Senate Finance Committee

Deb Martone 271-4980

SB 484-FN, prohibiting Medicaid premiums and limiting Medicaid expansion cost sharing.

Hearing Date: January 13, 2026

Time Opened: 2:17 p.m. **Time Closed**: 2:49 p.m.

Members of the Committee Present: Senators Gray, Innis, Birdsell, Pearl, Lang, Rosenwald and Watters

Members of the Committee Absent: Senator Carson

Bill Analysis: This bill repeals premium requirements under the New Hampshire granite advantage health care program and the children's health insurance program. The bill authorizes the department of health and human services to establish cost sharing under expanded Medicaid not to exceed $5 per service.

Sponsors:

Sen. Rosenwald	Sen. Watters	Sen. Perkins Kwoka
Sen. Fenton	Sen. Long	Sen. Prentiss
Sen. Altschiller	Rep. Wallner	Rep. Weber
Rep. Simpson	Rep. Telerski	Rep. Hakken-Phillips

Who supports the bill: Please see Deb Martone, Senate Finance Committee Legislative Aide, for the complete listing of individuals signing in favor of SB 484-FN.

Who opposes the bill: Julie Smith

Who is neutral on the bill: Olivia May; Robert Berry;

Summary of testimony presented in support

Senator Rosenwald, Prime Sponsor:

- SB 484-FN, Lowering the Cost of Health Care Act of 2026, will repeal the Medicaid premiums to be in line with federal law and implement a cap on the amount of cost sharing that will be required by federal law for Medicaid expansion enrollees. This will make health care less expensive for those Granite State families who can least afford the high cost.
- The Medicaid premiums enacted through HB 2 are slated to begin March 1st for certain children, and July 1st for Medicaid expansion enrollees. However, HR1 OBBA prohibits premiums for Medicaid expansion beginning January 1, 2028,

requiring cost sharing for certain services. Instead, states are allowed to set the amount of cost share, but it cannot exceed $35 per service.

- We will incur a cost for premium collection either by changing MMIS or buying a standalone software system. This cost was never accounted for in the budget and will only be used for 18 months before we can't charge premiums but have to collect cost sharing instead. This looks like a waste of money that the Medicaid program already doesn't have enough of. In addition, it is not realistic to expect someone living slightly over the poverty line to be able to pay $35 for every medical service. And some services are carved out. Primary care, prenatal care, mental health, and substance abuse are not subject to cost share, but all specialty services are.
- Think about someone who is on Medicaid expansion having radiation treatments every day for six weeks. The enrollee won't be able to pay $35 per treatment. Therefore, we can expect patients to skip care, or providers to either eat the loss and pass it on to other commercially insured customers. The more likely scenario is to limit the number of Medicaid beneficiaries they're willing to treat. None of these scenarios is a pretty picture for our Medicaid beneficiaries or our health care system.
- If we are required to have cost sharing, it should be low enough to not discourage people from seeking care. Senator Rosenwald suggests a $5 limit. This is similar to the increased drug co-pay that also passed in HB 2.
- When we first began developing Medicaid expansion in 2013, there was bipartisan consensus to avoid premiums because we understood they would be a barrier to enrollment. Last spring, the budget enacted premiums for Medicaid before we knew what Congress was going to do.
- The sensible thing for us to do now is to change course and not waste money on a system we can only use for 18 months.
- In addition, we must be sensitive to how important the issue of high health care costs are to families. SB 484-FN will lower their costs. And, we do have time to see how our revenue picture shapes up.
- Senator Watters inquired about the consequences of our state statute being contradictory to the federal statute on this. When Senator Rosenwald spoke with the Medicaid folks last spring about how we would do it, the choices they told her were either to change MMIS, which we pay $12 million a year for the license. We pay an unbelievable amount of money. We would either have to change that or we would have to buy a standalone system. And all that is fine except we can only use it for 18 months. HR1 says you can't have premiums for Medicaid expansion; but you must have cost share. We didn't know at the time what the federal government was going to tell states to do with their Medicaid programs.

<u>David Trumble, Weare:</u>

- What would it be like for someone who is eligible or would be required to pay this premium? It's set at 100 percent or more of the federal poverty level. For a family of one, that's $15,600. For a family of two, that's $21,150. And for a family of three, it's $26,000. What if you had two or three people in your family?

The monthly premium for that family of two would be $80. That's about $1,000 a year.

- Twenty percent of children in the US between infancy and age five grow up in homes where they live with their mother only. This is a fairly common scenario. If they have an apartment for $1,500 a month, that amounts to $18,000 out of their $21,150. They have $3,000 left for food, phone, electricity, Internet, transportation, and clothing. If they now have to pay a $1,000 premium on top of that, how can they possibly live?
- One of the first things a mother would do would be to stop taking medications, not bother going to the doctor for herself, and get her own healthcare. It's just not a humane or reasonable solution for the state.
- In this state the average person, someone between the 20th and 80th percentile of income, pays about 6.5 percent of their income in state and local taxes. People in the bottom 20 percent pay 9 percent currently. With this premium they would be paying 10-12 percent.
- It doesn't make sense in our state when the wealthiest people only pay two or three percent of their income in taxes, to ask those who have the least to pay even more.
- Parents and children have to be able to eat and have a place to live. They need to have access to health care.
- SB 484-FN would be the responsible, practical, and equitable thing for New Hampshire to do.

<u>James Monahan, Community Behavioral Health Association:</u>

- Mr. Monahan prefaced his remarks by stating he does much work involving Medicaid.
- The ten community mental health centers have concerns and are looking for some guidance.
- Eighty or ninety percent of the revenue that comes to the community mental health centers comes through the Medicaid program. They are very sensitive to changes or impacts on same.
- There is a misalignment when it comes to cost sharing. Under the "One Big Beautiful Bill Act" there is a requirement for cost sharing for the Medicaid expansion populations. It accomplishes that through a co-pay of $35 per encounter. But it does exempt mental health services, primary care, and substance abuse disorder. Those are very important services. If individuals don't receive these services, their illnesses get worse and they become more expensive to take care of. There is some logic to that.
- The way HB 2 approached cost sharing was through the collection of a premium, which does not include these exemptions.
- The Association is looking at preparing for an uncertain future. Will it be the cost sharing or the premiums? And there is a lack of information. Something needs to get worked out. They are hoping SB 484-FN becomes a vehicle to resolve the situation.
- Under state and federal law, mental health centers, FQC's, and hospitals have to care for people regardless of their ability to pay. If someone doesn't pay their premium and they lose their coverage, it becomes uncompensated care for the

community mental health centers. We should try to avoid more uncompensated care.

- Mr. Monahan hopes committee members understand the pending uncertainty for the mental health centers.
- Senator Watters wondered if some program which tries to allow the exceptions for the co-pay program would bring us into better compliance; if we took the categories that they accepted and exempted them. Mr. Monahan was unsure. He thought it would be challenging to do when it comes to premiums because you don't know what service they're going to provide. He does believe there is some logic to making sure the people that truly need these preventative services get them.

Sam Hawkins, NAMI New Hampshire:

- The health policy landscape has been evolving rapidly over the past year both here in New Hampshire and nationally through the most recent state budget, as well as the "One Big Beautiful Bill Act".
- Those at NAMI have been having countless conversations with the people that they serve, people with lived experience with a mental health condition or a substance use disorder, or family members, loved ones with those conditions who are Medicaid enrollees. They are hearing a lot of uncertainty from these folks, due to the confusion between these policies. But it is not just uncertainty.They are hearing that folks are afraid. They're afraid they're going to lose access to the services that keep them and the people they love safe, happy, and well.
- The positive benefits of accessing these services include decreased hospitalization, decreased homelessness, decreased incarceration, cost savings to providers, individuals, and the state. And of course, preventing the tragic loss of life. This is the access we need to protect. SB 484-FN is one step in doing that.
- NAMI, too, is concerned about potential conflicts with the policies contained in the federal act, as it moves away from premiums and toward cost sharing at the point of service. And also in the way that it specifically exempts mental health services and substance use disorder services from cost sharing. Charging folks a premium who are primarily accessing these services could either be in direct conflict with that policy or at least in conflict with the intent of the policy.
- We need to protect access to care.
- Senator Watters inquired if Mr. Hawkins could conceive that a group of NAMI's clients might sue over this issue? Mr. Hawkins indicated it may be an area of concern, the conflict between those policies, especially if it does negatively impact those folks in a way that the policy is not intended.

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

- Most, if not all committee members have a community health center in their district.
- Community health centers in New Hampshire do not benefit from the uncompensated care fund. They are actually regulated by the federal government, not by the state. If SB 484-FN does not pass and there's a conflict between the feds and state statute, which do we expect the community health centers to follow?

- When policy changes affect access to health insurance and health insurance coverage, as well as increased co-pays or premiums, people choose not to have insurance. Community health centers then see increased uncompensated care which affects an individual's ability to access care. This has been seen in the North Country in the last three months. One of the community health centers in Franconia had to shut down a site due to the uncompensated care burden. This also happened at HealthFirst at their Canaan site. They had to shut that site down because of uncompensated care and other issues.
- When we make policy changes like the ones made in HB 2 last year, it has negative consequences on our patients and the health centers who treat them.

Sam Burgess, Healthcare Policy Director, New Futures:

- Premiums and cost sharing cause real, immediate coverage losses. In 2003, Oregon added sliding scale premiums and lockouts. This led to dramatic drops in enrollment for people on Oregon's standard Medicaid plan. Those who lost coverage were four to five times more likely to use the emergency room for their ordinary care. A situation like that will drive up uncompensated care costs for hospitals and care systems that are already under a strain.
- It's also important to note that cost sharing has historically failed to save the state money. Cost sharing does a great job at shifting costs, but not necessarily reducing them.
- Medicaid and CHIP keep our neighbors healthy, stable, and able to work and care for their families.

Bianca Gentil, Advocacy Policy Director, Waypoint:

- Historically, Waypoint has focused on children and families.
- As of November 2025, 176,000+ people were covered under Medicaid in New Hampshire. Of those, almost 86,000 were children.
- Children don't exist in a vacuum. They are often times born into potentially low-income families, which are also on Medicaid. Their care has a direct impact on the wellbeing of children and families in our state.
- Ms. Gentil shared one brief anecdote from an individual in a Waypoint program. This individual was a mother who had fled domestic violence and was struggling to meet her son's significant health needs. By coordinating support with Medicare coverage along with other programs, she was able to access therapy, overcome substance abuse, earn her GED, and reconnect with her family.

Neutral Information Presented:

Robert Berry, General Counsel, DHHS Medicaid Division and Olivia May, Director-Medicaid Enterprise Development:

- The Medicaid Division determined SB 484-FN would result in a $23 million reduction in revenue in 2027/2028. In FY 2029, due to the imposition of the cost sharing it would be a $22,655,75 reduction in revenue.
- The Division is aware of the OBBA provision for cost sharing and the potential guidance it may need from CMS on how to reconcile these policies. They have reached out to CMS.

- Senator Rosenwald asked if the Department has figured out whether to change MMIS or build a freestanding system, and calculated the cost of that for the next 18 months? Director May stated based on where they are today, there is no impact to MMIS to implement premiums. Senator Rosenwald inquired if that was because the managed care companies will collect them. Director May replied they are looking at a few different options for implementation for premiums. But it would be the state collecting premiums, not the managed care entities. The Division would not be using MMIS to collect the premiums. It is primarily done through the eligibility system. Senator Rosenwald asked about the cost and if they had enough employees. Director May indicated they don't have any pending employee requests. And they don't have an estimate at this time of system costs.
- Senator Lang stated we're looking at a $23 million reduction in revenue if we do this. Not only are we going to lose the revenue, we're then going to increase spending by the same amount of money, $23 million, to compensate the Department for the reduction in funding for the Medicaid program. Attorney Berry stated the Department looked at it as a reduction in revenue based on the repeal of the premiums,
- Senator Rosenwald asked if she could look at it as implementing a $23 million cost on low income families. Director May stated the revenue reduction is merely reflecting the revenue amount built into HB 2.
- Senator Watters wondered if it was possible for the Department to speculate on costs that might be caused by implementing the program in HB 2. Attorney Berry was not comfortable speculating on costs. Senator Watters agreed it does become almost impossible to speculate. But it would be helpful if the Department could offer more clarity on the uncompensated care issue, and the community health centers' confusion about which rules they should follow. They don't receive uncompensated care funding. Senator Watters would like to see if there is a way to help them understand what they should do. Should we find a way to give them uncompensated care? It might be helpful for us to understand what the consequences will be of what we passed in HB2.

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