to this, SB 486 would deeply violate the conscience rights of employers and individuals who are morally opposed to abortion.

Under SB 486, all health insurance policies that cover maternity services would also have to cover abortions as well. This would mean that in New Hampshire the only maternity services coverage that anyone could offer or obtain would be under a policy that also provides abortion coverage. Hence, individuals who profoundly oppose abortion would be presented with this choice under the statute: either purchase insurance that includes abortion coverage, or refrain from offering or purchasing the health insurance at all. The same problem would be presented for employers with respect to the insurance plans they offer to employees. SB 486 would statutorily eliminate any possibility that New Hampshire citizens could offer or choose health plans that run in accord with the dictates of their consciences on abortion.

It should be noted that this moral quandary does not extend only to religious entities or to employers or employees with objections to abortion under all circumstances. By virtue of the fact that abortion in New Hampshire is essentially unrestricted, the moral quandary could even extend to those who actually support abortion rights but only as limited say to the earlier stages of a pregnancy.

Conscience is one of the most fundamental rights that we are vested with as human beings. Part 1 Article 4 of the New Hampshire Constitution says that rights of conscience are "in their very nature unalienable." No one -least of all the government- should disregard the obligation that conscience lays upon another person. As Martin Luther King Jr. said in the last sermon of his life, "There comes a time when one must take the position that is neither safe nor politic nor popular, but he must do it because his conscience tells him it is right." I urge even the members of the Committee who support abortion rights to vote against this bill out of respect for the conscience rights of your constituents who are profoundly opposed to abortion.

Third, SB 486 would, if passed, violate federal law.

In every year since 2004, Congress has included the so-called Weldon Amendment in the Departments of Labor, Health and Human Services, Education and Related Agencies Appropriations Act. The Amendment states in relevant part:

> None of the funds made available in this Act may be made available to a... State or local government, if such... government subjects any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions.

On January 24, 2020, the US Department of Health and Human Services Office for Civil Rights issued a Notice of Violation to the State of California on the grounds that California had contravened the Weldon Amendment by mandating that all California health care plan issuers cover abortions (a copy of that Notice of Violation is attached). SB 486 would create exactly the same type of discriminatory mandate in New Hampshire (indeed, it appears that SB 486 is even

more sweeping than the California mandate because California evidently included a narrow exemption for a limited set of "religious employers", an exemption that is not contained in SB 486.)

It is presumably because of the long-standing disputes over the applicability of the Weldon Amendment that proposed new RSA 417-D: 2-c in SB 486 includes the provision that the Commissioner of Insurance can grant exemptions to the SB 486 mandate as necessary to insure the receipt of federal funds. The uncertainty evidenced by this provision is yet one more reason why this bill should not be passed.

To conclude, I ask the Committee to consider how the vote on this bill will resonate in other areas. If we want our society to respect and value the child who is a refugee, or the child who is homeless, or the child who does not have access to health care, then we need to respect and value the child in the womb as well. If society designates certain ones of us as being expendable, we should not be surprised if society treats certain ones of us as expendable.

I respectfully urge the Committee to vote ITL on SB 486.

Thank you for your kind consideration of our views.

Very truly yours,

Robert E. Dunn, Jr., Esq.
Director, Office of Public Policy

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office for Civil Rights

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200 Independence Ave, S.W.• Washington, D.C. 20201
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VIA CERTIFIED U.S. MAIL AND ELECTRONIC MAIL [Xavier.Becerra@doj.ca.gov]

The Honorable Xavier Becerra
Attorney General
State of California
Department of Justice
1300 I Street
Sacramento, CA 95814

January 24, 2020

Notice of Violation – OCR Transaction Numbers 17-274771 and 17-283890

Dear Governor Newsom, Attorney General Becerra, Secretary Ghaly, and Director Rouillard:

The U.S. Department of Health & Human Services's ("HHS" or the "Department") Office for Civil Rights ("OCR") has completed its investigation of the complaints filed by Missionary Guadalupanas of the Holy Spirit, Inc. (OCR Transaction Number 17-274771)[1] and Skyline Wesleyan Church (OCR Transaction Number 17-283890)[2] (collectively, the "Complainants"). OCR finds that the State of California ("California") has discriminated, in violation of the Weldon Amendment,[3] against health care plans and issuers[4] that did, or would, limit or exclude abortion

[1] Letter from **REDACTED** Attorney, **REDACTED**., to Michael Leoz, Regional Manager, Office for Civil Rights, U.S. Dep't of Health & Human Servs. (June. 26, 2017) (on file with HHS OCR) [hereinafter "Guadalupanas Sisters Complaint"].

[2] Letter from **REDACTED**, Attorney, **REDACTED**, to Office for Civil Rights, U.S. Dep't of Health & Human Servs. (Sept. 22, 2017) (on file with HHS OCR) [hereinafter "2017 Skyline Complaint"].

[3] *See, e.g.,* Consolidated Appropriations Act, 2018, Pub. L. No. 115-141, Div. H, § 507(d), 132 Stat. 348, 764 (Mar. 23, 2018) [hereinafter "2018 Weldon Amendment"]; Department of Defense and Labor, Health and Human Services, and Education Appropriations Act, 2019 and Continuing Appropriations Act, 2019, Public Law 115–245, Div. B., sec. 507(d), 132 Stat. 2981, 3118 (Sept. 28, 2018), as extended by the Continuing Appropriations Act, 2020, and Health Extenders Act of 2019, Pub. L. No. 116-59, Div. A., sec. 101(8), 133 Stat. 1093, 1094 (Sept. 27, 2019) [hereinafter "2019 Weldon Amendment"]; Department of Defense and Labor, Health and Human Services, and Education Appropriations Act, 2019, and Continuing Appropriations Act, 2019, Public Law 115–245, Div. B., sec. 507(d), 132 Stat. 2981, 3118 (Sept. 28, 2018), as extended by the Further Continuing Appropriations Act, 2020, and Further Health Extenders Act of 2019, Pub. L. No. 116-69, Div. A., sec. 101(1), 133 Stat. 1134 (Nov. 21, 2019) [hereinafter "2020 CR Weldon Amendment"]; Further Consolidated Appropriations Act, 2020, Pub. L. No. 116-94, Div. A., § 507(d), 133 Stat. 2534, 2607 (Dec. 20, 2019) [hereinafter "2020 Weldon Amendment"].

[4] Under California law, a health care service plan is "[a]ny person who undertakes to arrange for the provision of health care services to subscribers or enrollees, or to pay for or to reimburse any part of the cost of those services, in return for a prepaid or periodic charge paid by or on behalf of the subscribers or enrollees." CAL. HEALTH & SAFETY CODE § 1345(f)(1). The "plan" "refers to the entity that offers health coverage, as distinct from one of more 'products' covering a specific package of benefits and services that a plan may offer to purchasers." Letter from **REDACTED**, Gen. Counsel & Deputy Dir., Dep't of Managed Health Care, Cal. Health & Human Servs. Agency, to Michael Leoz, Regional Manager, Office for Civil Rights, U.S. Dep't of Health & Human Servs., at 2 n.3 (Nov. 1, 2017) (on file with HHS OCR) [hereinafter "2017 DMHC Data Response"]. For purposes of this Notice of Violation, the term

coverage, by mandating abortion coverage in plans subject to regulation by the California Department of Managed Health Care ("DMHC").

BACKGROUND

The Knox-Keene Health Care Service Plan Act of 1975 ("Knox-Keene Act")[5] requires health plan issuers operating in California to provide seven categories of "basic health care services" in their plan products. California's DMHC licenses health plan issuers in the state[6] and has authority to determine the scope of basic health care services under the Knox-Keene Act.[7] In 2013, Loyola Marymount University and Santa Clara University, two religiously affiliated universities in California, implemented changes to their employee health care plans to no longer provide elective abortion coverage—changes that DMHC had previously approved.[8]

Abortion providers and advocacy groups, including Planned Parenthood, learned of this development and pressured DMHC to not only reverse its decision to allow the coverage changes, but also to make elective abortion coverage mandatory for all health care plans falling under DMHC's jurisdiction.[9]

On August 22, 2014, DMHC responded to the pressure campaign by sending letters to seven California health care service plan issuers (the "Health Plan Issuers") mandating they cover

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"issuer(s)" or "health plan issuer(s)" refers to a "health care service plan" as defined under California law, and the terms "plan(s)", "health plans", "health care plans", or "plan products" refers to the products covering a specific package of benefits and services that an issuer may offer to purchasers.

[5] CAL. HEALTH & SAFETY CODE § 1340 *et seq.*

[6] *See* CAL. HEALTH & SAFETY CODE § 1349 (requiring licensure unless exempted by § 1343 of California's Health and Safety Code).

[7] "The director shall by rule define the scope of each basic health care service that health care service plans are required to provide as a minimum for licensure under this chapter." *Id.* at §§ 1367(i), 1345(b); CAL. CODE REGS. tit. 28, § 1300.67.

[8] *See* OCR Interview with **REDACTED**, Vice Pres., California Catholic Conference, *et al.* (March 12, 2015) (on file with HHS OCR).

[9] *See* E-mail from **REDACTED**, Managing Attorney, Nat'l Health Law Prog., ("NHLP") to **REDACTED**, Dir. DMHC (Nov. 8, 2013) (on file with HHS OCR) (requesting to arrange a meeting between DMHC, NHLP, and other "allies" to address the "sensitive topic" of LMU's and SCU's decision to not cover elective abortions in their employee health plans). From November 2013 through Spring 2014, Planned Parenthood (lead by its Chief Legal Counsel, **REDACTED**) and, to a lesser extent, other advocacy groups, lobbied DMHC, CHHSA, and the California Governor's Office for a legislative or administrative "fix" for "the ongoing issue of DMHC approval of employee plans that exclude abortion coverage." E-mail from **REDACTED**, Legislative Advocate, Planned Parenthood, to **REDACTED**, Dep. Sec., CHHSA (March 17, 2014) (CHHS000052) (on file with HHS OCR). The weight of the details regarding the lobbying effort, including California's requesting legal guidance from Planned Parenthood, are found in the trial court record in *Skyline Wesleyan Church v. Cal. Dep't of Managed Health Care*, No. 16-cv-0501 (S.D. Cal. 2016). *See, e.g.*, Pl.'s Separate Statement Undisputed Material Facts Supp. Mot. Summ. J., *Skyline Wesleyan Church v. Cal. Dep't of Managed Health Care*, No. 16-cv-0501 (Dkt. # 92-5) (S.D. Cal. March 9, 2018), and the declarations, depositions, and exhibits referenced therein. *See also* OCR Telephone Interview with **REDACTED**, Assoc. Gen. Counsel, Blue Cross of California, dba Anthem Blue Cross (Feb. 26, 2015) (on file with HHS OCR) [hereinafter "Anthem Blue Cross Interview"] (recounting Planned Parenthood's advocating to DMHC that it implement the change in policy quickly).

abortion without exclusion or limitation in every plan product they offered (collectively, the "Mandate Letters"). The Health Plan Issuers were:

1. Aetna Health of California, Inc. ("Aetna");[10]
2. Blue Cross of California, dba Anthem Blue Cross ("Anthem Blue Cross");[11]
3. California Physicians' Service, dba Blue Shield of California ("Blue Shield");[12]
4. Health Net of California, Inc. ("Health Net");[13]
5. Kaiser Foundation Health Plan, Inc. dba Kaiser Foundation, Permanente Medicare Care Program ("Kaiser");[14]
6. GEMCare Health Plan, Inc., dba ERD Inc., Physicians Choice by GEMCare Health Plan ("GEMCare");[15] and
7. UnitedHealthcare of California ("UnitedHealthcare").[16]

Prior to sending the Mandate Letters, DMHC did not have any written rules, policies, or procedures related to abortion coverage for the health care plans under its jurisdiction.[17] The Mandate Letters, and the change in position they announced, were issued without prior public notice, public comment, or hearing.[18]

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[10] *See* Letter from **REDACTED**, Dir. Cal. Dep't of Managed Health Care, to **REDACTED**, Pres. Aetna, (Aug. 22, 2014), https://www.dmhc.ca.gov/Portals/0/082214letters/aetna082214.pdf [hereinafter "Aetna Letter"].

[11] *See* Letter from **REDACTED**, Dir. Cal. Dep't of Managed Health Care, to **REDACTED**, Cal. Pres. of Anthem Blue Cross, (Aug. 22, 2014), https://www.dmhc.ca.gov/Portals/0/082214letters/abc082214.pdf.

[12] *See* Letter from **REDACTED**, Dir. Cal. Dep't of Managed Health Care, to **REDACTED**, Pres. & Chief Exec. Officer, Blue Shield of Cal., (Aug. 22, 2014), https://www.dmhc.ca.gov/Portals/0/082214letters/bsoc082214.pdf.

[13] *See* Letter from **REDACTED**, Dir. Cal. Dep't of Managed Health Care, to **REDACTED**, Pres., W. Region Health Plan & Pres., Health Net, (Aug. 22, 2014), https://www.dmhc.ca.gov/Portals/0/082214letters/hn082214.pdf.

[14] *See* Letter from **REDACTED**, Dir. Cal. Dep't of Managed Health Care, to **REDACTED**, Senior Vice-Pres., Cal. Health Plan Operations, Kaiser, (Aug. 22, 2014), https://www.dmhc.ca.gov/Portals/0/082214letters/k082214.pdf.

[15] *See* Letter from **REDACTED**, Dir. Cal. Dep't of Managed Health Care, to **REDACTED**, Chief Exec. Officer, GEMCare, (Aug. 22, 2014), https://www.dmhc.ca.gov/Portals/0/082214letters/gc082214.pdf.

[16] *See* Letter from **REDACTED**, Dir. Cal. Dep't of Managed Health Care to **REDACTED**, UnitedHealthcare, Pres. & Chief Exec. Officer, (Aug. 22, 2014), https://www.dmhc.ca.gov/Portals/0/082214letters/uh082214.pdf.

[17] Sept. 27, 2017 Deposition of **REDACTED**, former Dep. Dir. Office of Plan Licensing, DMHC (on file with HHS OCR) 41:18-21; Sept. 19, 2017 Deposition **REDACTED**, Dep. Dir. Leg. Affairs, DMHC (on file with HHS OCR) 15:18-16:13, 17:20–24; Sept. 20, 2017 Deposition of **REDACTED** former Dep. Dir. Plan & Prov. Relations, DMHC (on file with HHS OCR) 29:13-17 (". . . DMHC didn't seem to have a policy on this issue and hadn't done—it seemed to me that they hadn't done the—the research in regards to whether or not that—what its policy should be in regards to those exclusions . . .").

[18] Consolidated Opening Br. Pet., Opp'n Demurrer, & Supp. Writ Mandamus & Declaratory Relief at 4, *Missionary Guadalupanas of the Holy Spirit, Inc. v. Rouillard*, No. 34-2015-80002226 (Cal. Super. Ct. Aug. 12, 2016).

As a result of its edict, California forced over 28,000 people out of plans that up until that time had chosen to not cover elective abortions.[19]

As described further below, OCR's current investigation was prompted by complaints alleging that California's actions directly caused Complainants to lose health care plans that were consistent with their sincere moral or religious beliefs regarding their objection to helping pay for or facilitate elective abortion.[20]

BACKGROUND OF THE COMPLAINTS

1. Missionary Guadalupanas of the Holy Spirit, Inc. ("Guadalupanas Sisters")

The Guadalupanas Sisters are a Catholic order of religious women organized as a Florida nonprofit corporation and headquartered in Los Angeles, California.[21] The Guadalupanas Sisters "endeavor to creatively live the attitudes modeled by Our Lady of Guadalupe: presence, accompaniment, solidarity and compassion towards the poorer people, especially the indigenous, migrants, and the marginalized."[22] The Guadalupanas Sisters are "faithful to the moral and theological teachings of the Roman Catholic Church"[23] and "believe that direct abortion, abortion willed either as an end or a means, is gravely contrary to the moral law."[24] On June 26, 2017, the Guadalupanas Sisters filed a complaint with OCR alleging that the Mandate Letters "burden[] their conscience rights by compelling them to fund, through their premiums payments [to Kaiser], the practice of abortion on demand for other plan participants."[25]

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[19] Letter from **REDACTED**, Gen. Counsel & Deputy Dir., Dep't of Managed Health Care, Cal. Health & Human Servs. Agency, to Michael Leoz, Regional Manager, Office for Civil Rights, U.S. Dep't of Health & Human Servs., at 5 (Jan. 20, 2015) (on file with HHS OCR) [hereinafter "2015 DMHC Data Response"].

[20] Pursuant to 45 C.F.R. sections 88.1 and 88.2 (effective March 25, 2011), OCR receives and handles complaints concerning alleged violations of the Weldon Amendment in coordination with HHS funding components as appropriate. *See also* Statement of Organization, Functions, and Delegations of Authority, 83 Fed. Reg. 2,802, 2,803 (Jan. 19, 2018). This notice of violation does not rely on the final rule published on May 21, 2019, "Protecting Statutory Conscience Rights in Health Care; Delegations of Authority," 84 Fed. Reg. 23,170, which has been vacated by courts in ongoing litigation. *See New York v. U.S. Dep't of Health & Human Servs.*, 2019 WL 5781789, at *70 n.76 (S.D.N.Y. Nov. 6, 2019) ("The 2011 Rule, which has governed HHS's administration of the Conscience Provisions for eight years and is unaffected by this decision, will remain in place, and continue to provide a basis for HHS to enforce these laws, pending any future rule that HHS may promulgate."); *Id.* at *72 ("The Conscience Provisions recognize and protect undeniably important rights."); *City and County of San Francisco v. Azar*, 2019 WL 6139750 (N.D. Cal. Nov. 19, 2019); *State of Washington v. Azar*, 2019 WL 6219541 (E.D. Wash. Nov. 21, 2019).

[21] V. Pet. Writ Mandamus & Compl. Injunctive & Declaratory Relief & Attorneys' Fees at ¶¶ 12-13, *Missionary Guadalupanas of the Holy Spirit, Inc. v. Rouillard*, No. 34-2015-80002226 (Cal. Super. Ct. Oct. 26, 2015).

[22] Misionares Guadalupanas del Espiritu Santo, About Us, Charism, http://mgsps.org/carisma-charism/ (last visited Jan. 23, 2020).

[23] V. Pet. at ¶ 14, *MGHS v. Rouillard* (2015).

[24] *Id.* at ¶ 16.

[25] Guadalupanas Sisters Compl. at 2. The Guadalupanas Sisters had previously "procured their insurance through a federally qualified Employee Retirement Income Security Act ("ERISA") trust available to certain, qualified Catholic religious entities...this ERISA trust [is] not subject to California state regulations [and] excludes coverage of direct abortion of any kind." In January 2015, the Guadalupanas Sisters no longer qualified for the ERISA trust and were

2. Skyline Wesleyan Church ("Skyline Church")

Skyline Church is a non-profit Christian church located in La Mesa, California.[26] As a member of the Wesleyan denomination, Skyline Church "adheres to the Wesleyan Doctrinal Statement, including the belief that the Holy Bible is the inspired Word of God, infallible and without error."[27] Skyline Church believes abortion "is a grave moral evil,"[28] that "violates the Bible's command against the intentional destruction of innocent human life," and "is inconsistent with the dignity conferred by God on creatures made in His image."[29] "Skyline Church believes and teaches that participation in, facilitation of, or payment for an elective or voluntary abortion is a grave sin."[30] Skyline Church expects its employees in their work and personal lives to abide by Skyline Church's religious beliefs and teachings on abortion.[31] "Because of its religious beliefs . . . Skyline Church seeks to offer health insurance coverage to its employees in a way that does not also cause it to pay for abortions."[32]

On September 22, 2017, Skyline Church filed a complaint with OCR alleging that the Mandate Letters violate the Weldon Amendment because California's discrimination against health care plans forced Skyline Church to provide insurance coverage for elective abortions, "despite [its] sincerely held religious beliefs against abortion."[33] Prior to the Mandate Letters, Skyline Church had been insured by Aetna under a plan that excluded elective abortion services.[34] Skyline alleges that California's actions deprived it of insurance coverage that was consistent with its beliefs.

Although OCR's investigation relates to the 2017 Guadalupanas and Skyline Complaints, OCR also received complaints from other parties raising similar allegations.[35]

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thus "compelled to seek recourse to commercial health plan markets to obtain health insurance for their sisters located in California," opting to obtain coverage through Kaiser. *Id.*

[26] Compl. Declaratory & Injunctive Relief & Nominal Damages, ¶ 14, *Skyline Wesleyan Church v. Cal. Dep't of Managed Health Care*, No. 37-2016-000036 (Cal. Sup. Ct. Feb. 4, 2016), *removed*, No. 16-cv-00501 (S.D. Cal. 2018), *appeal filed*, No. 18-55451 (9th Cir. Apr. 9, 2018).

[27] *Id.* ¶ 15.

[28] 2017 Skyline Compl. at 1.

[29] Compl. ¶ 22, *Skyline Wesleyan Church* (2018).

[30] *Id.* ¶ 23.

[31] *Id.* ¶ 26.

[32] *Id.* ¶ 29.

[33] 2017 Skyline Compl. at 2.

[34] Decl. **REDACTED** Supp. Pl.'s Mot. Summ. J., *Skyline Wesleyan Church v. DMHC*, No. 16-cv-00501, at ¶¶ 3-5 (S.D. Cal. Nov. 20, 2017).

[35] *See, e.g.*, Complaint filed by **REDACTED**, received through HHS OCR Complaint Portal (October 9, 2017) (OCR Transaction No. 18-284511) (on file with HHS OCR); complaint filed by **REDACTED**, received through HHS OCR Complaint Portal (Jan. 9, 2018) (OCR Transaction No. 18-338383) (on file with HHS OCR); and Letter from **REDACTED**, Att'y for **REDACTED**, to Roger Severino, Dir., Office for Civil Rights (Aug. 24, 2018) (OCR Transaction No. 18-316979) (on file with HHS OCR). *See also* Letter from Rep. Kevin McCarthy, House Majority Leader, et al., to Hon. Sylvia Burwell, Sec., U.S. Dep't Health & Human Servs., and Jocelyn Samuels, Dir.

JURISDICTION

Congress has included the Weldon Amendment in the Departments of Labor, Health and Human Services, Education, and Related Agencies Appropriations Act every year since 2004. The Weldon Amendment states, in relevant part:

> None of the funds made available in this Act may be made available to a . . . State or local government, if such . . . government subjects any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions.[36]

The Weldon Amendment protects "institutional or individual health care entit[ies]."[37] Under the Weldon Amendment, "the term 'health care entity' includes an individual physician or other health care professional, a hospital, *a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan.*"[38]

The Weldon Amendment prohibits HHS from providing applicable funds to an entity that discriminates in violation of the Amendment's terms. As a recipient, through grants or cooperative agreements, of the Federal funds from HHS that are subject to the Weldon Amendment, California is, and has been, subject to 45 C.F.R. § 75.300(a), which requires HHS funds to be awarded and implemented consistent with all U.S. statutory and public policy requirements, including nondiscrimination requirements. Therefore, HHS has the authority to ensure that both it, and covered entities, are spending Federal funds and operating programs consistent with the Federal laws applicable to those funds and programs.

OCR'S INVESTIGATION

As part of OCR's investigation, it sent a detailed data request[39] to the California Health and Human Services Agency ("CHHSA") and the DMHC, requesting information about California's actions including "whether, and if so, how, the [CHHSA] and [DMHC], respectively, implement, provide guidance on, enforce, or plan to enforce the Knox-Keene Health Care Service Plan Act of 1975, (Cal. Health & Safety Code§ 1340 *et seq.*), the California Reproductive Privacy Act (Cal. Health & Safety Code§§ 123460-123468), or Article 1, Section I, of the California Constitution, with regard to California health plans that do not cover abortions in their evidence

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Office for Civil Rights (June 28, 2016) (on file with HHS OCR); H. Rept. 115-862, at 122 (July 23, 2018) (https://www.congress.gov/115/crpt/hrpt862/CRPT-115hrpt862.pdf).

[36] *E.g.*, 2020 Weldon Amendment, § 507(d)(1), 133 Stat. at 2607.

[37] *Id.* § 507(d)(2).

[38] *Id.* (emphasis added).

[39] Letter from Michael Leoz, Regional Manager, Office for Civil Rights, U.S. Dep't of Health & Human Servs., to **REDACTED**, Sec., Cal. Health & Human Servs. Agency, and **REDACTED**, Dir., Cal. Dep't Managed Health Care (Oct. 2, 2017) [hereinafter "2017 Data Request"] (on file with HHS OCR).

of coverage filings, subscriber documents, other plan documents, or otherwise, or plans that seek approval without covering abortions."[40] OCR likewise inquired about enforcement of the Mandate Letters and provided California copies of the Guadalupanas Sisters and 2017 Skyline Complaints, along with notice of OCR's investigation.[41]

OCR reviewed and analyzed California's responses to the 2017 Data Request, as well as data request responses, interview notes, and other related documents obtained during OCR's investigation of three complaints filed with OCR in 2014 concerning the Mandate Letters that had been closed in 2016.[42]

OCR also reviewed and analyzed applicable pleadings, motions, briefs, discovery, deposition transcripts, declarations, affidavits, hearing transcripts and videos, and court decisions in the following matters:

- *Nat'l Family Planning & Reprod. Health Ass'n, Inc. v. Gonzales*, No. 04-cv-02148 (D. D.C. 2005).
- *Nat'l Family Planning & Reprod. Health Ass'n, Inc. v. Gonzales*, No. 05-5406 (D.C. Cir. 2006).
- *California ex rel. Lockyer v. United States*, No. 05-cv-00328 (N.D. Cal. 2005).
- *California ex rel. Lockyer v. United States*, Nos. 05–17292, 05–17312, 450 F.3d 436 (9th Cir. 2006).
- *Connecticut, et al. v. United States*, No. 09-cv-00054 (D. Conn. 2009).
- *Missionary Guadalupanas of the Holy Spirit, Inc. v. Rouillard*, No. 34-2015-80002226 (Cal. Super. Ct. 2015).
- *Missionary Guadalupanas of Holy Spirit Inc. v. Rouillard*, No. C083232 (Cal. Ct. App. 2019).
- *Skyline Wesleyan Church v. Cal. Dep't of Managed Health Care*, No. 16-cv-0501 (S.D. Cal. 2016).
- *Skyline Wesleyan Church v. Cal. Dep't of Managed Health Care*, No. 18-55451 (9th Cir. 2018).
- *Foothill Church, et al. v. Rouillard*, No. 15-cv-02165 (E.D. Cal. 2015).
- *Foothill Church, et al. v. Rouillard*, No. 19-15658 (9th Cir. 2019).

[40] 2017 Data Request at 3.

[41] *Id.*; Letter from Luis E. Perez, Deputy Director, Conscience and Religious Freedom Div., to **REDACTED**, Sec., Cal. Health & Human Servs. Agency, and **REDACTED**, Dir., Cal. Dep't Managed Health Care, et al. (Aug 30, 2018) (on file with HHS OCR).

[42] On June 21, 2016, OCR closed the complaints and declined to make any finding of violation. *See* Letter from Jocelyn Samuels, Dir., Office for Civil Rights, U.S. Dep't of Health & Human Servs., to **REDACTED**, Vice Pres. Of Legal Affairs, Life Legal Defense Found., *et al.* (June 21, 2016) ("Samuels Letter") (on file with HHS OCR). However, on January 26, 2018, the Department announced that the Samuels Letter, and the analysis contained therein, no longer reflects the views of HHS, OCR, or the HHS Office of the General Counsel. 83 Fed. Reg. 3880, 3890-91.

FINDINGS AND ANALYSIS

1. The DMHC Enforced California's Abortion Mandate against Health Care Entities that Limited or Excluded Abortion Coverage.

As the gatekeeper to the California health plan issuer market, which provides health care coverage to over 26 million Californians, the DMHC Director wields significant leverage through its regulation of over ninety-six percent of "commercial and public health plan enrollment" within the State of California.[43] This translates to approximately 171 different health care service plans and about 10,000 different products.[44] With limited exceptions, a health plan issuer must obtain a license from the DMHC Director to do business in California.[45] The DMHC Director issues a license when the Director determines that the health plan issuer's application, which must contain, among other materials, copies of the evidence of coverage form, satisfies the requirements of the Knox-Keene Act.[46] A health plan issuer's failure to provide "basic health care services" is grounds for disciplinary action.[47] A health plan issuer that commits an act or omission constituting grounds for disciplinary action may, after appropriate due process procedures, have its license suspended or revoked, or face administrative penalties.[48] Health plan issuers that do not comply with DMHC directives are subject to penalties.[49]

The DMHC states that it "aggressively monitor[s]" health plan issuer compliance with the Knox-Keene Act.[50] Through post-license reviews and routine tri-annual surveys, DMHC states that it monitors "all aspects of the health plan[issuer]'s operations," including "changes they make to their operations . . . changes in service areas, contracts, benefits or systems."[51] If DMHC identifies deficiencies, the DMHC "takes timely action against health plan[issuer]s that violate the law."[52] In 2017 alone, the DMHC closed 2,203 cases with penalties under the Knox-Keene Act, with assessed penalties totaling $8.9 million.[53]

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[43] DEP'T OF MANAGED HEALTH CARE, CAL. HEALTH & HUMAN SERVS. AGENCY 2017 ANNUAL REPORT 10 at 3 (May 2018). Available at: http://dmhc.ca.gov/Portals/0/Docs/DO/2017-Annual-Report-web.pdf. [hereinafter "2017 Annual Report"].

[44] **REDACTED** Dep. 14:13-15:9.

[45] *See* CAL. HEALTH & SAFETY CODE § 1349 (requiring licensure unless exempted by § 1343 of California's Health and Safety Code).

[46] *Id.* §§ 1351, 1353.

[47] *Id.* § 1386(b)(3)-(4).

[48] *Id.* § 1386(a).

[49] 2017 Annual Report at 12 and 16. *See also* **REDACTED** Dep. 122:5-21 (testifying that failure of a healthcare plan to provide coverage for all legal abortions is considered a violation of the Knox-Keene Act subject to administrative penalties handled by the enforcement office).

[50] 2015 DMHC Data Resp. at 3.

[51] 2017 Annual Report at 10.

[52] *Id.* at 2, 16.

[53] *Id.* at 16.

The DMHC Director informed each Health Plan Issuer that its "contracts contain language that . . . limit[s] or exclud[es] coverage for termination of pregnancies."[54] The DMHC Director also mandated each of the Health Plan Issuers to "amend current health plan [issuer] documents to remove . . . coverage exclusions and limitations" for abortion.[55] "These limitations or exclusions include, but are not limited to, any exclusion of coverage for 'voluntary' or 'elective' abortions and/or any limitation of coverage to only 'therapeutic' or 'medically necessary' abortions."[56] DMHC further instructed each Health Plan Issuer, within 90 days, to file an amendment to the Health Plan Issuer's license by submitting revised documents, such as evidence of coverage forms.[57]

The Mandate Letters declared that the limitation or exclusion of abortion in health coverage by health care entities is "inconsistent with the Knox-Keene Act and the California Constitution,"[58] and effectively presented an ultimatum: Either amend and refile license documents in violation of health care entities' rights under the Weldon Amendment, or operate without approved plans and face possible enforcement action for being in violation of California law as set forth in the Mandate Letters.[59] This action discriminated against plans on the basis that they did not cover all abortions, notwithstanding the fact that DMHC had, for many years, consistently approved plan language limiting abortion coverage.[60]

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[54] *E.g.*, Aetna Letter at 1.

[55] *E.g.*, Aetna Letter at 2.

[56] *Id.* (emphasis in original).

[57] *Id.*

[58] *E.g.*, Aetna Letter at 2. In a lawsuit filed by Missionary Guadalupanas challenging the DMHC's issuance of its Mandate Letters under the California Administrative Procedure Act, the California Court of Appeals determined that, "[b]ecause California law guarantees every woman the right to choose whether to bear a child or obtain an abortion, the only legally tenable interpretation of the law is that abortions are basic health care services, which health care service plans are required to cover." *Missionary Guadalupanas of Holy Spirit Inc. v. Rouillard*, 38 Cal. App. 5th 421, 427-28 (Cal. Ct. App. 2019), *review denied* (Nov. 20, 2019).

[59] *See* CAL. HEALTH & SAFETY CODE § 1386(b)(3)-(4) (identifying a health plan issuer's failure to provide a basic health care service as grounds for disciplinary action), and § 1386(a) (identifying that a health plan issuer that commits an act or omission constituting grounds for disciplinary action may, after appropriate due process procedures, have its license suspended or revoked or have to face administrative penalties).

[60] *See, e.g.,* Email Communications from **REDACTED,** Department of Managed Health Care, to **REDACTED,** Associate General Counsel, Blue Shield CA, approving sample plan language that explicitly excluded coverage for "services which are…for or incident to elective abortion." (Sept. 12, 2008, 11:40am) (on file with HHS OCR); "[P]rior to August 22, 2014, CDMHC's position had been that voluntary abortions were not medically necessary under the Knox-Keene Act such that managed health care plans were not required to provide coverage." Anthem Blue Cross Interview; "[T]here had been managed care products on the market for years with the option not to cover voluntary abortions." Telephone Interview with **REDACTED,** Western Region General Counsel, Aetna Health of CA (Feb. 26, 2015) (on file with HHS OCR) [hereinafter "Aetna Interview"]; "For religious groups, United Healthcare has historically covered medically necessary termination of pregnancy" as opposed to covering "voluntary termination of pregnancy… United Healthcare has refiled for certain religious employers since 1997 using the same preapproved language regarding medically necessary termination of pregnancy." Telephone Interview with **REDACTED,** Dir. of Regulatory Affairs, United Healthcare et al. (Mar. 12, 2015) (on file with HHS OCR) [hereinafter "United Healthcare Interview"]; *See also* Aetna Letter at 1. ("The DMHC has reviewed the relevant legal authorities and has concluded that it erroneously approved or did not object to such discriminatory language in some evidence of coverage (EOC) filings.").

In response to the Mandate Letters, each of the issuers identified above removed coverage exclusions and limitations regarding abortion coverage because they viewed these alterations in their plan language as imperative for compliance.[61] The mandated changes impacted at least 35 employer groups associated with at least 28,647 "lives enrolled" in health care plans that excluded or limited abortion coverage,[62] including thirteen that met the definition of "religious employer" under California law.[63]

This estimate likely significantly underrepresents the number of lives impacted for two reasons. First, this estimate is based on data from only five of the seven Health Plan Issuers.[64] Second, relevant data from Kaiser used for this estimate represents the number of employer IDs rather than lives enrolled.[65] Because more than one "life enrolled" may be associated with an employer ID,[66] Kaiser's data likely underrepresents the number of lives enrolled in its products that limited or excluded abortion coverage.

2. California Does Not Exempt Health Care Entities that Otherwise Would Provide—and Did Provide—Coverage Limiting or Excluding Abortion.

Subsequent to the release of the Mandate Letters, the California Court of Appeals ruled that California law unequivocally requires health care service plans to cover abortion as a basic health care service, but also upheld provisions of the Knox-Keene Act that allow "the [DMHC] director [], for good cause, by rule or order" to exempt any plan or class of plan contracts from the

[61] "Kaiser orally notified groups whose plans included abortion coverage restrictions that Kaiser was required to comply with CDMHC's August 22 letter...[Life Legal Defense Fund] encouraged Kaiser to challenge the August 22 letter but Kaiser advised [Life Legal Defense Fund] that it had no choice but to comply with the letter." Telephone Interview with **REDACTED**, Kaiser Executive Director of Policy, and **REDACTED**, Kaiser National Legal Department Senior Counsel (Mar. 3, 2015) (on file with HHS OCR) [hereinafter "Kaiser Interview"]; "Aetna viewed the amendment as necessary for regulatory compliance." Aetna Interview; "United Healthcare was required to make a filing pursuant to the [DMHC] letter." United Healthcare Interview.

[62] 2015 DMHC Data Resp.at 5; Cal. Dep't of Managed Health Care, Cal. Health & Human Servs. Agency, Health Plan Responses to DMHC Abortion Data Call 000728-31 (Sept. 30, 2014) (on file with HHS OCR) [hereinafter "DMHC Health Plan Issuer Responses"]. Of the 28,647 estimated, 22,747 represented "lives enrolled" in plan products that limited or excluded abortion coverage for Anthem Blue Cross, Blue Shield, Health Net, Aetna, and UnitedHealthcare, collectively. *Id.* The remainder of the estimate, 5,900, represented the number of employer IDs associated with Kaiser plan products that limited or excluded abortion coverage. *Id.* at 000729. DMHC had this information prior to issuing the Mandate Letters. *See* **REDACTED** Dep. 90:17-94:13, 103:2-6, 104:23-105:1, 107:2-7, 117:22-118:8; Aetna, DMHC Data Call – Abortion Coverage, Ex. E-1 (July 2, 2014) (AGO000467) (on file with HHS OCR) (responding to "data call issued . . . June 10, 2014, in which the Department seeks . . . the number of employer groups that have purchased coverage that limits or excludes abortion services . . . the number of those employers that would qualify as a 'religious employer' . . . [and] the total number of lives covered by [such] plans. . . .").

[63] DMHC Health Plan Issuer Responses at 000728; *See* CAL. HEALTH & SAFETY CODE § 1367.25(c)(1) (defining "religious employer").

[64] DMHC requested information from six of the seven Health Plan Issuers affected and received estimates from Kaiser, United Healthcare, Blue Shield, Aetna, and Health Net. 2015 DMHC Data Resp.at 4. Anthem did not respond. *Id.* at 5 n.5. DMHC did not request data from GEMCare due to its small enrollment figures and status of its commercial business. *Id.*

[65] DMHC Health Plan Issuer Responses at 000730 n.5.

[66] *Id.*

requirement to provide all basic health care services, including abortion.[67] While exemptions are at the discretion of the director, there are no written rules, policies, or procedures governing how to handle an exemption request.[68]

The Mandate Letters did not reference any available exemption process,[69] but did state (in a footnote) that no "religiously sponsored health carrier" may be required by law "to participate in the provision of or payment for a specific service if they object to doing so for reason of conscience or religion."[70] This reference is a nearly verbatim copy of a Washington State insurance statute,[71] except it excludes, without explanation, the text of a key subsection which states, "[n]o individual or organization with a religious or moral tenet opposed to a specific service may be required to purchase coverage for that service or services if they object to doing so for reason of conscience or religion."[72] This indicates that, while DMHC may have contemplated the possibility of exempting "religiously sponsored health carriers" (without explaining how an entity qualifies as a "carrier"), it would not, at the same time, exempt religious individuals[73]—who object to paying for abortion coverage for themselves, their children, or others in the insurance pool—and would not exempt religious organizations, such as Complainants, that object to purchasing abortion coverage for their employees.

OCR notes that the DMHC discussed granting an exemption with some of the health care entities, and granted Anthem Blue Cross an exemption "to offer products that restrict abortion coverage to employers that meet the definition of a religious employer" under California law.[74] However, this lone exemption does not cure the impact of the Mandate Letters.

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[67] CAL. HEALTH & SAFETY CODE § 1367(i); *Missionary Guadalupanas of Holy Spirit Inc. v. Rouillard*, 38 Cal. App. 5th 421, 439 (Cal. Ct. App. 2019), *review denied* (Nov. 20, 2019) ("the director clearly has the authority to exempt plan contracts from the requirements of the Knox-Keene Act.").

[68] Sept. 19, 2017 Deposition of **REDACTED**, Dep. Dir. Legal Affairs, DMHC (on file with OCR) 32:18; 35:17.

[69] Sept. 28, 2017 Deposition of **REDACTED**, Dir., DMHC (on file with HHS OCR) 45:14-19; **REDACTED** Dep. 130:9-12.

[70] Aetna Letter at 1, n.3.

[71] *Compare, e.g.*, Aetna Letter at 1, n.3 *with* WASH. REV. CODE ANN. § 70.47.160(2)(a) ("No individual health care provider, religiously sponsored health carrier, or health care facility may be required by law or contract in any circumstances to participate in the provision of or payment for a specific service if they object to so doing for reason of conscience or religion.").

[72] WASH. REV. CODE ANN. § 70.47.160(3)(a). Ms. **REDACTED** was instructed by counsel not to answer why the Mandate Letters excluded this subsection. *See* **REDACTED** Dep. 48:19-49:7.

[73] Complainants' religious beliefs regarding abortion are shared by their employees. *See* Consolidated Opening Br. Pet' Opp'n Demurrer, & Supp. Writ Mandamus & Declaratory Relief at 4, *Missionary Guadalupanas of the Holy Spirit, Inc. v. Rouillard*, No. 34-2015-80002226, at 8 (Cal. Super. Ct. Aug. 12, 2016) ("Petitioner's members have therefore been coerced into financially supporting procedures that they believe involve the killing of other human lives, in violation of their deeply-held religious and moral convictions."); Pl.'s Mem. Points & Authorities Supp. Mot. Summ. J., *Skyline Wesleyan Church v. DMHC*, No. 16-cv-00501, at 16 (S.D. Cal. Nov. 20, 2017) ("Enforcing the abortion mandate against the church's internal healthcare decisions simply is not in the public interest. The only people affected are those who work at the church, and they necessarily share the church's beliefs about abortion.").

[74] 2017 DMHC Data Resp. at 5, citing CAL. HEALTH & SAFETY CODE § 1367.25(c); *see also* Order Granting Def.'s Cross Mot. Summ. J. at 4, *Skyline Wesleyan Church*, No. 3:16-cv-0501 (S.D. Cal. March 9, 2018).

First, California was put on notice of the burdens imposed by the Mandate Letters by complaints filed with OCR and through long-running lawsuits over these issues filed by private entities (including the Complainants in this matter). Lawsuits are strong and explicit requests for relief, yet the State has refused to provide any relief at all in response to the litigation.[75]

Second, the only exemption California offered (to a health plan issuer) was limited to plans covering a narrow set of "religious employers" under California law.[76] However, the Weldon Amendment protects from discrimination *all* plans that decline to cover abortion, without requiring any plan issuers, sponsors, or beneficiaries to have a religious character or have a religious reason for not providing or paying for such coverage. Based on the information available to OCR about those affected by the DMHC policy, even a categorical exemption of "religious employers," as defined by California law, would have only been available to approximately 37% of those employer groups who, prior to the Mandate Letters, had health care coverage that limited or excluded abortion.[77]

Third, for California's regime to be compliant with the Weldon Amendment, exemptions from the abortion mandate cannot be discretionary, but rather, must be available to all health care entities that desire to limit or exclude coverage of abortion.

Fourth, the DMHC Director has never exempted abortion-free plans as a class,[78] nor the plans purchased by the Complainants at issue here, despite the fact that compliance with federal

[75] To OCR's knowledge, DMHC has not taken any action to ensure Skyline Church has access to an exempted plan, despite having knowledge, since 2014, of the fact that Skyline Church meets the definition of a "religious employer" under California law, and possessing the statutory authority to exempt any person or plan contract from the abortion requirement. *See* Letter from **REDACTED**, Legal Counsel for Skyline Wesleyan Church, Foothill Church, Calvary Chapel Chino Hills, and Shepherd of the Hill Church, to **REDACTED**, Dir., DMHC (July 12, 2018) (attached as Ex. 1 to Appellant's Mot. Supplement Record, *Skyline Wesleyan Church v. DMHC*, No. 18-55451 (9th Cir. Sept. 14, 2018); Appellants' Opening Br., *Foothill Church v. Rouillard*, No. 19-15658, at 43 (9th Cir. Aug. 14, 2019) ("Five years later, the DMHC still refuses to make a similar accommodation for churches whose religious beliefs allow for abortion only when necessary to save the life of the mother."). *See also* Oral Arg., 23:58-24:06, *Skyline Wesleyan Church v. DMHC*, No. 18-55451 (9th Cir. Nov. 4, 2019) (https://www.ca9.uscourts.gov/media/view_video.php?pk_vid=0000016448). (Statement by Friedland, J. to counsel for DMHC: "I don't understand why we should think that they really have a chance of getting an exemption when you've been fighting this tooth and nail.").

[76] California defines "religious employer" narrowly to include only those employers for which:

(A) The inculcation of religious values is the purpose of the entity.
(B) The entity primarily employs persons who share the religious tenets of the entity.
(C) The entity serves primarily persons who share the religious tenets of the entity.
(D) The entity is a nonprofit organization as described in Section 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code of 1986,1 as amended.

Cal. Health & Safety Code § 1367.25(c)(1).

[77] *See supra*, discussing the policy's known impact on at least 35 employer groups, 13 of which met the definition of "religious employer" under California law, and 28,647 lives enrolled.

[78] *See* **REDACTED** Dep. 57:3-9. The DMHC Director claims that she cannot commit as to whether DMHC would approve a product sold to religious employers that excluded abortion in all cases, including rape and incest, except to save the life of the mother. **REDACTED** Dep. 51:8-54:17. California claims it has not had a chance to evaluate such a request. *See* Ans. Br. at 14, *Skyline Wesleyan Church v. DMHC*, No. 18-55451 (9th Cir. Dec. 14, 2018) ("Yet, no health plan has sought an exemption for a product that excludes all abortion coverage (including in cases of rape and incest, where the only exception is to protect the life of the woman. SER 83.") (citing Decl. **REDACTED** Supp. Defs' Mot. Summ. J. or in the Alt. Summ. Adjudication Claims at ¶ 2, *Skyline v. DMHC*, No. 16-cv-00501 (S.D. Cal. Nov. 20, 2017)

law, namely, the Weldon Amendment, is *per se* good cause for doing precisely that, and DMHC has long been aware of the conflict.

Finally, before concluding this investigation, OCR wrote California, asking it to confirm or deny whether it would utilize the exemption process under state law "to align DMHC practices to be consistent with the Weldon Amendment" and to clearly provide relief to all plans as a class so that they may decline to provide abortion coverage without discrimination by the State.[79] In response, California ignored OCR's specific request and instead reasserted its purported authority to issue the Mandate Letters and stated that it would consider exemption requests from regulated health plan issuers without any reference to how such requests will be solicited, treated, or resolved, if at all.[80] California's response further confirms its non-compliance.

3. California's Arguments Regarding the Weldon Amendment Fail.

California has argued that, because the "[Health Plan Issuers] that received the letter already covered the legally required abortion services for the vast majority of their enrollees . . . the requirements outlined in the letter do not discriminate against the [Health Plan Issuers] for failure to cover abortion."[81] California misconstrues the plain language of the Weldon Amendment.

Pursuant to the Weldon Amendment, a covered state or local government has an absolute duty to refrain from subjecting "any . . . health care entity to discrimination on the basis that the health care entity does not . . . provide coverage of . . . abortions."[82] It is irrelevant that some or even most of the Health Plan Issuers' plans covered abortion without exclusion or limitation, because the Weldon Amendment plainly defines a protected "health care entity" as a "health insurance plan . . . or any other kind of health care...plan."[83] An issuer protected by Weldon does not lose protection because they do not object to abortion coverage in 99% of their plans, just as a covered health care professional does not lose the right to be free from state discrimination for refusing to participate in partial-birth abortions because they are willing to participate in early-term medication abortions.

("To date, no plan has requested an exemption that would mandate that women who become pregnant as a result of rape or incest be forced to carry to term.")). However, there is evidence in the record indicating DMHC approved such a plan in 2002. *See* Letter from **REDACTED**, Pres. and CEO, Daughters of Charity Health System, to **REDACTED**, Esq., Associate Gen. Counsel, Blue Shield of Cal. (Aug. 20, 2008) at 2 (DMHC000026) (on file with HHS OCR) (explaining DMHC had approved plan language since January 2002 that limited abortion coverage to "only if the member's life or member's spouse's life would be in jeopardy as a direct result of pregnancy due to an existing medical condition.").

[79] *See* Letter from Roger Severino, Dir., Office for Civil Rights, U.S. Dep't of Health & Human Servs., to **REDACTED**, Dir., DMHC, et al. (Jan. 10, 2020) (on file with OCR).

[80] Letter from **REDACTED**, Dept. Att'y Gen., Cal., to Roger Severino, Dir., Office for Civil Rights, U.S. Dep't of Health & Human Servs. (Jan. 21, 2010), at 2 (on file with OCR).

[81] 2015 DMHC Data Resp.at 1, incorporated by reference in 2017 DMHC Data Resp. at 1-2.

[82] *E.g.*, 2020 Weldon Amendment, § 507(d)(1), 133 Stat. at 2607.

[83] *Id.* § 507(d)(2).

By broadly conditioning licensure on abortion coverage, California discriminated, and continues to discriminate, against health care entities that did or would limit or exclude abortion coverage precisely because they would not provide coverage for abortion.

CONCLUSION AND REMEDY

Based on the evidence gathered in its investigation, and having considered California's responses to the allegations in the complaints, OCR finds California in violation of the Weldon Amendment[84] for having discriminated, and continuing to discriminate, against health care plans and issuers that did, or would otherwise, limit or exclude abortion coverage in their plan products. Because California refuses, despite ample notice and opportunity, to provide exceptions or take remedial action sufficient to comply with the Weldon Amendment, California's violation is ongoing, and implicates funding that HHS made available to it from the 2018, 2019, and 2020 Appropriations Acts applicable to the Department of Health and Human Services.

OCR is charged with helping ensure entities come into compliance with Federal laws protecting conscience and prohibiting coercion in health care, including the Weldon Amendment. Accordingly, OCR requests that the State of California notify OCR **within thirty (30) days from the date of this letter** whether the State of California intends to continue to enforce the Mandate Letters' requirement that all health care plans cover abortions, or will instead agree to take corrective action to come into compliance with the law and remedy the effects of its discriminatory conduct. OCR stands ready to assist California in coming into compliance with the Weldon Amendment.

If OCR does not receive sufficient assurance that California will cease requiring all health care plans, as a class, to cover abortion, or that it is willing to negotiate in good faith towards that end, OCR will forward this Notice of Violation and the evidence supporting OCR's findings in this matter to the appropriate HHS funding components for further action under applicable grants and contracts regulations. Such referral may ultimately result in limitations on continued receipt of certain HHS funds in accordance with the Constitution and applicable Supreme Court case law. *See, e.g.*, 45 C.F.R. § 75.371.

[84] 2018 Weldon Amendment, § 507(d), 132 Stat. at 764; 2019 Weldon Amendment, § 507(d), 132 Stat. at 3118; 2020 CR Weldon Amendment, § 507(d), 132 Stat. at 3118; 2020 Weldon Amendment, § 507(d)(1), 133 Stat. at 2607.

ADVISEMENTS

Nothing in this letter precludes OCR from making referrals to any other HHS component or other federal agencies, including the Department of Justice, for appropriate action.[85]

OCR will share this Notice of Violation with the Health Plan Issuers and with the Complainants and their counsel. This Notice of Violation will be made available to the public and may include redactions.

Sincerely,

/s/

Roger T. Severino, Director

/s/

Luis E. Perez, Deputy Director
Conscience and Religious Freedom Division

[85] OCR will inform the State of California of any such referral.

Cc:

The Honorable Gavin Newsom
Governor
State of California
1303 10th Street, Suite 1173
Sacramento, CA 95814

Sarah Ream
Deputy Director & General Counsel
California Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814

Mark Ghaly
Secretary
California Health & Human Services Agency
1600 Ninth Street, Room 460
Sacramento, CA 95814

Michelle (Shelley) Rouillard
Director
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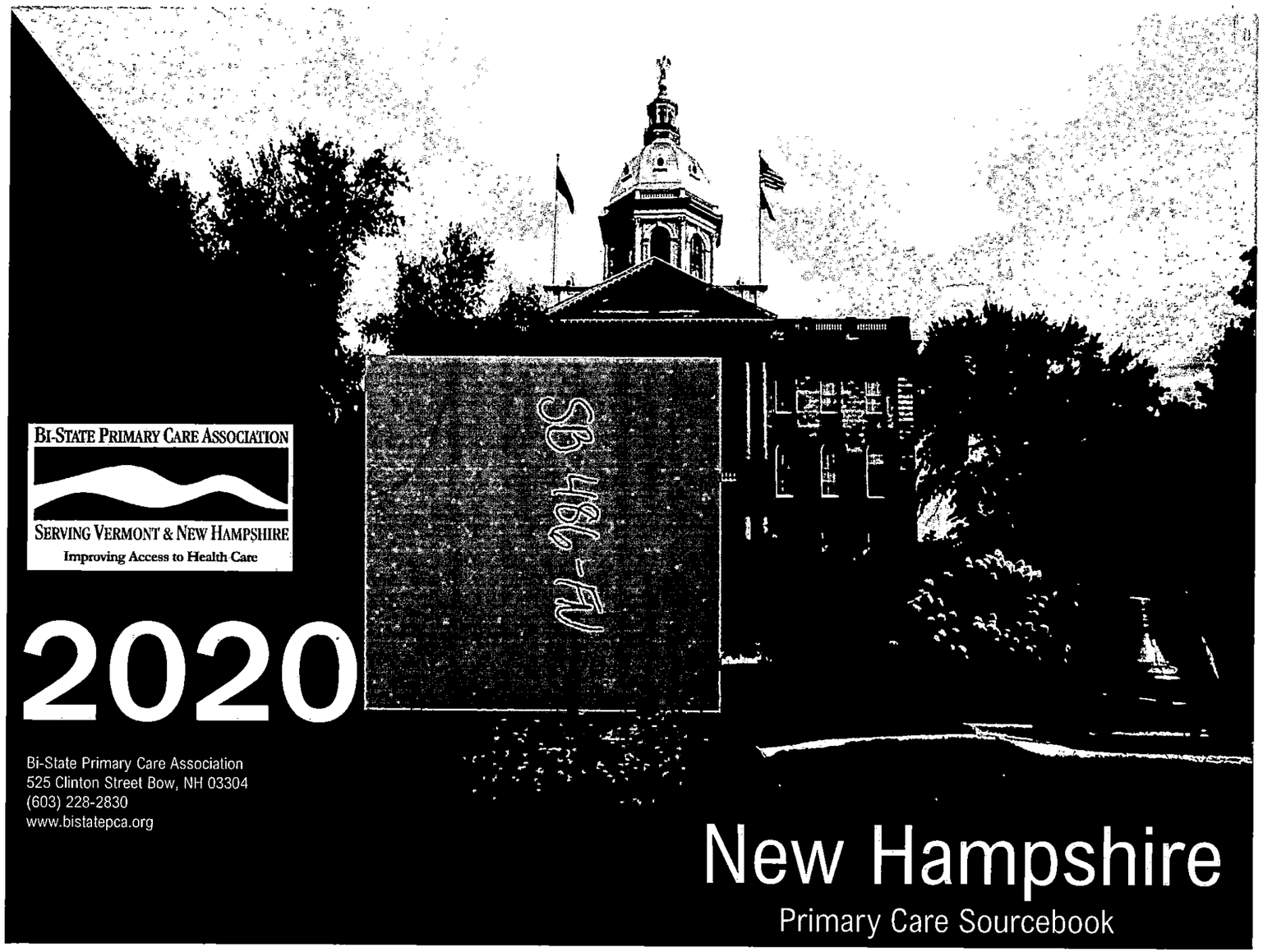

BI-STATE PRIMARY CARE ASSOCIATION

SERVING VERMONT & NEW HAMPSHIRE

Improving Access to Health Care

2020

Bi-State Primary Care Association
525 Clinton Street Bow, NH 03304
(603) 228-2830
www.bistatepca.org

New Hampshire

Primary Care Sourcebook

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TABLE OF CONTENTS

What is a Primary Care Association?

Each of the 50 states (or in Bi-State's case, a pair of states) has one nonprofit Primary Care Association (PCA) to serve as the voice for Community Health Centers. These health centers were born out of the civil rights and social justice movements of the 1960s with a clear mission that prevails today: to provide health care to communities with a scarcity of providers and services. That includes bringing comprehensive services to rural regions of the country.

Bi-State's Mission

Promote access to effective and affordable primary care and preventive services for all, with special emphasis on underserved populations in Vermont and New Hampshire.

Bi-State's Vision

Healthy individuals and communities with quality health care for all.

Who We Are

Bi-State Primary Care Association is a 501(c)3 nonprofit organization that was formed by two health and social service leaders in 1986 to expand access to health care in Vermont and New Hampshire. Today, Bi-State represents 31 member organizations across both states that provide comprehensive primary care services to over 300,000 patients at 142 locations. Our members include federally qualified health centers (FQHCs), clinics for the uninsured, rural health clinics, Area Health Education Center (AHEC) programs, and Planned Parenthood of Northern New England. We provide training and technical assistance for improving programmatic, clinical, and financial performance and operations. We provide workforce assistance and candidate referrals for providers including physicians, dentists, nurse practitioners, and physician assistants. We also work with federal, state, and regional policy organizations, foundations, and payers to develop strategies, policies, and programs that support community-based primary health care.

NH Public Policy

Bi-State is committed to improving the health status of Granite Staters and ensuring that all individuals have access to affordable and high-quality primary medical, mental health, substance use, and oral health care, regardless of insurance status or ability to pay.

Workforce & Recruitment

Bi-State's Recruitment Center has worked with over 1,500 health care providers interested in practicing in VT and NH over the last year. We helped recruit 47 new providers to New Hampshire and Vermont between July 2018 – June 2019.

Continuous Quality Improvement

Bi-State manages 7 active peer learning networks for members. In FY2019 our VRHA training webinar series engaged 215 participants from 18 organizations, and our newly-launched clinical quality symposium welcomed 130 attendees.

Annual Conference

In 2019, our annual Primary Care Conference drew 222 participants from VT and NH. The conference provides an important learning and networking opportunity for colleagues from both states.

Bi-State Primary Care Association's New Hampshire Members

Ammonoosuc Community Health Services, Inc. (FQHC)
Franconia, Littleton, Warren, Whitefield, Woodsville -- Coos and Grafton Counties
Edward Shanshala II, Executive Director & Chief Executive Officer
25 Mt. Eustis Road, Littleton, NH 03561
Phone: (603) 444-8223
ed.shanshala@achs-inc.org

Amoskeag Health (FQHC)
Manchester - Hillsborough County
Kris McCracken, President & Chief Executive Officer
145 Hollis Street, Manchester, NH 03101
Phone: (603) 935-5210; (603) 935-5229
kmccracken@mchc-nh.org

Community Health Access Network (CHAN)
Newmarket - Rockingham County
Joan Tulk, Executive Director
207A South Main Street, Newmarket, NH 03857
Phone: (603) 292-7205
jtulk@chan-nh.org

Charlestown Health Center (FQHC)
- **Springfield Medical Care Systems' New Hampshire Site**

Charlestown - Sullivan County
Anila Hood, Director, Charlestown Health Center;
Josh R. Dufresne, Acting Chief Executive Officer
Springfield Medical Care Systems
250 Ceda Road, Charlestown, NH 03603
Phone: (603) 826-5711; Fax: (802) 885-3014
ahood@springfieldmed.org;
jdufresne@springfieldmed.org

Coos County Family Health Services (FQHC)
Berlin, Gorham - Coos County
Ken Gordon, Chief Executive Officer
54 Willow Street, Berlin, NH 03570
Phone: (603) 752-3669 Ext. 4018
kgordon@ccfhs.org

Greater Seacoast Community Health:
- **Families First Health and Support Center (FQHC)**

Dover, Exeter, Hampton, Portsmouth, Rochester - Rockingham and Stafford Counties
Janet Laatsch, Chief Executive Officer
100 Campus Drive, Suite 12,
Portsmouth, NH 03801
Phone: (603) 516-2550; Fax: (603) 953-0066
jlaatsch@goodwinch.org

- **Goodwin Community Health (FQHC)**

Somersworth - Strafford County
Janet Laatsch, Chief Executive Officer
311 Route 108, Somersworth, NH 03878
Phone: (603) 516-2550; Fax: (603) 953-0066
jlaatsch@goodwinch.org

Harbor Care Health and Wellness Center, A Program of Harbor Homes (FQHC)
Nashua - Hillsborough County
Peter Kelleher, Executive Director
45 High Street, Nashua, NH 03060
Phone: (603) 821-7788; (603) 882-3616 Ext. 1171
pkelleher@nhpartnership.org

Health Care for the Homeless Program (FQHC)
Manchester - Hillsborough County
Amy Pratte, Director, External Affairs & Fiscal Manager HCH
199 Manchester Street
Manchester, NH 03103
Phone: (603) 663-8716; Fax: (603) 663-8766
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Bi-State Primary Care Association's New Hampshire Members

HealthFirst Family Care Center (FQHC)
Franklin, Laconia – Belknap and Merrimack Counties
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Phone: (603) 934-0177 Ext. 107
rkeene@healthfirstfamily.org

Indian Stream Health Center (FQHC)
Colebrook - Coos County
Kevin Kelley, President & Chief Executive Officer
141 Corliss Lane, Colebrook, NH 03576
Phone: (603) 388-2473; (603) 388-2430
kkelley@indianstream.org

Lamprey Health Care (FQHC)
Nashua, Newmarket, Raymond - Hillsborough and Rockingham Counties
Greg White, Chief Executive Officer
207 South Main Street, Newmarket, NH 03857
Phone: (603) 292-7214; 603-659-2494 Ext. 7214
gwhite@lampreyhealth.org

Mid-State Health Center (FQHC)
Bristol, Plymouth - Grafton County
Robert MacLeod, Chief Executive Officer
101 Boulder Point Drive, Plymouth, NH 03264
Phone: (603) 536-4000 Ext. 1001
rmacleod@midstatehealth.org

NH Area Health Education Center Program (AHEC)
Lebanon - Grafton County
Kristina Fjeld-Sparks, Director
One Medical Center Drive, WTRB Level 5
Lebanon, NH 03756
Phone: (603) 653-3278
Kristina.E.Fjeld-Sparks@Dartmouth.edu

North Country Health Consortium
Littleton - Grafton County
Nancy Frank, Executive Director
262 Cottage St, Ste 230, #8226
Littleton, NH 03561
Phone: (603) 259-3700; Fax: (603) 444-0945
nfrank@nchcnh.org

Planned Parenthood of Northern New England (CHC)
Claremont, Derry, Exeter, Keene, Manchester - Cheshire, Hillsborough, Rockingham, and Sullivan Counties
Meagan Gallagher, Chief Executive Officer
784 Hercules Drive, Colchester, VT 05446
Phone: (802) 448-9778; (802) 448-9700 Ext. 9778
meagan.gallagher@ppnne.org

Weeks Medical Center (RHC)
Groveton, Lancaster, North Stratford, Whitefield - Coos County
Michael Lee, President
173 Middle Street, Lancaster, NH 03584
Phone: (603) 788-5026
Michael.Lee@weeksmedical.org

White Mountain Community Health Center (FQHC LOOK-ALIKE)
Conway - Carroll County
JR Porter, Executive Director
298 Route 16, Conway, NH 03818
PO Box 2800, Conway, NH 03818
Phone: (603) 447-8900 Ext. 321
jrporter@whitemountainhealth.org

2020 New Hampshire Public Policy Principles

Bi-State is committed to improving the health of New Hampshire residents. We work to ensure that all individuals have access to appropriate, high-quality, integrated primary and preventive health care regardless of insurance status or ability to pay. Integrated primary and preventive care includes behavioral health, substance use disorder treatment, and oral health services (including the dentition and surrounding oral cavity in a broader sense). Access to care is dependent on many factors, including an adequate health care workforce, discount prescription drug programs, and care coordination.

Bi-State strives to educate policymakers, non-profit leaders, and the business community on the value community health centers provide to the Granite State. We accomplish our goals by partnering with the state, health care providers, non-profit advocacy organizations, and business leaders. Bi-State supports investments that promote public health through comprehensive primary and preventive care, lower prescription drug prices, and efficiencies in New Hampshire's health care system.

Public Policy Priorities

- Increasing investments in health care workforce development and recruitment in underserved areas;
- Expanding the adult Medicaid dental health benefit to include educational, preventive, and restorative services;
- Ensuring the success of the Granite Advantage Health Care Program as a reliable source of health insurance for low-income Granite Staters; and
- Increasing state support for integrated primary care, preventive, and reproductive health care services for our underserved populations.

Snapshot of Our New Hampshire Members

- Community Health Centers (CHC)s include:
  - Federally Qualified Health Centers (FQHCs):
    11 New Hampshire FQHCs encompassing 46 sites in 8 counties
  - Planned Parenthood of Northern New England:
    5 locations
  - Weeks Medical Center (RHC): 4 Rural Health Clinics
  - White Mountain Community Health Center:
    A Federally Qualified Health Center Look-Alike (FQHC LAL)
- Community Health Access Network (CHAN)
- NH Area Health Education Center Program (AHEC)
- North Country Health Consortium (NCHC)

Bi-State's 14 Community Health Centers and clinics serve 121,668 patients at 56 locations across every county in New Hampshire.

1 in 4 uninsured Granite Staters receives care at a New Hampshire Community Health Center.

Community-based primary and preventive health care

Comprehensive means primary and preventive medical, dental, oral, mental health, and enabling services.

Enabling means services that are not clinical in nature but which reduce barriers to care. Examples include: translation and interpretation, help accessing transportation, and assistance navigating financial issues.

Community Health Centers (CHCs)

CHCs provide comprehensive and enabling services in medically underserved regions. CHCs offer services to all residents in their service areas, determining charges based upon the resident's ability to pay. Every CHC is unique, tailoring programs and services to the needs of their communities. Collaborations with community partners allow CHCs to go above and beyond in delivering high quality of primary care. In many communities, CHCs are the *only* comprehensive, patient-centered medical home open to all patients without restrictions, especially underinsured and Medicaid patients.

In 2018, 14 CHCs:

- Served 121,668 patients in NH.
- Conducted 490,310 patient visits.
- Offered services in every NH county, across 56 sites.

Bi-State's Community Health Centers in New Hampshire include:
- 11 New Hampshire FQHCs
- Planned Parenthood of Northern New England
- Weeks Medical Center
- White Mountain Community Health Center

Rural Health Clinics (RHCs)

The Rural Health Clinic Services Act of 1977 (Public Law 95-210) was enacted to address an inadequate supply of physicians serving Medicare patients in rural areas and to increase the use of non-physician practitioners such as nurse practitioners and physician assistants in rural areas. RHCs can be public, nonprofit, or for-profit heath care facilities. They must be located in rural, underserved areas. They are required to use a team approach of physicians working with non-physician practitioners such as nurse practitioners, physician assistants, and certified nurse mid-wives to provide services. RHCs are required to provide outpatient primary care services and basic laboratory services.

In 2018, 4 RHCs:

- Served 10,228 patients in NH.
- Conducted 57,490 patient visits.
- Offered services in Coos county across 4 sites.

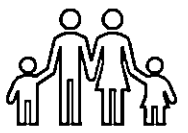
Bi-State's member, Weeks Medical Center, is an RHC with 4 sites in Coos county.

Federally Qualified Health Centers (FQHCs)

FQHCs are a subset of NH's CHCs. The federal government supports FQHCs as the nation's primary safety net system for health care. FQHCs are governed by a board of directors, of whom a majority of the members receive care at the FQHCs. FQHCs provide comprehensive and enabling services in medically underserved regions. FQHCs accept patients regardless of ability to pay, offer a sliding fee scale to persons with incomes below 200% of the federal poverty level, and work with their communities to address a range of barriers to health.

In 2018, 11 FQHCs:

- Served 94,891 patients in NH.
- Conducted 403,262 patient visits.
- Offered services in 8 NH counties, across 46 sites.



Federally Qualified Health Center Look-Alikes (FQHC LALs)

FQHC LALs are Community Health Centers that meet the requirements to be FQHCs (including having a patient-majority board), but do not receive grant funding from HRSA. They provide services in medically underserved areas, provide care on a sliding fee scale, and operate under a governing board that includes patients.

In 2018, 1 FQHC LAL:

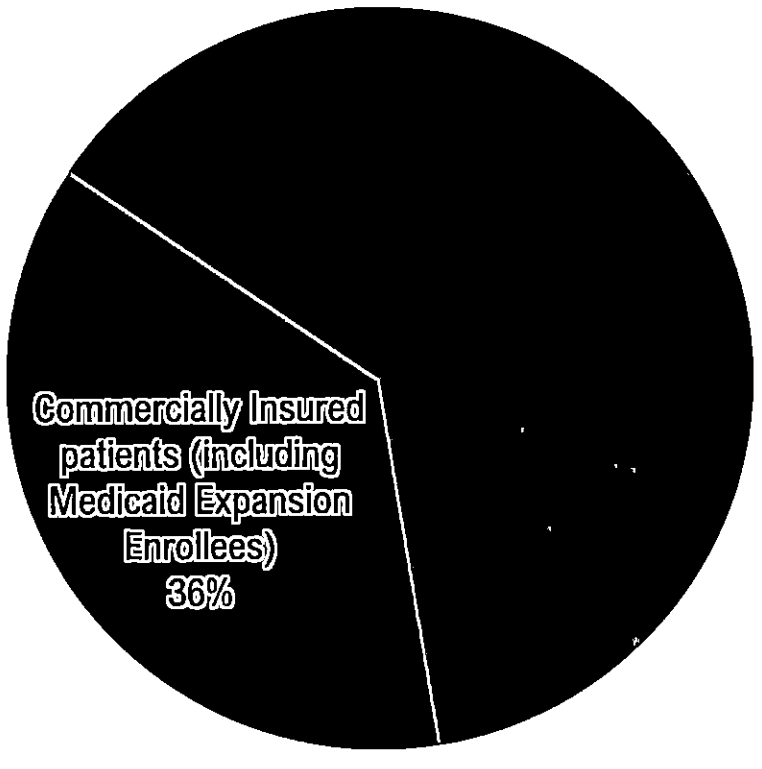
- Served over 2,600 patients in NH.
- Conducted over 9,400 patient visits.
- Offered services in Carroll county.

Bi-State's member, White Mountain Community Health Center, is an FQHC LAL with a site in Carroll county.

New Hampshire's Federally Qualified Health Centers Serve 94,891 Granite Staters

- 11 New Hampshire Federally Qualified Health Centers (FQHCs) serve as the medical home for approximately 95,000 Granite Staters who made over 403,000 visits in 2018.
- In the past 5 years, New Hampshire's FQHCs have experienced a growing demand for services:
  - 13% increase in patients served
  - 17% in Medicare patients served
  - 21% increase in patient visits
- 1 in 14 Granite Staters receives care at a New Hampshire FQHC.
- 1 in 7 Granite Staters enrolled in Medicaid receives care at a New Hampshire FQHC.
- 1 in 5 uninsured Granite Staters receives care at a New Hampshire FQHC.

Federally Qualified Health Center Patient Mix



2018 NH UDS Data and Self-Reported data in BSPCA member surveys
NH Statewide Data from Kaiser Family Foundation
This FQHC data does not include Springfield Medical Care Systems' NH Site: Charlestown Health Center.

FQHCs Improve Access to Integrated Primary Care Services

NH's FQHCs Serve:

Over 22,000 Children
~
23% of NH patients

Nearly 3,000 Veterans

16% of Patients are Older Adults
~
FQHCs serve 8% of Medicare Enrollees

FQHCs serve 15% of Medicaid Enrollees
~
30% of an FQHC's payer mix is Medicaid

Patients Experiencing Homelessness: Nearly 7,000

Nearly 14,000 Uninsured Patients
~
470 Migrant/Seasonal Agricultural workers & Dependents

Numbers reflect 2018 UDS data

In the past 5 years, demand for New Hampshire FQHC services has grown, with an increase of over 11,000 patients served (13%) and an increase of about 69,000 (21%) patient visits.

Based on UDS numbers from 2014-2018

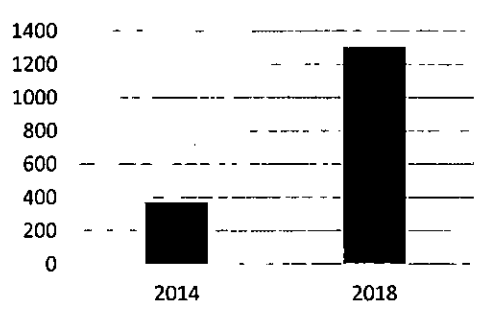
NH FQHCs are a Dental Safety Net

100% of NH's FQHCs integrate oral health into their primary care services.

2018 UDS

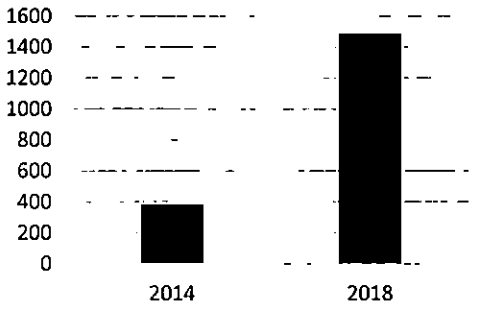
A Growing Demand for FQHC Services in New Hampshire

Vision Patients



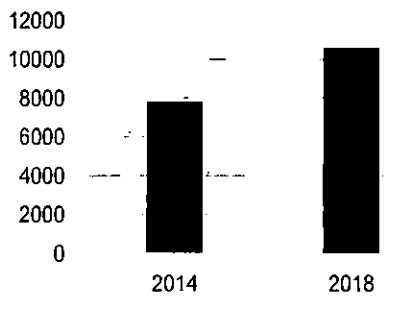
251% increase in NH patients receiving vision services

Vision Office Visits



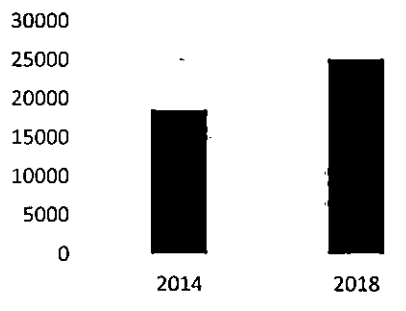
287% increase in office visits provided for vision services

Dental Patients



36% increase in NH patients receiving oral health services

Dental Office Visits

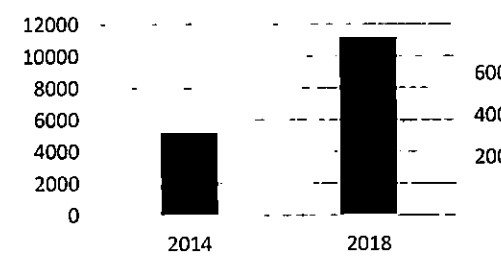


35% increase in office visits provided for dental services

REDUCING THE STIGMA OF SUBSTANCE USE DISORDER IMPROVES PUBLIC HEALTH

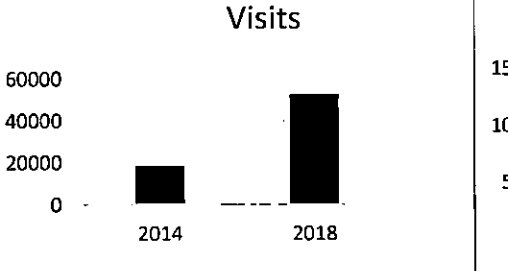
NH's FQHCs responded to the demand for substance misuse treatment by reducing the stigma associated with substance use disorder and expanding their capacity to see more patients. As a result, NH FQHCs expanded Granite Staters' access to substance use disorder treatment.

Mental Health Patients



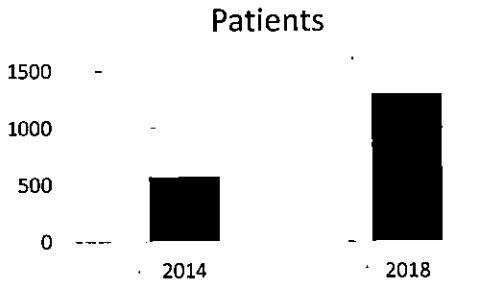
115% increase in NH patients receiving treatment for mental health

Mental Health Office Visits



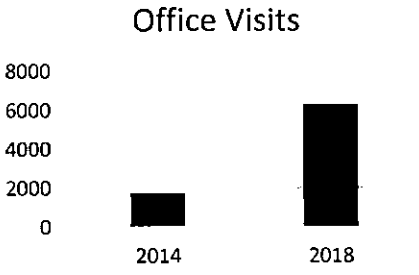
187% increase in office visits provided for mental health treatment

Substance Use Disorder Patients



128% increase in NH patients treated for substance use disorder

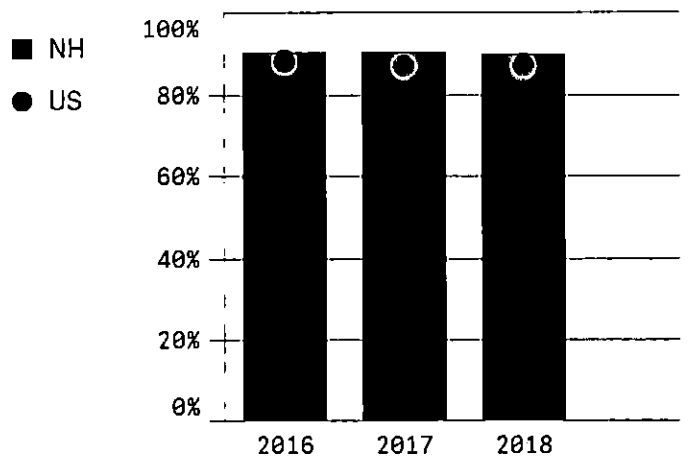
Substance Use Disorder Office Visits



257% increase in office visits provided for substance use disorder treatment

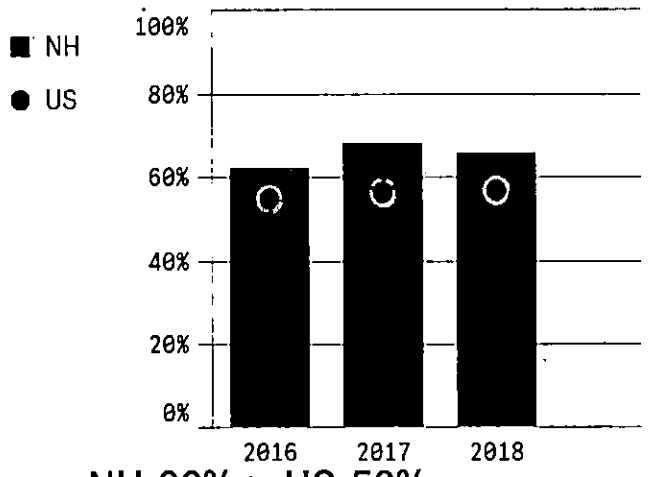
New Hampshire's FQHCs Exceeded National FQHC Average for Many Clinical Quality Measures in 2018

Asthma Medication Rate



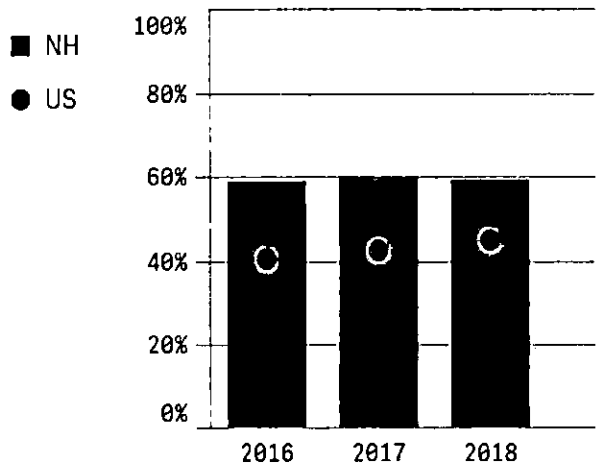
NH 90% > US 87%

Cervical Cancer Screening Rate



NH 66% > US 56%

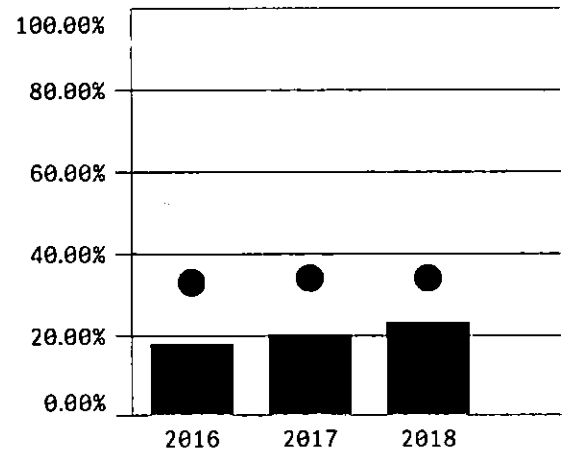
Colorectal Cancer Screening Rate



NH 59% > US 44%

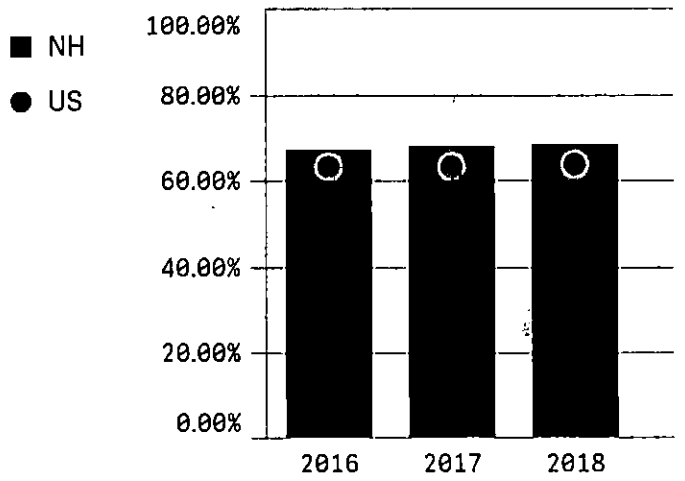
Diabetes Poor Control Rate

LOWER = BETTER



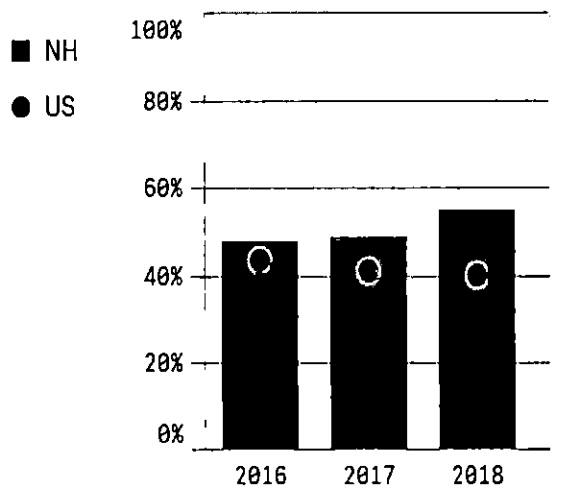
NH 23% < US 33%

Hypertension Control Rate



NH 68% > US 63%

Kids Immunization Rate



NH 55% > US 39%

New Hampshire's Community Health Centers Serve 121,668 Granite Staters

- 14 New Hampshire Community Health Centers – including 11 FQHCs, Planned Parenthood of Northern New England, Weeks Medical Center, and White Mountain Community Health Center - serve as the medical home for over 121,000 Granite Staters who made over 490,000 visits in 2018.
- In the past 5 years, New Hampshire's CHCs have experienced a growing demand for services:
  - 10% increase in patients served
  - 14% increase in patient visits
  - 17% in Medicare patients served
- 1 in 11 Granite Staters receives care at a New Hampshire CHC.
- 1 in 4 uninsured Granite Staters receives care at a New Hampshire CHC.
- 1 in 5 Granite Staters enrolled in Medicaid receives care at a New Hampshire CHC.
- 1 in 10 Granite Staters enrolled in Medicare receives care at a New Hampshire CHC.

Community Health Center Patient Mix

2018 NH UDS Data and Self-Reported data in BSPCA member surveys
NH Statewide Data from Kaiser Family Foundation
This CHC data does not include Springfield Medical Care Systems' NH Site: Charlestown Health Center.

Investing in primary and preventive care is an investment in containing the growth of the total cost of care in New Hampshire.

Investing in primary and preventive care is the most effective way to reduce the growing costs of care in our state – keeping people well instead of paying to fix problems after they occur.

Nationally, CHCs generate on average $24 billion a year in savings to the national health system.

[illegible] receiving care at a CHC [illegible] health system approximately [illegible] compared to other [illegible]

[illegible] (Milliman report, 2015)

CHCs serve about 20% of (1 in 5) NH Medicaid enrollees.

CHCs ensure that Medicaid enrollees receive cost-effective, comprehensive primary care.

(2018 NH UDS data, self-reported data in BSPCA member surveys, and statewide data from Kaiser Family Foundation)

CHCs are economic engines in their communities, often serving as the largest local employer. CHCs employ over 1,295 employees in the Granite State, while creating jobs in other industries and boosting the local economy through the purchase of goods and services from local businesses.

Our members offer sliding fee [illegible] scales, including free care, to ensure that everyone can afford their services.

Health centers are ready to respond to the changing needs of their communities. Whether helping fight outbreaks of flu and Zika, dispensing care in disaster-stricken areas, providing substance misuse treatment, or serving our veterans – health centers proudly answer the call. And stand ready to do even more.

(NACHC, "Building Upon a Successful Model," 2018)

Our members serve Granite Staters in every corner of the state.

Our goal is for geography to never be a barrier to accessing comprehensive, quality services in New Hampshire. Our members operate in 56 sites across the state, in every county. Our members also look for creative ways to extend their coverage, such as mobile clinics, school visits, and expanding use of telehealth connections.

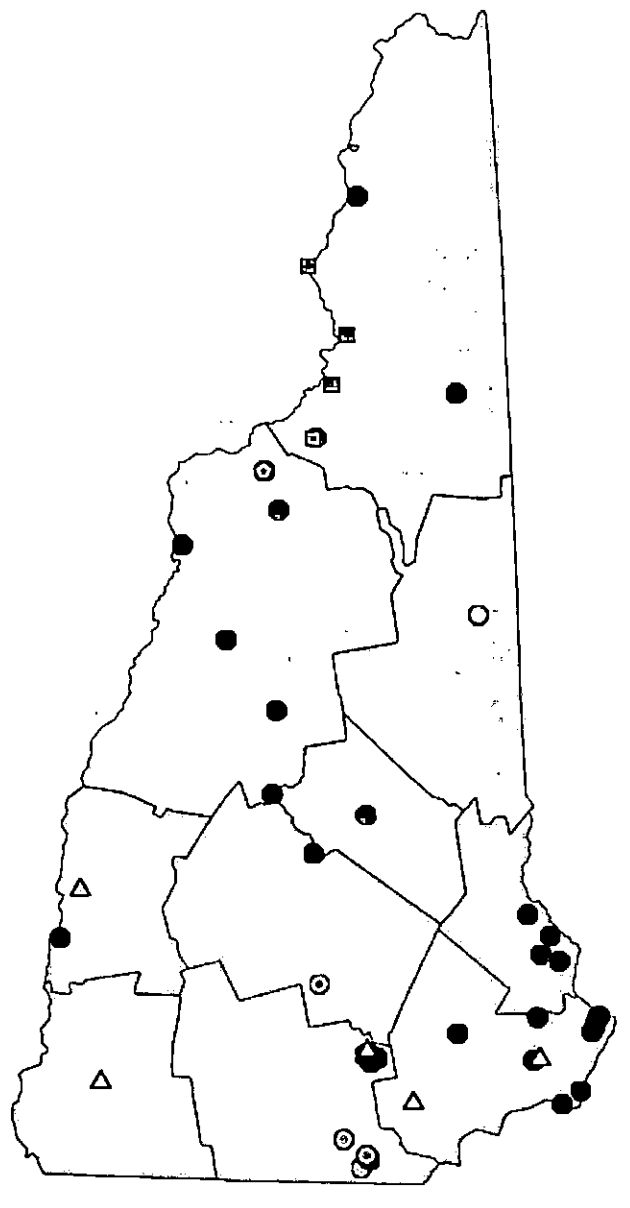
Our members had more than 490,000 visits in 2018.

- ■ Ammonoosuc Community Health Services, Inc. (FQHC)
- ■ Amoskeag Health (FQHC)
- ■ Coos County Family Health Services (FQHC)
- ■ Greater Seacoast Community Health (FQHC)
- □ Harbor Homes, Harbor Care Health and Wellness Center (FQHC)
- ■ Health Care for the Homeless Program of Manchester (FQHC)
- ■ HealthFirst Family Care Center (FQHC)
- ■ Indian Stream Health Center (FQHC)*
- ■ Lamprey Health Care (FQHC)
- ■ Mid-State Health Center (FQHC)
- ■ Springfield Medical Care Systems (FQHC)
- □ Weeks Medical Center (RHC)
- ▫ White Mountain Community Health Center (FQHC Look-Alike)

△ Planned Parenthood of Northern New England (CHC)

● Community Health Access Network
● North Country Health Consortium

Area Health Education Center (AHEC) Regions Shaded by County
□ Northern New Hampshire
■ Southern New Hampshire



*Indian Stream Health Center has a location in Canaan, Vermont.

Bi-State's Recruitment Center & Workforce Development

Bi-State's Recruitment Center combines local outreach with national strategic marketing campaigns to recruit clinicians in primary care, oral health, mental health, and substance use disorder treatment. This workforce program was established in 1994. Since then, we have worked with more than 100 sites and our work has helped recruit **560 providers** to practice in Vermont and New Hampshire communities.

New Hampshire • Vermont
RECRUITMENT CENTER
A Service of Bi-State Primary Care Association

BiStateRecruitmentCenter.org

25 Years of Recruitment Experience

Our recruitment advisors identify physicians, nurse practitioners, physician assistants, dentists, and mental health and substance use disorder treatment providers who will thrive in our rural communities. In FY19, we identified 1,566 providers with interest in NH and VT.

We monitor national and regional recruitment and retention trends in order to advise practices on ways to be innovative and competitive in hiring.

We are a resource for information on State and Federal Loan Repayment programs and the J1 Visa Waiver program, and we connect eligible providers with qualifying health care facilities.

Workforce Development

Bi-State led a workforce coalition in New Hampshire from 2018-2019 that brought together over 50 organizations to successfully advance a range of reforms, including reducing administrative burdens, advanced training opportunities, and increasing reimbursement rates, in an effort to address primary care workforce shortages. In 2019, with our knowledge of local and national trends, Bi-State provided input and data for the Vermont Rural Health Services Task Force on its workforce findings and recommendations.

Retention is the Key to Successful Recruitment

A first step in retention is matching candidates with communities where they will thrive. Bi-State has a strong reputation for successful recruitment to rural New England. Bi-State offers programs that support health care employees as they develop networks and skills that root them in serving our communities.

For example, our Leadership Development Program held biannually has graduated 212 students; our peer-to-peer groups offer support in areas such as clinical quality improvement, billing and coding, and care coordination; we host an annual primary care conference and in 2019 launched a Clinical Quality Symposium which had 130 attendees in its inaugural year.

The Recruitment Center makes trainings available to community health centers in both states to help them develop strategies for integrating retention best practices from the beginning of the recruitment process and beyond.

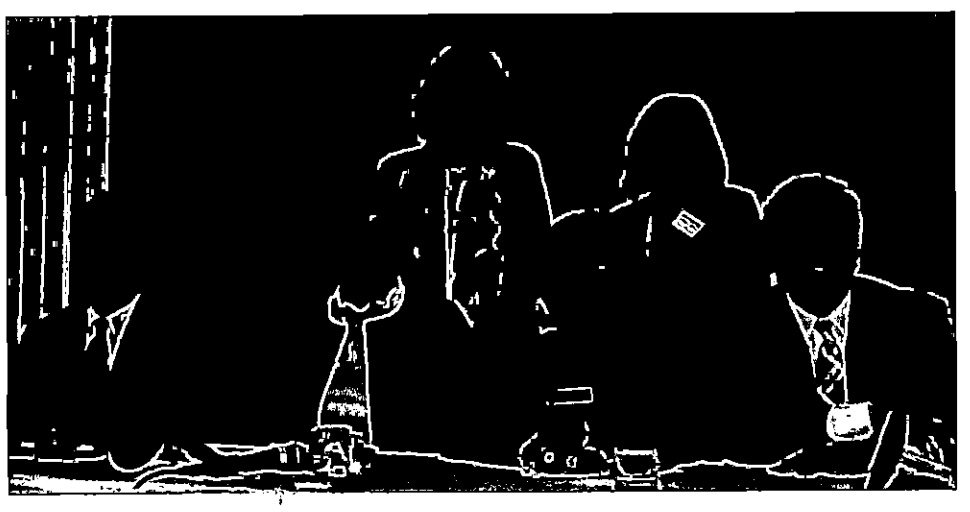
In a pilot survey on retention of candidates Bi-State placed in NH over a 20-year period, 26% had stayed at their original location (40% had been practicing between 14-20 years), and 66% of the recruited providers have remained in the same region.

Bi-State's Recruitment Center serves all interested New Hampshire and Vermont health care organizations, placing special emphasis on rural and underserved areas. In 2019, we were actively recruiting for an average of 53 vacancies in New Hampshire and 62 vacancies in Vermont. For more information, contact Stephanie Pagliuca, Director of Workforce Development and Recruitment, at (603) 228-2830 x111 or spagliuca@bistatepca.org.

Identifying Key Solutions to Address the Health Care Workforce Shortage and Improve Access to Care

With over 2,000 health care worker vacancies statewide, including 109 Community Health Center vacancies, New Hampshire does not have the workforce to meet the health care needs of our residents. In response, Bi-State Primary Care Association led the effort to form the bipartisan NH Health Care Workforce Coalition, which grew to include 53 Granite State health care organizations that worked with legislative leaders to develop a package of solutions to the health care workforce shortage:

- ✓ Invested $6.5 million in the State Loan Repayment Program, the #1 tool for recruiting and retaining providers in rural and underserved areas.
- ✓ Supported Medicaid Providers by implementing 3.1% across-the-board Medicaid rate increases.
- ✓ Utilized telehealth as a resource to expand access to care and help clinicians work more efficiently.
- ✓ Required health care professionals to complete the State Office of Rural Health survey that enables DHHS and HRSA to track health care vacancies statewide.
- ✓ Implemented online background checks to make it easier for NH businesses including Community Health Centers to hire qualified, interested employees.



2019 NH Legislative and Business Breakfast
Pictured (back row, l-r): Tess Stack Kuenning, Kristine Stoddard; (front row, l-r): Sen. Jeb Bradley, Rep. Erin Hennessey, Sen. Cindy Rosenwald, and Sen. Dan Feltes

NH Member Profiles

ACHS

Ammonoosuc Community Health Services, Inc.
Edward D Shanshala II, MSHSA, MSEd,
Executive Director/Chief Executive Officer
603-444-2464 • www.ammonoosuc.org
25 Mt. Eustis Road, Littleton, NH
202 Cottage Street, Littleton, NH
333 Route 25, Main Street, Warren, NH
79 Swiftwater Road, Woodsville, NH
14 King's Square, Whitefield, NH
1095 Profile Rd, Suite B., Franconia, NH

HRSA Health Center Program – HEALTH DISPARITIES REDUCER 2018 AWARDEE
HRSA Health Center Program – ACCESS ENHANCER ★★★★★ 2019 AWARDEE
HRSA Health Center Program – ADVANCING HIT FOR QUALITY 2019 AWARDEE
HRSA Health Center Program – HEALTH CENTER QUALITY LEADER 2018 AWARDEE
PCMH

ABOUT OUR CLIENTS

Where They Live: ACHS patients come from 40 communities in Grafton and Coos Counties, as well as neighboring towns in Vermont - a service area of approximately 68,000.

Socioeconomic status: 12% of residents in the county of Grafton, and 13% of residents in Coos County have household incomes at or below 200% of the federal poverty level.

Insurance Status (2018):
10% were uninsured
15% were covered by Medicaid
29% were covered by Medicare
46% were covered by private insurance, including Medicaid Expansion products.

NUMBERS OF PATIENTS SERVED

Total Medical Patients: 9,923
Total Visits (includes all services): 42,127
Total Dental Patients: 1,260
Total Dental Visits: 4,024
Total Mental Health Visits: 4,433

HIGHLIGHTS IN ACHS HISTORY

1975: Established to provide family planning, WIC, prenatal, and child health care in northern NH
1995: Designated as a Federally Qualified Health Center providing comprehensive primary care services
1998: Received initial JCAHO accreditation (recertified in 2001)
2002: Added fifth health center site in Franconia, NH
2007: Woodsville Expanded Medical Capacity grant and implementation
2015: Added Dental and Oral Health Center in Littleton, NH
2016: In partnership with area optometrists, offers an affordable Vision Program

FINANCIAL INFORMATION

Agency Revenue (2018): $11,890,014
Employees (2018): 107 FTEs

VALUE OF DISCOUNTED SERVICES PROVIDED TO PATIENTS

Total: $729,978
Medical: $220,736
Dental: $410,489
Behavioral Health: $16,399
Pharmacy: $82,354

ACHS SERVICES

- Integrated Primary Medical Care
- Prenatal Care
- Women's Health: Birth Control, STD Checks, Pap/Pelvic Exams, Long-Term Contraceptives
- Behavioral Health: Counseling, Drug and Alcohol Treatment, Medication-Assisted Treatment for Substance Use
- Dental and Oral Care: Diagnostic, Preventive, Restorative, Prosthetics, Simple Extractions
- Health and Nutritional Education, Promotion, and Counseling
- Chronic Disease Management
- Prescription Drug Program
- Cancer Screening
- Hospice and Palliative Care
- Medical Legal Partnership
- Patient Navigation
- Vision and Clinical Pharmacy Services
- Support Programs
- Breast and Cervical Cancer Screenings
- Text 4 baby: Free Educational Program of the National Healthy Mothers, Healthy Babies Coalition
- HIV/STD Counseling and Testing

AMOSKEAG HEALTH

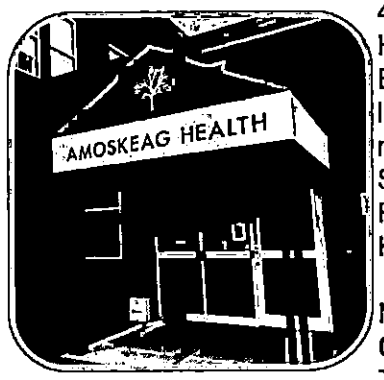
Kris McCracken, President/Chief Executive Officer
145 Hollis Street Manchester, NH
184 Tarrytown Road Manchester, NH
1245 Elm Street Manchester, NH
1555 Elm Street Manchester, NH ProHealth
88 McGregor Street Manchester, NH

www.amoskeaghealth.org • 603-626-9500

About Our Patients
Where They Live: 86% in Manchester and neighboring towns; 14% are from various other counties.

Socioeconomic Status: Approximately 80% of Amoskeag Health patients are known to be at 200% of the Federal poverty level or below ($40,840 or less annually for a family of 3).

Outpatient Insurance Status
24% were uninsured; 6% were covered by Medicare; 50% were covered by Medicaid. 20% were covered by private insurance, including Medicaid Expansion products.



Languages Spoken
43% (over 7,500 Amoskeag Health patients) do not use English as their primary language. The predominant non-English languages are Spanish, Arabic, Nepali, French, Portuguese and Kiswahili.

Number of Adult and Children Served Last Year
Total Patients: 14,672
Total Visits: 67,491

noskeag Health History

ı Deitch establishes Child Health Services (CHS) to provide family-oriented primary health care to the uninsured, underinsured or to those lacking access to quality health care.

1993: Manchester Community Health Center (MCHC) opens as a joint endeavor of Elliot Hospital and Catholic Medical Center (CMC) with the support of many local non-profit leaders, including Dr. Deitch.

1999: CHS achieves Joint Commission on the Accreditation of Healthcare Organizations and Primary Care Effectiveness Review accreditation, the first facility of its kind in the nation to achieve this joint recognition.

2004: Citizens Bank and WMUR name MCHC the 'Community Champion in Healthcare'.

2008: MCHC moves from its original Elm St. location to the current Hollis St. location. CMC and Dartmouth Hitchcock create West Side Neighborhood Health located in the CMC Medical Building on McGregor St.

2013: MCHC adds a second location at Tarrytown Rd.

2014: MCHC and CHS combine operations.

2015: MCHC assumes management of the West Side Neighborhood Health Center on McGregor Street.

2018: MCHC opens first FQHC-based Optometry Clinic in NH for eye health and vision services.

2019: MCHC, CHS, West Side Neighborhood Health Center, and Tarrytown are brought together under one name: Amoskeag Health.

2019: ProHealth, co-located physical and mental health services with the Mental Health Center of Greater Manchester, opens its doors.

Financial Information
Agency Budget: $21,550,987; Employees: 220 FTEs

AMOSKEAG HEALTH SERVICES

- Primary Medical Care
  Healthcare for adults and children of all ages, regardless of insurance status
- Prenatal Care
  Care through pregnancy and childbirth in collaboration with Bedford Commons OB/GYN for high-risk patients
- Specialty Care
  Podiatry services, dental referral services, and other special medical programs such as care coordination, developmental screenings and nutritional care
- Chronic Disease Care
  Services such as diabetic eye care, chronic disease self- management courses and high blood pressure program
- Behavioral Health Services
  Services such as mental health therapy, substance misuse counseling, medication assisted therapy and perinatal substance use disorder (SUD) care
- Optometry Care
  Vision care for patients ages five and older, including routine eye care for diabetic patients, and free glasses for children who qualify
- Preventive Care
  Lifestyle changes programs, nutritional counseling, breast feeding education, screening for breast, cervical and colorectal cancer
- Social Services and Support
  Case management, transportation, language interpretation, food pantries, teen clinic, medical/legal partnership, ACERT & Family Justice Center collaborations

CHAN Community Health Access Network

Community Health Access Network (CHAN)
Joan Tulk, Executive Director
207A South Main Street
Newmarket, NH 03857-1843
603-292-7274 · www.chan-nh.org

ABOUT US
CHAN is the only Health Center Controlled Network (HCCN) in NH. CHAN has developed and supports an integrated clinical and administrative system infrastructure that affords innovative opportunities for its Federally Qualified Health Center (FQHC) members, which include 2 Healthcare for the Homeless programs. CHAN's endeavors, particularly in the Health Information Technology arena, enable the provision of enriched patient experiences and quality care.

OUR MEMBERS
- Greater Seacoast Community Health
- Health First Family Care Center
- Lamprey Health Care, Inc.
- Amoskeag Health
- Health Care for the Homeless Program, Catholic Medical Center
- Shackelford County Community Resource Center, dba Resource Care (TX)
- Affiliate members include Ammonoosuc Community Health Services, Coos County Family Health Services, and The Health Center (VT)

HIGHLIGHTS IN CHAN HISTORY
1995: Five community health care centers with a collective history of over 75 years of experience in providing primary care services to the uninsured, underinsured, and Medicaid populations formed an Integrated Services Network (ISN), called CHAN.
1996: A NH Health Care Transition Fund Grant helped to expand the HCCN and develop shared services.
1997: Two additional community healthcare centers joined the network, and CHAN was awarded our first Bureau of Primary Health Care grant.
2008: CHAN was awarded the HIMSS Nicholas E. Davies award for improving healthcare through the use of HIT.
2010: CHAN expanded across state lines and welcomed a health center from Texas into the network
2016: CHAN began hosting the IT infrastructure for a VT health center

CHAN SERVICES

Electronic Health Record
Electronic health record system that enables clinicians and staff to document patient visits, streamline clinical workflow and securely exchange data

Practice Management
Practice management billing system provides all the tools needed to manage the specific needs of practices and boost efficiency

Data Warehouse
Updated daily with clinical, operational and financial data. Supporting standard quality and operational reports, analysis and member-generated ad hoc reports

Clinical Standards
Supporting clinical operations and providing support for chronic disease management and prevention.

IT Services
Services such as systems maintenance, upgrades, disaster recovery, electronic reports and custom data entry screens/forms development

Performance Improvement
Monitoring and improvement activities for clinical operations; Quality Improvement technical assistance, training and audits

Charlestown Health Center

SPRINGFIELD MEDICAL CARE SYSTEMS

Where People Come First

Charlestown Health Center
Anila Hood, Director
250 CEDA Road, Charlestown, NH 03603
603-826-5711
www.springfieldmed.org/charlestown-health-center/

ABOUT OUR CLIENTS

Where they live: Patients served reside in Charlestown, NH and surrounding communities in Sullivan County, portions of Cheshire County, NH, as well as some residents of adjacent Vermont communities.

Socio-economic Status: Sullivan County, population 43,742, is rural with the second least populous county in the state. The unemployment rate is 2.0.

2014-2018 median household income is $60,780.

Per capita income in past 12 months, 2014-2018 is $31,668.

Percent in poverty is 11.2%

Persons without health insurance, under age 65 years, 7.2%.

Persons with disability, under age 65, 2015-2018, 9.4%

Source: www.census.gov/quickfacts/sullivancounty

INSURANCE STATUS

7% Uninsured
23% Medicaid
25% Medicare
45% Commercial Insurance/
Medicaid Expansion Products

NUMBER OF PATIENTS SERVED

Total Patients (2018): 4,043
Total Visits (2018): 12,226

GENERAL INFORMATION

Employees: 22
New facility opened in July, 2017

A GROWING DEMAND FOR SERVICES

- Patient count grew 35.7% from 12/31/17 to 12/31/18.
- Patient visits grew by 18.5% from 12/31/17 to 12/31/18.

PCMH

CHARLESTOWN HEALTH CENTER SERVICES

- Integrated Primary Medical Care
- Walk-in Access 7 days a week
- Preventive Health Screenings
- Chronic Disease Management and Diabetes Education
- Support programs for Breast and Cervical Cancer screenings
- Nutrition Counseling
- Smoking Cessation Counseling
- Discount Pharmaceuticals
- Behavioral Health and Substance Use Disorder Counseling
- On-site Lab and X-ray services
- SMCS In-Network Dental and Vision Care Access

coös county Family Health

Coos County Family Health Services
Ken Gordon, Chief Executive Officer
www.coosfamilyhealth.org
133 Pleasant Street Berlin, NH 03570 · 603-752-2040
2 Broadway Avenue Gorham, NH 03581· 603-466-2741
73 Main Street Berlin, NH 03570 · 603-752-2424
59 Page Hill Road Berlin, NH 03570 · 603-752-2900
54 Willow Street Berlin, NH 03570 · 603-752-3669

HRSA Health Center Program — HEALTH CENTER QUALITY LEADER 2018 AWARDEE

HRSA Health Center Program — ADVANCING HIT FOR QUALITY 2019 AWARDEE

PCMH

WHO WE PROVIDE CARE FOR

Where They Live: Patients come from over 13 communities of Coos County and neighboring towns in Maine, which are federally-designated Medically Underserved Population (MUP) areas, and both Medical and Dental Health Professional Shortage Areas (HPSAs).

Socioeconomic Status: Approximately 65% of CCFHS patients have household incomes below 200% of the federal poverty level ($40,840 or less annually for a family of 3).

Insurance Status (2018)

7% were uninsured.
21% were covered by Medicaid.
30% were covered by Medicare.
42% were covered by private insurance, including Medicaid Expansion products.

NUMBERS OF CHILDREN AND ADULTS SERVED (2018)

Total Patients: 12,366
Total Visits: 52,407

HIGHLIGHTS IN CCFHS HISTORY

1974: Started as a Title X Family Planning Agency.
1980: Merged with Family Health Programs to provide prenatal and infant care and added WIC and RESPONSE.
1993: Designated as a Federally Qualified Health Center (FQHC), providing comprehensive primary care services.
2004: Expanded to an additional site in Berlin and one in Gorham, adding an additional 10,000 patients.
2016: Coos County Family Dental Clinic established.
2018: Medication Assisted Treatment program began operations.

FINANCIAL INFORMATION

Agency Revenue (2018): $13,410,184
Employees: 112 FTEs
Annual Savings to health care system (2014-2018): $15.2 million dollars ($1,263 saved per person)

A GROWING DEMAND FOR SERVICES (2014-2018)

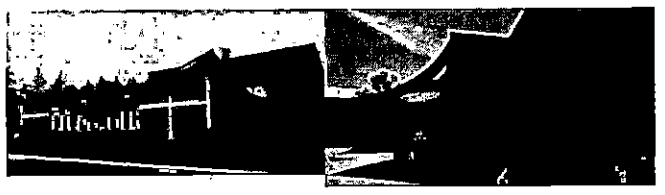
12% increase in patient visits
413% increase in mental health patients
2,475% increase in dental patients

CCFHS SERVICES

- Primary Medical Care/Family Medicine
- Prenatal Care & Obstetrics: In Partnership with Androscoggin Valley Hospital
- Family Planning: Reproductive Health Services
- Breast & Cervical Cancer Screenings
- HIV Testing & Counseling
- Chronic Disease Management
- Behavioral Health Services
- Substance Use Treatment
- Reduced-Cost Prescription Drugs
- Women, Infant and Children (WIC) Nutrition/Health Services
- Dental/Oral Health Services
- Health Promotion and Education
- Nutrition Counseling Services
- On-site Laboratory Services
- Medical Social Work
- Podiatry
- Telehealth: in Partnership with the Dartmouth Hitchcock Medical Center
- Medical Appointment Offered 7 Days per Week
- RESPONSE: Advocacy and counseling program for survivors of domestic violence and sexual assault, shelter for battered women and their children, and transitional housing

GREATER SEACOAST COMMUNITY HEALTH

Goodwin Community Health | Families First | Lilac City Pediatrics



Greater Seacoast Community Health
Janet Laatsch, CEO · www.GetCommunityHealth.org

Mission: To deliver innovative, compassionate, integrated health services and support that are accessible to all in our community, regardless of ability to pay.

Health Center Locations
- **Families First Health & Support Center:** 100 Campus Dr., Portsmouth
- **Goodwin Community Health:** 311 Route 108, Somersworth
- **Lilac City Pediatrics:180** Farmington Rd, Rochester
- **Mobile Health Clinics:** Rochester, Dover, Portsmouth, Hampton and Exeter (9 sites total)

Program Partner Locations
- **SOS Recovery Community Organization:** Recovery centers in Dover, Rochester and Hampton; office in Somersworth.
- **Strafford County Public Health Network:** 311 Route 108, Somersworth
- **Women, Infants, and Children Nutrition Program:** 311 Route 108, Somersworth

2018 Data
- Total Patients: 16,250
- Medical Services: 13,316 patients in 45,123 visits
- Dental Services: 5,078 patients in 10,667 visits
- Mental Health Services: 1,265 patients in 6,879 visits
- Substance Use Services: 248 patients in 1,664 visits
- Family Programs (incl. home visits): 1,872 served
- 86% of Health Center patients had household incomes below 200% of the federal poverty level.
- 37% were covered by Medicaid; 17% were uninsured

2019 Accomplishments
- Expanded access to pediatric behavioral health care
- Opened a third SUD recovery center (in Hampton)
- Ranked among the top 30% of all health centers nationwide in overall performance on clinical quality measures
- Increased access for our patients
- Expanded parenting programs to Somersworth
- Renewed Level 3 Patient-Centered Medical Home recognition (Somersworth location)
- Received $217k federal grant to expand oral health services
- Began offering acupuncture services to SUD and other patients

2019 Budget and Staffing
- Agency Operating Budget: $19.7 million
- Employees: 305

GREATER SEACOAST SERVICES

PRIMARY & PRENATAL CARE
· Primary care for adults
· Pediatric care
· Prenatal care
· Mobile health care for people experiencing homelessness and others with low incomes
· Child-development screenings
· Breast and cervical cancer screenings
· Nutrition education and counseling
· Education and support for management of chronic diseases

DENTAL CARE
· On-site dental hygiene, treatment and urgent care
· School-based education, screening, cleanings and sealants
· Mobile dental clinics

BEHAVIORAL HEALTH SERVICES
· Behavioral health counseling
· Psychiatric care
· Substance Use Disorder counseling
· Medication-Assisted Recovery
· Intensive Outpatient Program

PARENT & FAMILY PROGRAMS
· Parenting classes and groups, with free child care; Playgroups and family programs; Individual, in-home support for families under stress, including families with a chronically ill child

... AND MORE
· Social work services and care coordination
· Insurance and benefits enrollment
· Prescription assistance
· In-house pharmacy and 340B drug discount program
· Transportation, translation and child care for appointments
· On-site lab services

Peter Kelleher, President and CEO
45 High Street Nashua, NH 03060
615 Amherst Street Nashua, NH 03063
12 Amherst Street Nashua, NH 03064
Mobile Health Van, Hillsborough County
603-882-3616
www.harborhomes.org

HarborCare
HEALTH AND WELLNESS CENTER
A PROGRAM OF HARBOR HOMES

ABOUT US
Harbor Care Health and Wellness Center (HCHWC) is the Federally Qualified Health Center (FQHC) of Harbor Homes and Partnership for Successful Living Affiliates. As one of only three Health Centers in NH designated as a Health Care for the Homeless Health Center, HCHWC serves approximately 3,200 unique patients through nearly 25,000 visits annually with primary care, MAT, mental health, and SUD services. Our primary Service Area is Greater Nashua, NH.

Socioeconomic Status
More than 40% of NH's homeless live in our Service Area. 76% of the patients we serve are homeless. 90% of the patients we serve are below 200% of the Federal Poverty Level ($40,840 or less annually for a family of 3). Over 65% of our total visits were substance misuse or mental health related.

Insurance Status (2018):
14% uninsured
20% covered by Medicare
17% covered by private insurance
About half of our patients are covered by Medicaid.

Highlights in 2018: Harbor Care Health and Wellness Center is the health care provider of Nashua's Safe Station Program, which has served over 2,500 clients through December 2018. Safe Stations is a program of the City of Nashua, Nashua Fire Rescue, American Medical Response, and Harbor Homes. Any person can present at one of seven Nashua Fire Stations seeking assistance with substance use disorder. Clients are medically screened and evaluated for outpatient and residential services.

NUMBERS OF PATIENTS SERVED (2018)
Unique Patients: 3,063; Medical Visits including MAT: 6,561
Dental Visits: 2,882; Behavioral Health & Substance Misuse Visits: 10,172

FINANCIAL INFORMATION (2018)
Full-Time Equivalents: 73; Total Uncompensated Care: $2,618,196

A GROWING DEMAND FOR SERVICES (2015-2018)
236% increase in Medicaid patients
37% reduction in Uninsured patients
215% increase in Behavioral Health and Substance Use Disorder patients
382% increase in Homeless patients
197% increase in Total Visits provided
156% increase in Total Patients served

HARBOR HOMES SERVICES

Access to a comprehensive set of services designed to address social determinants of health and end or prevent homeless

- Housing (Permanent, Temporary, Veteran)
- Employment Supportive Services
- Case Management
- Safe Stations: A gateway to recovery services
- Primary and Acute Medical Care, including Same Day Visits
- Women's Health and Pediatrics
- Early Invention Services including PrEP and PEP
- Medication Assisted Treatment (MAT) including Substance Use Disorder Treatment and Withdrawal Management Services
- Behavioral Health Care, including Mental Health Medication Management, Mental Health Counseling
- Mobile Crisis Response Team
- Pharmacy: 340B Low-Cost Prescription Program
- Patient Navigation and Insurance Enrollment
- Sliding Fee Scale, Payment Plans and Discounted Services

24x7x365 After-Hours Coverage

Health Care for the Homeless

A Program of the Manchester Health Department based at Catholic Medical Center

CMC
CATHOLIC MEDICAL CENTER
a member of GraniteOne Health

New Horizons for NH
199 Manchester Street
Manchester, NH
603-663-8718

Health Care for the Homeless Program
Amy Pratte, Director, External Affairs/Fiscal Manager HCH
195 McGregor Street
Manchester, NH
603-663-8716

Wilson Street Integrated Health
293 Wilson Street, Suite 102
Manchester, NH
603-665-7450

Families in Transition
177 Lake Avenue
Manchester, NH
603-782-7414

PCMH

HRSA Health Center Program — HEALTH CENTER QUALITY LEADER 2019

HRSA Health Center Program — ADVANCING HIT FOR QUALITY 2019

ABOUT OUR CLIENTS

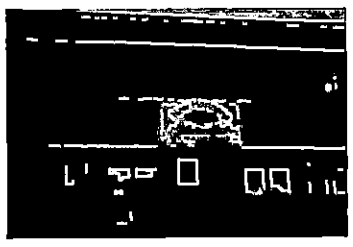
Who They Are: Men, women, children, teens, veterans, families and working poor residents of the greater Manchester, New Hampshire area

Where They Live: Our clients are individuals and entire families who do not have a regular (nor adequate) place to sleep or call home. Many who are homeless, such as battered women and runaway/throwaway youth, are in precarious situations fleeing domestic violence unable to return to their homes. Others live in transitional housing, temporary shelters, or "couch surf," doubled up for the night with other families, friends /acquaintances. Some sleep in places not intended or designed for human habitation, such as cars, abandoned buildings, and tent camps along the river or in the woods.

Socioeconomic Status: 98% of HCH patents earn below 200% of poverty level ($40,840 or less for a family of 3).

Insurance Status

25% were uninsured. 57% were covered by Medicaid. 9% were covered by Medicare.
9% had private insurance, including Medicaid Expansion products.



NUMBERS SERVED

Health care users: 1,471
Health care visits: 6,249

HIGHLIGHTS IN HCH HISTORY

In 1987, the Manchester Health Department (MHD) was awarded a federal (330h) health center grant from HRSA as part of the national Health Care for the Homeless Program to establish a *clinic without walls,* providing primary health care and addiction services to people and families who are homeless in the greater Manchester area. MHD contracts with Catholic Medical Center (CMC) to implement program operations. Clinic sessions are offered at three locations, including New Horizons Shelter, Families in Transition emergency shelter, and Wilson Street Integrated Health (WSIH). Co-located with community partners within the Manchester Recovery & Treatment Center, WSIH was opened in 2019 in response to the growing need for substance use disorder services. Outreach is also conducted, touring streets, parks, woods and other smaller shelters in the area.

The HCH team works closely with CMC, Poisson Dental Facility, Elliot Hospital, Amoskeag Health, The Mental Health Center of Greater Manchester, Dartmouth Hitchcock Medical Center, Waypoint, Granite Pathways, Farnum Center, Southern NH Services and most local health and human service providers.

GROWING DEMAND: Homelessness is growing in part due to the high cost of housing. In 2019, NH Housing Wage required to rent a 2-bedroom home was $23.23 per hour. The average 2-bedroom rental cost is $1,347 per month. Demand for services has increased due to the Opioid Epidemic and Safe Station program partnership. All are welcome. No one is turned away.

HEALTH CARE FOR THE HOMELESS SERVICES

- Primary Medical Care, Medical Case Management, Chronic Disease Management for Diabetes, Asthma, and Hypertension
- Integrated Behavioral Health Services, Counseling and Medication Assisted Therapy for Substance Use Disorders
- Easily Accessible Clinics, Street Outreach, and Safe Station Partners
- Health Education and Mindfulness-Based Stress Reduction
- Testing and Treatment for STD/HIV
- Tuberculosis Screening and Cancer Screening
- Medication Assistance
- Transportation
- Referrals to Specialty Care
- Social Work/Case Management

HEALTH FIRST

HealthFirst Family Care Center
Russell G. Keene, Executive Director
841 Central Street, Franklin, NH · 603-934-1464
22 Strafford Street #1 Laconia, NH · 603-366-1070
www.healthfirstfamily.org

HRSA Health Center Program — ACCESS ENHANCER 2019

HRSA Health Center Program — HEALTH DISPARITIES REDUCER 2019

HRSA Health Center Program — ADVANCING HIT FOR QUALITY 2019

ABOUT OUR CLIENTS

Where They Live: Our clients come from 23 rural townships within the Twin Rivers and Lakes Region of New Hampshire (i.e., Belknap, Carroll, Merrimack and Grafton counties), a population of approximately 81,000 people.

Socio-Economic Status: 83% of HealthFirst clients are at 200% of the federal poverty level or below ($40,840 or less for a family of 3).

Insurance Status:

9% were uninsured.
18% were covered by Medicare.
30% were covered by private insurance, including Medicaid Expansion products.
43% were covered by Medicaid.

NUMBERS OF CHILDREN AND ADULTS SERVED

Total Patients: 4,981
Total Visits: 21,790

PCMH

HRSA Health Center Program — HEALTH CENTER QUALITY LEADER 2019

HIGHLIGHTS IN HEALTHFIRST HISTORY

1995: Established with funding from the NH DHHS
1997: Received designation as a Federally Qualified Look-Alike
2002: Designated as a Federally Qualified Health Center
2006: Opened second primary care site in Laconia
2012: Expanded behavioral health integrated into primary care
2019: MAT program offered

FINANCIAL INFORMATION

Agency Budget: $6,860,000
Employees: 60 (Full-Time Employees: 55)
Total Uncompensated Care: $250,000
Uninsured Clients Served: Over 500

A GROWING DEMAND FOR SERVICES (2016-2019)

50% increase in mental health patients served
37% increase in dental patients served
23% increase in total patients served

HEALTHFIRST SERVICES

Primary Healthcare for Men, Women and Children of All Ages, Regardless of Ability to Pay or Insurance Status

- Women's Health Care Including but Not Limited to: Free Breast and Cervical Cancer Screenings for Eligible Women
- Disease Management and Education on Managing Chronic Diseases Such as Diabetes, Asthma, Hypertension
- HealthFirst Participates in the Federal Health Disparities Collaborative for Diabetes.
- Onsite Certified Application Counselor to Assist Clients with Accessing Health Insurance and Medicaid
- Health and Wellness Promotion and Education
- Screenings and Treatments for Chronic Illnesses
- Minor Procedures
- Nutrition Counseling
- Behavioral Health Services Integrated in Primary Care Substance Use Counseling Addiction Treatment
- Same Day Appointments for Existing Patients

INDIAN STREAM HEALTH CENTER

Kevin J. Kelley, President/CEO
Locations:
141 Corliss Lane, Colebrook, NH 03576 · 603-237-8336
253 Gale Street, Canaan, VT 05903 · 802-266-3340
www.indianstream.org

ABOUT OUR CLIENTS
Where They Live: Patients come from 850 square miles encompassing the northern most regions of New Hampshire, Vermont and Maine.
Socioeconomic Status: Over 60% of Indian Stream patients have household incomes at or below 200% of the federal poverty level ($40,840 or less for a family of 3).

Insurance Status
10% were uninsured.
20% were covered by Medicaid.
34% were covered by Medicare.
36% were covered by private insurance, including Medicaid Expansion products.

NUMBERS OF CHILDREN AND ADULTS SERVED
Total Patients: 3,786
Total Visits: 16,124

HIGHLIGHTS IN INDIAN STREAM HISTORY
1979: Practice established as Indian Stream Professional Association
by the husband and wife team, Dr. Gifford & Dr. Parsons
1993: Received Rural Health Clinic designation
2001: Clinic purchased by Dartmouth-Hitchcock Clinic
2003: Established as Indian Stream Health Center, Inc., a 501(c)(3) not-for-profit corporation
2006: Designated as a Federally Qualified Health Center (FQHC)

FINANCIAL INFORMATION
Agency Revenue (2018): $5,939,623
Employees: 58 FTEs
Annual Savings to health care system (2016):
24% lower costs for ISHC Medicaid Patients;
$2 million in savings to Medicaid

A GROWING DEMAND FOR SERVICES (2014-2018)
48% increase in mental health patients
6% increase in total patient visits

INDIAN STREAM SERVICES

Primary Medical Care
For men, women and children of all ages regardless of insurance status

Pediatric primary care
Developmental screenings, preventive care and treatment of acute illnesses

Chronic Disease Management
Education and counseling for chronic diseases

Behavioral Health Services
Family therapy, substance misuse treatment and counseling, behavioral health counseling for issues such as depression and anxiety

Case Management Services
Help with transportation to medical appointments, and access to services such as Meals on Wheels

In House Pharmacy
Providing reduced cost medications; available to patients and the community

School Nurse Program
On-site nursing care and services at schools across the North County

LAMPREY HEALTH CARE

Where Excellence and Caring go Hand in Hand

Greg White, Chief Executive Officer
Newmarket Center: 603-659-3106
207 South Main Street Newmarket, NH
Raymond Center: 603-895-3351
128 State Route 27 Raymond, NH
Nashua Center: 603-883-1626
22 Prospect Street Nashua, NH
InteGreat Health: 603-402-1501
7 Prospect Street, Nashua, NH
www.lampreyhealth.org

ABOUT OUR PATIENTS
Where They Live: Our patients come from over 40 communities within Rockingham, Hillsborough and parts of Strafford Counties.

Socioeconomic Status: Approximately 76% of Lamprey Health Care patients are at or below 200% of the Federal poverty level ($40,840 or less for a family of 3).

Insurance Status: In 2018, aggregating figures from all three centers showed 19% were uninsured; 27% were covered by Medicaid; 15% were covered by Medicare; and 39% had private insurance, including Medicaid Expansion products. However, in the Nashua Center, 33% of patients are uninsured.

NUMBERS SERVED (2018)
Total Patients: 16,262
Patient Visits: 68,940

HIGHLIGHTS IN LAMPREY HEALTH CARE HISTORY
2018: Launched InteGreat Health Program
2017: Launched Nurse Practitioner Fellowship Program
2015: Integrated Behavioral Health Services
2015: Added Seacoast Public Health Network
2013: Recognized as NCQA Level III Patient Centered Medical Home
2011: Expansion of the Nashua Center
2005: Expansion of the Newmarket Center
2000: Implemented an Electronic Medical Records (EMR) system; Third Center established in Nashua
1996: Expansion of the Raymond Center
1995: Developed School-Based Dental Program
1981: Second Center established in Raymond
1973: First Center established in Newmarket
1972: Created Transportation Program to improve access to health & community services for Seniors & Individuals with disabilities.
1971: Founded by a group of citizens to bring medical, health and supportive services to communities in Rockingham & Strafford Counties.

FINANCIAL INFORMATION
Agency Budget: $16.5 million; Employees: 178
FTEs: 148.3

LAMPREY HEALTH CARE SERVICES

- Primary Medical Care: For adults and children of all ages, regardless of ability to pay
- Behavioral Health: Provided services to **1,154** patients
- Prenatal Care: Includes care management and nutritional counseling for **478** patients
- Diabetes Care Management: Diabetes education and treatment for **1,535** patients
- Asthma Care Management: Asthma education and treatment for approximately **1,723** patients
- Breast & Cervical Cancer Program: Enrolled and screened **191** women age 50+
- Nutrition Education: Education provided in **453** patient visits
- Case Management & Community Education **1,591** patient visits
- Interpretation: Interpretation services provided for **3,619** patients non-English speaking (mostly Spanish and Portuguese)
- Preventive Dental Health: School-based dental program in **10** schools provided education to **3,388** students, screened **2,405** children & referred 663 for follow up care
- Senior Transportation Program: Providing over **5,617** rides to elderly or disabled residents in **29** towns
- Reach Out & Read: Provided **over 2,000** books to pediatric patients ages 6 months – 5 years to promote early literacy & a lifetime love of books
- Health Care for the Homeless: Provided health & care management services to **953** homeless patients
- Health Care for Veterans: Provided health & care management services to **418** Veterans

MID-STATE HEALTH CENTER

Where your care comes together.

Robert MacLeod, Chief Executive Officer
101 Boulder Point Drive
Plymouth, NH 03264 • 603-536-4000
100 Robie Road
Bristol, NH 03222 • 603-744-6200
www.midstatehealth.org

ABOUT OUR CLIENTS
Where They Live: Patients come from 19 geographically isolated, rural communities within Grafton, Belknap and Merrimack Counties. All of the towns are designated as Medically-Underserved Populations.
Socioeconomic Status: 28% of our service area residents are 200% of the Federal Poverty Level or below.

Insurance Status:
7% were uninsured.
15% were covered by Medicaid.
28% were covered by Medicare.
50% had private insurance, including Marketplace options and Medicaid Expansion products.

NUMBERS OF CHILDREN AND ADULTS SERVED (2018)
Total Patients: 11,529
Total Visits: 43,626 (includes medical, mental health, oral health, substance use disorder treatment & enabling service visits)

HIGHLIGHTS IN MID-STATE HISTORY
1998: Established as a separate, nonprofit corporation
2005: Changed name to Mid-State Health Center
2005: Designated a Federally Qualified Health Center Look-Alike
2013: Designated as a funded Federally-Qualified Health Center
2014: Built a new health center facility in Bristol, NH
2015: Added oral health preventive and restorative services
2016: Expanded services to include Medication Assisted Treatment
2018: On-site Pharmacy partnership with Genoa Health
2019: Behavioral Health Workforce Education & Training Program collaboration with Plymouth State University
2020: Onsite visiting specialist program (January 2020);
2020: Launch Intensive Outpatient Treatment Program for Substance Use Disorder (February 2020)
2020: Onsite diagnostic Imaging (March 2020)

FINANCIAL INFORMATION (2018)
Agency Budget: $9.4 million
Employees: 105 individuals; Full-Time Employees: 90

A GROWING DEMAND FOR SERVICES (2014-2018)
16% increase in total patients
7,800% in dental patients
34% increase in Mental Health and Substance Use Disorder patients
19% increase in total patient visits

MID-STATE SERVICES
- Primary Medical Care
- Chronic Disease Education, Care Management and Supports for Illnesses Such as Asthma, Diabetes, and Hypertension
- Same-Day Program – Open to Walk-ins
- 24-Hour Clinical On-Call Service for Registered Patients
- Behavioral/Mental Health Counseling
- Substance Use Disorder Recovery Supports including Outpatient Medication Assisted Treatment
- Dental Services including Exams. Cleanings, Fillings, Crowns, Bridges, Extractions, Periodontal Evaluations, Dental Appliances, and Standby Hours for Emergencies
- On-site Laboratories
- Prescription Services
- Infusion Services
- Marketplace Education and Outreach
- Language Interpretation Services
- Nutrition Consults and Education
- School-Based Oral Health Outreach Program
- Transportation Services

COMING TO MID-STATE IN 2020:
- On-site Diagnostic Imaging (i.e., x-ray, ultrasound)
- Extended Specialty Services including Orthopaedics; ENT/Otolaryngology; Dermatology

nh AHEC NEW HAMPSHIRE AREA HEALTH EDUCATION CENTER

Kristina Fjeld-Sparks, MPH, Director
One Medical Center Drive; WTRB Level 5
Lebanon, NH 03756
Email: Kristina.E.Fjeld-Sparks@Dartmouth.edu

ABOUT US
The New Hampshire Area Health Education Center (NH AHEC) focuses on the health care pipeline/workforce in New Hampshire. NH AHEC is one of a national network of programs that provide educational support to current and future members of the health care workforce and collaborate with community organizations to improve population health. The NH AHEC operates as a partnership between Geisel School of Medicine at Dartmouth and Regional centers in Littleton and Raymond to serve the entire state.

The structure of AHEC in NH is one program office and two center offices:

Program office: Dartmouth Institute for Health Policy & Clinical Practice (Lebanon, NH)
Center office: Northern NH AHEC at North Country Health Consortium (Littleton, NH)
Center office: Southern NH AHEC at Lamprey Health Care (Raymond, NH)

In addition to the statewide AHEC network, AHECs are part of an active National AHEC Organization, representing over 85% of the counties in the the United States.

MISSION
NH AHEC strives to improve care and access to care, particularly in rural and underserved areas by enhancing the health and public health workforce in New Hampshire.

HIGHLIGHTS IN NH AHEC HISTORY
The national AHEC program began in 1972 to help prepare primary care physicians for community practice at a time when cost training occurred in the hospital setting. Its establishment coincided with the establishment of community health centers and the National Health Service Corps - supporting education, clinical care and workforce. NH AHEC began in 1997.

NH AHEC SERVICES
- Connecting students to health careers
- Promoting health career awareness and recruitment for young people, including activities such as health career day and residential camps
- Improving care and access to care
- Team training for health professions students from multiple disciplines
- New Hampshire AHEC Health Service Scholars
- Wellness activities
- Continuing education provided to health and public health providers throughout NH lunch and learn workshops

NORTH COUNTRY HEALTH CONSORTIUM

Nancy Frank, Executive Director
262 Cottage St., Suite 230
Littleton, NH 03561
603-259-3700
www.nchcnh.org

ABOUT NORTH COUNTRY HEALTH CONSORTIUM

The North Country Health Consortium (NCHC) was created in 1997 as a vehicle for addressing common issues through collaboration among health and human service providers serving Northern NH.

NCHC is engaged in activities for:

- Solving common problems and facilitating regional solutions;
- Creating and facilitating services and programs to improve population health status;
- Health professional training, continuing education and management services to encourage sustainability of the health care infrastructure;
- Increasing capacity for local public health essential services;
- Increasing access to health care for underserved and uninsured NH residents.

MISSION

To lead innovative collaboration to improve the health status of the region.

NCHC MEMBERS

NCHC's Board of Directors and Membership are inclusive of all health and human service organizations in the North Country, an area inclusive of Coos and Northern Grafton Counties.

NCHC membership includes:

45th Parallel EMS
Adaptive Sports Partners of the North Country
AHEAD, Inc.
Ammonoosuc Community Health Services
Androscoggin Valley Home Care Services
Androscoggin Valley Hospital
Center for New Beginnings
Coos County Family Health Services
Cottage Hospital
Family Resource Center
Franklin Pierce University Physician Assistant Program
Grafton County Human Services
Grafton County Senior Citizens Council
Indian Stream Health Center
Littleton Regional Healthcare
Mid-State Health Center
Morrison Nursing Home
New Hampshire Health Care Association
NH AHEC/Geisel School of Medicine
North Country Healthcare
North Country Home Health & Hospice
Northern Human Services
Plymouth State University Center for Active Living & Healthy Communities
RS Consulting
Tri-County Community Action Program
University of New England, College of Osteopathic Medicine
Upper Connecticut Valley Hospital
Weeks Medical Center
White Mountains Community College
Village to Village

NORTH COUNTRY HEALTH CONSORTIUM SERVICES

Education
Health status monitoring and assessment to identify health needs; Information and education about health issues affecting rural populations; Training and continuing education for North Country Health professionals

Leadership
Program development and implementation, project management, and grant writing; Planning and implementation of positive youth development programming to increase leadership skills and resiliency factors; Management and financial services for regional collaborative initiatives

Advocacy
Working to improve the health status of rural people; Mobilizing community and regional partners; Promoting policies and plans that support individual and community health efforts

Planned Parenthood® of Northern New England

Meagan Gallagher, Chief Executive Officer
Health Centers in New Hampshire:
Claremont Health Center of Claremont, NH: 136 Pleasant Street Claremont, NH 03743 · 603-542-4568
Derry Health Center of Derry, NH: 4 Birch Street Derry, NH 03038 · 603-434-1354
Exeter Health Center of Exeter, NH: 108 High Street Exeter, NH 03833 · 603-772-9315
Keene Health Center of Keene, NH: 8 Middle Street Keene, NH 03431 · 603-352-6898
Manchester Health Center of Manchester, NH: 24 Pennacook Street Manchester, NH 03104 · 603-669-7321
www.plannedparenthood.org

ABOUT OUR NH CLIENTS

Where They Live: Our patients live across the New England States.
PPNNE serves NH patients in Manchester, Derry, Exeter, Keene and Claremont.
Socioeconomic Status: Approximately 67% of our patients are at or below 200% FPL ($40,840 or less annually for a family of 3).
Insurance Status:
2% covered by Medicare
24% covered by Medicaid
24% uninsured
47% covered by private insurance, including Medicaid Expansion products
Total NH patients: 13,923
Total NH visits: 20,119

FINANCIAL INFORMATION

Agency Budget: $24 Million
Employees: 236

HIGHLIGHTS IN PPNNE HISTORY

1965: Planned Parenthood of Vermont (PPV) formed
1966: Planned Parenthood Association of the Upper Valley (PPAUV) formed
1984: PPV/PPAUV merge to form PPNNE
1986: PPNNE merges with Family Planning Services of Southwestern New Hampshire (Keene), Health Options (Manchester), Southern Coastal Family Planning, and Rockingham County Family Planning
2015: PPNNE Celebrates 50 years

NUMBERS OF CHILDREN AND ADULTS SERVED IN 2018

Medical care users: 45,126 patients
11% are men; 89% are women.
Medical care visits: 67,651
89,854 STD screenings
12,936 pregnancy tests
4,406 pap exams
5,382 breast exams
$8.3 million in discounted and free health care provided

PLANNED PARENTHOOD SERVICES

Primary Medical Care
Care to men and women regardless of health insurance status; services include well woman visits, HPV and Hepatitis A & B immunizations, cervical, breast, colorectal and testicular cancer screenings, pap exams, flu vaccines, high blood pressure, thyroid, cholesterol and diabetes screenings, PrEP and PEP, and trans-inclusive healthcare including hormone therapy

Health Care Education
Peer sexuality education for high school students and community-based sexuality education

Family Planning Services
Services such as contraception, STD/HIV testing and treatment, emergency contraception

NCH north country healthcare | Weeks Medical Center

Weeks Medical Center
Michael Lee, President
173 Middle Street, Lancaster, NH
603-788-4911
1-800-750-2366 (In NH only)
www.weeksmedical.org

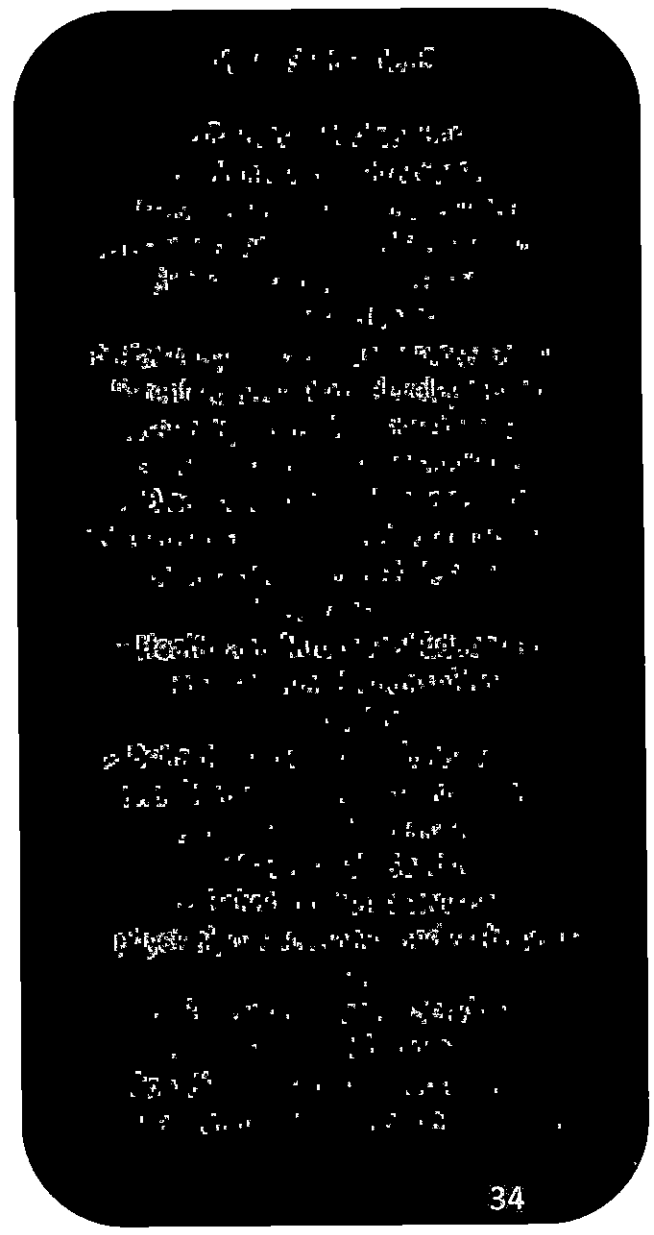
Locations:
Groveton Physicians Office: 47 Church St.
Lancaster Physicians Office: 173 Middle St.
North Stratford Physicians Office: 43 Main St.
Whitefield Physicians Office: 8 Clover Lane

ABOUT OUR CLIENTS
Where They Live: Patients come from North Country towns of New Hampshire and Vermont.
Insurance Status:
5% were uninsured.
21% were covered by Medicaid.
28% were covered by Medicare.
46% had private insurance.

NUMBERS OF CHILDREN AND ADULTS SERVED
Total Patients: 10,228
Total Visits: 57,490

GROWING DEMAND (2017-2018)
1% increase in insured patients
3% increase in patient encounters
8% increase in patients
0% increase in Medicare patients
3% increase in Medicaid patients

HIGHLIGHTS IN WEEKS HISTORY
1996: Weeks Names Lars Nielson, MD New Chief Medical Officer
2006: Weeks Auxiliary Raises $22,000 for Artery Disease Test Equipment
2007: Weeks installs Baby Abduction Protection System
2008: Weeks Auxiliary donates $26,795.00 for the purchase of a Glidescope for the Emergency Dept., Recumbent bike for Rehab, and a portable ventilator for Respiratory.
2009: Weeks Auxiliary donates $ $47, 797.00 for the purchase of a Bladder Scanner for Nursing, 2 Echocardiology beds, Small Joint Arthroplasty Equipment for OR and two transport monitors for Med-Surg.
2010: Weeks Auxiliary donates $16,547.00 for the purchase of 4 CADD Pumps for Med-surg.
2011: Weeks Auxiliary donates $19,335.00 for the purchase of a Spirometry for the Whitefield Physician Office, Renovated the Quiet room at the hospital and helped the Gift Shop purchase a Point of Sale System.
2012: Weeks Auxiliary donates $19,695.00 for the purchase of 3 Ceiling Lifts for Med-surg.
2013: Weeks Auxiliary donates $14,598.00 for the purchase of Volunteer Smocks, Blanket Warmer Oncology, Ceiling lift for Med-surg.
2014: Weeks Auxiliary donates $26,000.00 for the hospital parking lot renovation project.
2015: Weeks Auxiliary donates $15,000 for hospital cafeteria renovations.
2016: Weeks Auxiliary donates $21,600.00 for the purchase of a Glidescope for the Emergency Department and 10 Elevated Chairs for the Physician Offices and Hospital Lobby.
2017: Weeks Auxiliary donates $5,150.00 for the purchase of communication white boards for patient rooms and $7,500.00 for a ceiling lift for med-surg. They also gave the Gift Shop $10,000 to upgrade their Point of Sale System.
2018 & 2019: Weeks Auxiliary donates a total of $60,000 to the new Lancaster Patient Care Center Building (45,000square feet) completed in December 2019.
2019: The new Lancaster Patient Care Center opened.



WHITE MOUNTAIN COMMUNITY HEALTH CENTER

Whole Person. Whole Family. Whole Valley.

White Mountain Community Health Center
Kenneth "JR" Porter, Executive Director
298 White Mountain Highway, Conway, NH 03818
603-447-8900
www.whitemountainhealth.org

ABOUT OUR CLIENTS
Where They Live: Patients come from nine rural New Hampshire communities in northern Carroll County, as well as from neighboring Maine towns.
Socioeconomic Status: 76% of White Mountain Community Health Center patients are at or below 200% of the federal poverty level ($40,840 or less for a family of 3).

Insurance Status (2018):
7% were covered by Medicare.
22% were uninsured.
26% had private insurance, including Medicaid Expansion products.
45% were covered by Medicaid.

FINANCIAL INFORMATION
Full-Time Employees: 19
Annual Savings to health care system (2014): $3.8 million dollars ($1,263 saved per person)

NUMBERS OF CHILDREN AND ADULTS SERVED
Health care users: 2,626
Patient care visits: 9,439

HIGHLIGHTS IN WMCHC HISTORY
2000: White Mountain Community Health Center is established (Children's Health Center, established in 1968, and Family Health Center, established in 1981, merge)
2005: Began offering dental hygiene services, both on site and through a school-based program
2017: Medication-assisted treatment for substance abuse disorder added
2018: Designated a Federally Qualified Health Center Look-Alike

CHANGING WITH THE COMMUNITY NEEDS
White Mountain Community Health Center screens all patients age 12 and older for depression and substance misuse annually. Families of children with mild to moderate iron deficiency anemia are not only educated about nutritional changes, they are also provided with a Lucky Iron Fish to assist with iron supplementation. Using a daily supply of drinking water that has been prepared using the Iron Fish can help raise iron levels without the uncomfortable side effects sometimes seen with iron supplements. Hepatitis C treatment is available through telemedicine appointments with a specialist at Dartmouth-Hitchcock.

WHITE MOUNTAIN SERVICES

- **Primary Medical Care**
- **Dental Services:** Children's full-service program and adult hygiene
- **Prenatal Care:** Comprehensive care with two certified nurse midwifes and deliveries at Memorial Hospital
- **Family Planning Services**
- **Teen Walk-in Clinic:** A safe and confidential

place for teens, with a teen educator on staff

- **HIV/STD Testing**
- **Nutrition Counseling**
- **Social Services and Case Management:**

Assistance with obtaining fuel, food, or housing assistance, care coordination and case management, with social workers and a community health worker on staff.

- **Mental Health Services:** Short-term mental health counseling
- **Substance Misuse Treatment:** Medication-assisted treatment with integrated social work
- **Affordable Healthcare Assister:**

Free one-on-one help enrolling in affordable health insurance programs and accessing other programs to make healthcare affordable, including the Medication Bridge Program

- **Private Assistance Funds:** To help reduce other barriers to care, such as diabetes supplies and transportation

Resources

FQHC Federal Requirements

Federally Qualified Health Centers (FQHCs) are health care practices that have a mission to provide high quality, comprehensive primary care and preventive services regardless of their patients' ability to pay or insurance coverage. FQHCs must successfully compete in a national competition for FQHC designation and funding. Additionally, they must be located in federally-designated medically underserved areas and/or serve federally-designated medically underserved populations. FQHCs submit extensive financial and clinical quality data to their federal regulators annually, the Health Resources and Services Administration (HRSA) in a submission called UDS. HRSA regulators audit each FQHC with a multi-day onsite visit every three years.

Per Federal Regulations, FQHCs must comply with 90+ requirements. In summary, they must:

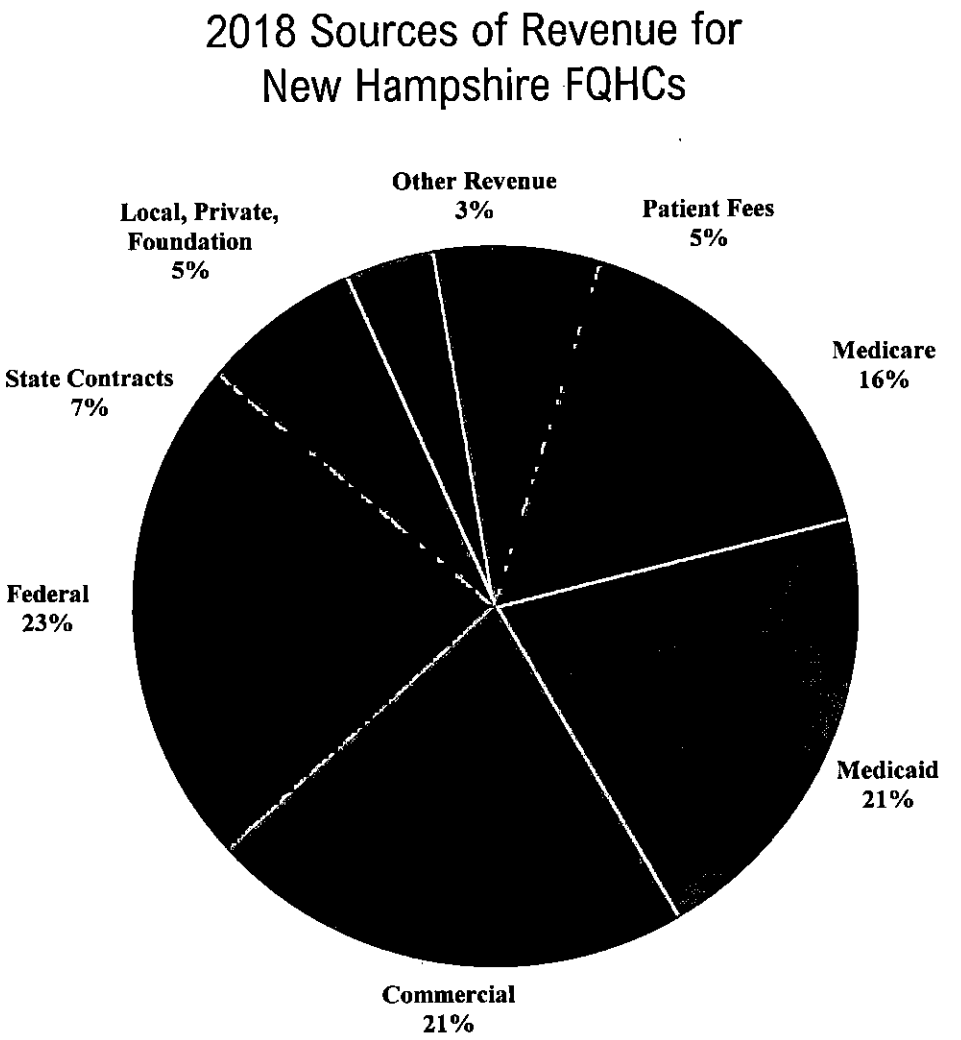
- Provide all required primary, preventive, enabling health services (either directly or through established referrals).
- Ensure a majority of board members for each health center are patients of the health center. The board, as a whole, must represent the individuals being served by the health center in terms of demographic factors such as race, ethnicity, and sex.
- Provide services at times and locations that assure accessibility and meet the needs of the population to be served.
- Have a system in place to determine eligibility for patient discounts adjusted on the basis of the patient's ability to pay. No patient will be denied services based on inability to pay.
- Maintain a core staff as necessary to carry out all required primary, preventive, enabling, and additional health services. Staff must be appropriately credentialed and licensed.
- Document the needs of their target populations.
- Provide professional coverage during hours when the health center is closed.
- Ensure their physicians have admitting privileges at one or more referral hospitals to ensure continuity of care. Health centers must firmly establish arrangements for hospitalization, discharge planning, and patient tracking.
- Have an ongoing Quality Improvement/Quality Assurance program.
- Exercise appropriate oversight and authority over all contracted services.
- Make efforts to establish and maintain collaborative relationships with other health care providers.
- Maintain accounting and internal control systems to safeguard assets and maintain financial stability.
- Have systems in place to maximize collections and reimbursement for costs in providing health services.
- Develop annual budgets that reflect the cost of operations, expenses, and revenues necessary to accomplish the service delivery plans.
- Have systems which accurately collect and organize data for reporting and which support management decision-making.
- Ensure governing boards maintain appropriate authority to oversee operations.
- Ensure bylaws and/or policies are in place that prohibit conflict of interest by board members, employees, consultants, and those who furnish goods or services to the health center.

Summary of Health Center Program Compliance Manual Requirements. (November 2018) from Bureau of Primary Health Care, Health Resources and Services Administration, https://bphc.hrsa.gov/programrequirements/index.html

FQHC Funding

FQHCs are eligible to receive federal appropriations to support services that are not reimbursed by Medicaid, Medicare, commercial payers, and patient self-pay. Some of these services may include care provided to uninsured and underinsured low-income patients and enabling services, outreach, transportation, and interpretation.

- Federal FQHC grants are awarded based upon a very competitive national application process.
- When FQHCs are awarded federal funds, they must meet strict program, performance, and accountability standards. Almost 100 additional regulations are connected to FQHC status.
- Federal FQHC appropriations are not transferable to any other entity.
- Medicare and Medicaid FQHC reimbursement is a prospective encounter rate.
- FQHCs bill commercial insurers just like any other primary care practice.
- No payer reimburses FQHCs for their full costs.



FQHC Sliding Fee Scale

NH FQHCs discounted over $11.5 million in 2018.*

- FQHCs must provide the patients in their service area access to services regardless of their ability to pay and must develop a schedule of fees or payments, called a sliding fee scale, for the services they provide to ensure that the cost for services not covered by insurance are discounted on the basis of the patient's ability to pay, for those with incomes below 200% of the Federal Poverty Level (FPL).
- Ability to pay is determined by a patient's annual income and household size according to the most recent U.S. Department of Health & Human Services Federal Poverty Guidelines.

Example of Sliding Fee Schedule**

Sliding Fee Schedule (SFS) Example One

Annual Income Thresholds by Sliding Fee Discount Pay Class and Percent Poverty						
Poverty Level*	At or Below 100%	125%	150%	175%	200%	Above 200%
Family Size	Charge					
	Nominal Fee ($5)	20% pay	40% pay	60% pay	80% pay	100% pay
1	0-$12,490	$12,491-$15,613	$15,614-$18,735	$18,736-$21,858	$21,859-$24,980	$24,981+
2	0-$16,910	$16,911-$21,138	$21,139-$25,365	$25,366-$29,593	$29,594-$33,820	$33,821+
3	0-$21,330	$21,331-$26,663	$26,664-$31,995	$31,996-$37,328	$37,329-$42,660	$42,661+
4	0-$25,750	$25,751-$32,188	$32,189-$38,625	$38,626-$45,063	$45,064-$51,500	$51,501+
5	0-$30,170	$30,171-$37,713	$37,714-$45,255	$45,256-$52,798	$52,799-$60,340	$60,341+
6	0-$34,590	$34,591-$43,238	$43,239-$51,885	$51,886-$60,533	$60,534-$69,180	$69,181+
7	0-$39,010	$39,011-$48,763	$48,764-$58,515	$58,516-$68,268	$68,269-$78,020	$78,021+
8	0-$43,430	$43,431-$54,288	$54,289-$65,145	$65,146-$76,003	$76,004-$86,860	$86,861+
For each additional person, add	$4,420	$5,525	$6,630	$7,735	$8,840	$8,840

2018 NH UDS Data*
NHSC Sliding Fee Discount Schedule Information Package Revised June 2018;
Poverty level is based on ASPE 2018 Federal Poverty Guidelines**

Acknowledgements

Special thanks to our New Hampshire Bi-State Members for providing high quality health care in their communities and valuable data for the Primary Care Sourcebook.

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Special Thanks to Our Sponsor:

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Information and data in the print version of the Sourcebook is updated as of January 2020.
For online version visit www.bistatepca.org.

Voting Sheets

Senate Commerce Committee
EXECUTIVE SESSION RECORD
2019-2020 Session

Bill # SB 486-FN

Hearing date: 2/18/20

Executive Session date: 3/3/20

Motion of: OTP **Vote:** 3-2

Committee Member	Made by	Second	Yes	No
Sen. Cavanaugh, Chair	☐	☑	☑	☐
Sen. Morgan, V- Chair	☐	☐	☑	☐
Sen. French	☐	☐	☐	☑
Sen. Morse	☐	☐	☐	☑
Sen. Soucy	☑	☐	☑	☐

Motion of: _____ **Vote:** _____

Committee Member	Made by	Second	Yes	No
Sen. Cavanaugh, Chair	☐	☐	☐	☐
Sen. Morgan, V-Chair	☐	☐	☐	☐
Sen. French	☐	☐	☐	☐
Sen. Morse	☐	☐	☐	☐
Sen. Soucy	☐	☐	☐	☐

Motion of: _____ **Vote:** _____

Committee Member	Made by	Second	Yes	No
Sen. Cavanaugh. Chair	☐	☐	☐	☐
Sen. Morgan, V- Chair	☐	☐	☐	☐
Sen. French	☐	☐	☐	☐
Sen. Morse	☐	☐	☐	☐
Sen. Soucy	☐	☐	☐	☐

Reported out by: Sen Cavanaugh

Notes: _____

Committee Report

STATE OF NEW HAMPSHIRE

SENATE

REPORT OF THE COMMITTEE

Wednesday, March 4, 2020

THE COMMITTEE ON Commerce

to which was referred **SB 486-FN**

AN ACT relative to insurance plans that cover maternity benefits.

Having considered the same, the committee recommends that the Bill

OUGHT TO PASS

BY A VOTE OF: 3-2

Senator Kevin Cavanaugh
For the Committee

Aaron Jones 271-1403

COMMERCE

SB 486-FN, relative to insurance plans that cover maternity benefits.
Ought to Pass, Vote 3-2.
Senator Kevin Cavanaugh for the committee.

General Court of New Hampshire - Bill Status System

Docket of SB486

Docket Abbreviations

Bill Title: relative to insurance plans that cover maternity benefits.

Official Docket of **SB486.:**

Date	Body	Description
1/14/2020	S	**Introduced** 01/08/2020 and Referred to Commerce; **SJ 2**
2/13/2020	S	**Hearing:** 02/18/2020, Room 100, SH, 02:15 pm; **SC 7**
3/4/2020	S	Committee Report: Ought to Pass, 03/11/2020; **SC 10**
3/11/2020	S	Sen. Birdsell Floor Amendment **#2020-1135s**, **RC** 10Y-14N, AF; 03/11/2020; **SJ 6**
3/11/2020	S	Sen. Giuda Moved Laid on Table, **RC** 10Y-14N, MF; 03/11/2020; **SJ 6**
3/11/2020	S	**Ought to Pass**: **RC** 14Y-10N, MA; OT3rdg; 03/11/2020; **SJ 6**
6/30/2020	H	Introduced and Laid on Table MA VV 06/30/2020

NH House | NH Senate

Other Referrals

Senate Inventory Checklist for Archives

Bill Number: SB 486-FN **Senate Committee:** Commerce

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
N/A 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):

___ - amendment # _____ ___ - amendment # _____
___ - amendment # _____ ___ - 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):

X - amendment # 1135s ___ - 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):
___ Enrolled Bill Amendment(s)
___ Governor's Veto Message

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

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

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

Aaron Jones 7/8/20
Committee Aide **Date**

Senate Clerk's Office _____