

Special points of interest:

- Health Care Reform Law
- Coverage of Dependent Children to Age Twenty-Six
- Over-the-Counter (OTC) Drugs
- Tax Credit for Small Employers
- COBRA Premium Subsidy Extension
- Actions Needed
- Industry Trends

Quarterly Newsletter

HEALTH CARE REFORM LAW

The Patient Protection and Affordable Care Act ("PPACA") was signed into law on March 23, 2010. The related Health Care and Education Reconciliation Act of 2010 ("HCERA"), which modified certain provisions of PPACA, was signed into law on March 30, 2010. These two statutes make important changes to existing law governing employer sponsored Group Health Plans.

While some of the more significant provisions included in the new Health Care Reform Law will not go into effect until January 1, 2014 and beyond, there are some mandates that will become effective by the end of 2010. Regulatory agencies are working and plan to issue guidelines within the next sixty days regarding the implementation of these initial mandates. This Newsletter will focus on some of the more immediate upcoming changes.

PPACA includes a rule for "Grandfathered Health Plans" which prevents some of the provisions of PPACA from applying to Group Health Plans that were in effect on the date of enactment, March 23, 2010. HCERA curtailed the "Grandfather" rule by applying some, but not all of the mandates to "Grandfathered" Plans. An issue that needs to be determined by further regulations is whether a "Grandfathered" Plan will remain "Grandfathered" if it is amended significantly with a new Plan design and also what will make a Plan lose their "Grandfather" status.

Initial changes required for "Grandfathered" Group Health Plans, effective with the first Plan Year that begins on or after September 23, 2010, include the following:

- Restricted annual limits on essential health benefits;
- No lifetime limits on essential health benefits;

Health and Human Services (HHS) has yet to define "essential health benefits"; however currently the following services are to be included:

1. Ambulatory services;
2. Emergency services;
3. Hospitalization;
4. Maternity & newborn care;
5. Mental health and substance abuse;
6. Prescription drugs;
7. Rehabilitative & habilitative services;
8. Laboratory services;
9. Preventive & wellness services and chronic disease management; and
10. Pediatric services, including oral & vision care

- No rescissions of coverage (except for fraud or misrepresentation);
- Extension of coverage to adult children up to age 26; (detailed information follows below)
- No pre-existing condition limitation applied to participants under 19 years of age.

DEPENDENT COVERAGE of CHILDREN to AGE 26

Source: SPBA

The regulatory agencies (IRS, DOL, and HHS) have just released Interim Final Rules to provide guidance on the implementation of the dependent coverage provision of PPACA. These regulations provide that a Group Health Plan offering dependent coverage of children must make such coverage available for children until they attain 26 years of age. This provision is effective for Plan years beginning on or after September 23, 2010. This provision does not mandate Plans to provide dependent child coverage; it only applies if a Plan already offers dependent child coverage.

Restrictions on Plan Definition of Dependent.

With respect to a child who has not attained age 26, a Group Health Plan may not define dependent for purposes of eligibility for dependent coverage of children, other than in terms of a relationship between a child and the participant. A Group Health Plan may not deny or restrict coverage for a child who has not attained age 26 based on the presence or absence of the child's financial dependency, residency with the participant or with any other person, student status, employment, marriage or any combination of those factors.

In addition, a Group Health Plan may not deny or restrict coverage of a child based on eligibility for other coverage (except where the "special rule" applies). The "special rule" applies to "Grandfathered Health Plans" for Plan years beginning before January 1, 2014. Under the "special rule," a "grandfathered health Plan" may exclude from coverage an adult child who has not attained age 26 if the adult child is eligible to enroll in an employer-sponsored health Plan other than the Group Health Plan of a parent.

New Enrollment Opportunity Created. The Interim Final Regulations require a Plan to give eligible children, who were dropped from the Plan due to a failure to satisfy a dependent status condition, an opportunity to enroll in the Plan. This new enrollment opportunity must continue for at least 30 days. Coverage must begin not later than the first day of the first Plan year beginning on or after September 23, 2010, even if the request for enrollment is made after the first day of the Plan year. Any child enrolling under this provision must be given the same treatment as HIPAA special enrollees: the child must be offered the same benefit packages and charged the same as similarly situated individuals who did not lose coverage.

New Written Notice Required. A New Written Notice explaining the new enrollment opportunity must be provided not later than the first day of the first Plan year beginning on or after September 23, 2010. Plans will want to send this notice well before the first day of the first Plan year beginning on or after September 23 so they can avoid retroactive coverage.

When Must the New Enrollment Period Be Provided? The opportunity to enroll must be provided not later than the first day of the first Plan year beginning on or after September 23, 2010. The written notice of the new enrollment opportunity must be provided in a similar timeframe.

Content of Written Notice. The written notice must include a statement that children whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in the Plan. The notice may be included with other enrollment materials that Plans distribute to employees, provided the statement is prominent.

Parent Not Enrolled. If a parent is not enrolled in the Plan but is otherwise eligible and a child qualifies for the new enrollment opportunity, the Plan must provide an opportunity to enroll the parent, in addition to the child.

Switch Benefit Package Option. The Plan must provide an opportunity to enroll the child in any benefit package option for which the child is otherwise eligible; thereby allowing the parent to switch benefit package options.

Child on COBRA. A child who qualifies for the New Enrollment Opportunity and is currently covered under COBRA must be given the opportunity to enroll as a dependent of an active employee.

Child Never Enrolled. Children, not yet 26, who never enrolled because the children were too old under the terms of the Plan, must be given an opportunity to enroll.

Coverage of Grandchildren Not Required. The interim final rules clarify that PPACA does not require coverage of grandchildren.

Adult Child Eligible for Both Parents Plans. In the case of an adult child who is eligible for coverage under the Plans of the employers of both parents, neither Plan may exclude the adult child from coverage based on the fact that the adult child is eligible to enroll in the Plan of the other parents' employer.

Additional Upcoming Changes

OVER-THE-COUNTER (OTC) DRUGS AND MEDICATIONS CHANGE EFFECTIVE JANUARY 1, 2011

Another provision of PPACA amends the definition of qualified medical expenses for a Flexible Spending Account (FSA), Health Savings Account (HSA) or a Health Reimbursement Account (HRA). Effective January 1, 2011, OTC drugs except for insulin, cannot be reimbursed from an FSA, HSA or HRA unless they are accompanied by a doctor's prescription. Items like adult diapers, blood glucose monitors, and diabetic test strips can still be purchased on a pre-tax basis without a doctor's prescription.

Participant's that utilize a healthcare debit card will no longer be able to use their card at the drug store or pharmacy for OTC drugs. They would need to obtain a prescription from their doctor and turn in a paper claim to their administrator along with the doctor's prescription.

TAX TREATMENT OF EMPLOYER-PROVIDED HEALTH BENEFITS FOR CHILDREN UNDER AGE 27 CHANGE EFFECTIVE MARCH 30, 2010

Source: EBIA

Recent Health Care Reform legislation generally requires Group Health Plans offering dependent coverage for children to continue providing that coverage for adult children until age 26. The legislation also extends Code Section 105(b) income exclusion for medical care expense reimbursements under an employer-provided accident or health Plan, to employees' children who are under age 27 as of the end of the taxable year.

Effective Date. The tax treatment changes are effective March 30, 2010. In contrast, the requirement to provide coverage for children who have not attained age 26 is effective for Plan years beginning on or after September 23, 2010.

Exclusion for Reimbursements. The exclusion for medical care reimbursements applies to an employee's child who is under age 27 during the entire taxable year, even if the child does not qualify as the employee's tax dependent. For this purpose, the term "child" includes children, stepchildren, legally adopted children, children placed with the employee for adoption, and eligible foster children. The taxable year is the employee's taxable year, which employers may assume is the calendar year. Employers may rely on an employee's representation as to a child's date of birth.

Exclusion for Coverage. On and after March 30, 2010, employer provided accident or health coverage for an employee's child who is under age 27 as of the end of the taxable year is also excluded from the employee's gross income.

The IRS intends to amend the regulations under Code Section 106 retroactively to March 30, 2010, to provide for this exclusion. Taxpayers can rely on the Notice until amended regulations are issued.

Health FSAs, HRAs, and Cafeteria Plans. Health FSAs and HRAs can offer tax-advantaged coverage and reimbursements for children who are under age 27 as of the end of the employee's taxable year. Employers may permit employees to immediately begin making pre-tax salary reductions for accident or health benefits (including health FSAs) for these children even if the cafeteria Plan has not yet been amended to include them, so long as a retroactive amendment is made no later than December 31, 2010. The IRS intends to amend the permitted election change regulations, retroactively to March 30, 2010, to include a change in status events affecting nondependent children under age 27 (e.g., a child's becoming newly eligible for coverage or eligible for coverage beyond the date on which coverage would otherwise have been lost).

Employment Taxes. The guidance clarifies that coverage and reimbursements under an employer-provided accident or health Plan for an employee's child are excluded from wages for FICA and FUTA purposes, without application of any age limit, residency, support, or other test.

Further information can be found at:
<http://www.irs.gov/pub/irs-news/ir-10-053.pdf>

NEW TAX CREDIT FOR SMALL EMPLOYERS EFFECTIVE 2010

Source: EBIA

The Patient Protection and Affordable Care Act (PPACA), added a new small employer tax credit for small businesses and tax-exempt organizations that provide health coverage to their employees.

Background. Beginning in 2010, the small employer tax credit (new Code Section 45R) is available to employers that (1) have fewer than 25 full-time equivalent (FTE) employees, (2) pay average annual wages of less than \$50,000 per FTE, and (3) contribute a uniform percentage of at least 50% of the premium cost of single coverage for enrolled employees. (For purposes of the credit, a premium paid by a salary reduction arrangement under a cafeteria Plan is not treated as paid by the employer.) The maximum credit available for tax years 2010 through 2013 is 35% of premiums paid (25% for eligible small tax-exempt employers), but that amount is available only for employers with 10 or fewer FTEs and average annual wages of \$25,000 or less. The tax credit then phases out for employers with between 10 and 25 FTEs and those with annual average wages between \$25,000 and \$50,000. Starting in 2014, the maximum credit increases to 50% of premiums paid (35% for eligible small tax-exempt employers).

The Frequently Asked Questions (FAQs) provide some helpful details about how the credit works, including what employers are eligible, how the credit is calculated, how average annual wages and FTEs are determined (including treatment of part-time and seasonal workers), and how the credit is claimed. IRS will use postcards to contact millions of small businesses to encourage them to take advantage of this credit. **Please see attachment that can be used to determine if you qualify for the tax**

credit for small employers. Additional information including the FAQs is available at:

<http://www.irs.gov/newsroom/article/0,,id=220848,00.html>

EARLY RETIREE REINSURANCE PROGRAM EFFECTIVE JUNE 2010

The Patient Protection and Affordable Care Act ("PPACA") includes a temporary program for the reimbursement of participating Plan sponsors who provide health coverage to early retirees. The program which has been appropriated \$5 billion will be administered by the U.S. Department of Health and Human Services (HHS). Under the program, Plan sponsors who have been certified by HHS may receive reimbursement for 80% of certain early retiree claims. One of the purposes for this program was to provide a bridge until health care exchanges become available in 2014 at which time retirees will have more options.

Early Retiree Defined. "Early retirees" for this purpose generally are participants in an employer sponsored health Plan who are age 55 or older, are not active employees, and are not eligible for Medicare. The term includes the spouse and other dependents of the retiree, regardless of their age and Medicare eligibility. "Dependent" is defined by the terms of the Plan, not by the federal tax code.

Amount of Reimbursement. For each early retiree, a Plan sponsor may receive reimbursement of 80% of the claims costs for health benefits exceeding \$15,000, but not exceeding \$90,000, during the Plan Year. "Health benefits" is broadly defined in the regulations to include benefits for the "diagnosis, cure, mitigation, or prevention of physical or mental disease". Claims submitted under the program must be based on the actual amount expended by the participating employment-based Plan within the Plan year. In determining the amount of a claim, the Plan must take into account any negotiated price concessions (such as discounts, direct or indirect subsidies, rebates, and direct or indirect remunerations) obtained by the Plan with respect to the health benefit. The costs paid by the early retiree or the retiree's spouse, surviving spouse, or dependent in the form of deductibles, co-payments, or co-insurance must be included in the amounts paid by the participating employment-based Plan for purposes of determining the amount of the claim.

Required Programs and Procedures. To qualify for the program, the sponsor's Plan must include programs and procedures that generate (or have the potential to generate) cost savings with respect to participants with chronic and high-cost conditions. These policies and procedures need not be newly created for the program. The sponsor must have a written agreement with its Plan or insurer to make required disclosures including disclosures of health information protected by HIPAA, and must maintain policies and procedures to detect and reduce fraud and abuse.

Application Process for the Plan. Before submitting a claim, a Plan and its sponsor must be certified by HHS. To become certified, the Plan sponsor must submit a detailed application. Applications will be available by the end of June. Among other things, the Plans sponsor must designate the Plan years covered by the application and must include the projected reimbursement amounts for each of the first two Plan year cycles. Applications will be processed in the order received. If an application does

not satisfy all of the requirements, it will be rejected and the Plan Sponsor will need to submit a new application which will then be placed at the "end of the line". Plan sponsors may submit claims for Plan years that begin before June 1, 2010; however, costs incurred prior to June 1, 2010 can be used only to satisfy the \$15,000 cost threshold, costs incurred after June 1 may be reimbursed (once the \$15,000 threshold is met and up to the \$90,000 maximum).

Required Use of Reimbursements. Amounts paid to a participating employment-based Plan must be used to lower costs for the Plan. Such payments may be used to reduce premium costs, premium contributions, co-payments, deductibles, co-insurance or other out-of-pocket costs for Plan participants. Such payments must not be used as general revenue for the sponsoring employer. HHS will develop a mechanism to monitor the appropriate use of such payments by employers and Plans.

Appeals for Claim Determination. HHS will establish an appeals process to permit participating employment based Plans to appeal a determination made with respect to a claim; in addition HHS will conduct annual audits of claims data submitted by participating employment based Plans to ensure that such Plans are in compliance.

Officials at HHS have acknowledged that the \$5 billion in appropriated funds could well run out before the program's expiration date of January 1, 2014.

Additional information regarding this new program is available by going to the website at www.hhs.gov.

JUST A REMINDER

COBRA PREMIUM SUBSIDY EXTENSION

The American Recovery and Reinvestment Act of 2009 (ARRA), which was enacted in February 2009, provides a government paid subsidy of 65% of the COBRA cost for certain qualified beneficiaries whose loss of health coverage results from an involuntary termination of employment. Initially, to be eligible for the subsidy, an individual needed to be a qualified beneficiary because of an involuntary termination during the period from September 1, 2008 through December 31, 2009.

An initial extension of the subsidy period was signed into law on December 19, 2009 as part of the Department of Defense Appropriations Act, 2010. The Act extended the eligibility period for the ARRA premium reduction for an additional two months (from December 31, 2009 through Feb. 28, 2010) and the maximum period for receiving the subsidy to an additional six (6) months (from nine to fifteen months).

A subsequent extension of the subsidy period was signed into law on March 2, 2010 as part of the Temporary Extension Act of 2010 (TEA). The Act extended the eligibility period for the ARRA premium reduction for an additional month (from February 28, 2010 through March 31, 2010). TEA also provides that an involuntary termination of employment is a qualifying event for purposes of ARRA, if the involuntary termination follows a qualifying event that was a reduction of hours that occurred at any time from September 1, 2008 through March 31, 2010.

The most recent extension was signed into law on April 15,

2010. President Obama signed HR 4851 ("Continuing Extension Act of 2010"). The Act extends the eligibility period for the ARRA premium reduction for an additional two months (from April 1, 2010 through May 31, 2010) and maintains the provision that an involuntary termination of employment is a qualifying event for purposes of ARRA if the involuntary termination follows a qualifying event that was a reduction of hours that occurred at any time from September 1, 2008 through May 31, 2010.

Congress is currently considering another extension of the COBRA subsidy for individuals involuntarily terminated that would extend the subsidy through the end of 2010.

The Department of Labor has updated its COBRA Premium Reduction Fact Sheet that incorporates the latest changes.

The DOL Fact Sheet can be found at: <http://www.dol.gov/ebsa/newsroom/fscobrapremiumreduction.html>

In addition the DOL has issued revised model COBRA notices.

COBRA Model Notices can be found at: <http://www.dol.gov/ebsa/COBRAmodelnotice.html>

ACTIONS NEEDED

CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT OF 2009 (CHIPRA) MODEL NOTICES

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), which extended and expanded the state Children's Health Insurance Program (CHIP) became effective April 1, 2009. One provision of this law allows states to subsidize premiums for employer provided Group Health Plan coverage for eligible children and families.

The U.S. Department of Labor (DOL) has recently issued the sample Employer CHIP Notice to meet the new notice requirement under CHIPRA.

If a Group Health Plan provides benefits for medical care to participants or dependents in a state that provides a premium assistance subsidy for the purchase of Group Health Plan coverage, the employer sponsoring the Plan is required to meet the CHIPRA notice requirements (Employer CHIP Notice).

The Employer CHIP Notice must be provided annually, on an automatic basis and free of charge. It must inform each employee, regardless of whether the employee is enrolled in the Group Health Plan, of potential opportunities for premium assistance in the state in which the employee resides. Because the state in which the employee resides may or may not be the same as the state in which the employer or the Group Health Plan, are located, the DOL designed the model Employer CHIP Notice as a national notice to cover an array of situations where employees (or their families) entitled to the notice may reside in various states. The model Employer CHIP Notice, which is available on the DOL's website (a Spanish version is also available), provides a list of states along with contact information (current as of April 16, 2010) that offer qualifying premium assistance programs. A copy of the most recent Notice is attached. The DOL intends to update this list annually on its Web site at: http://www.dol.gov/ebsa/compliance_assistance.html#section2

The initial Employer CHIP Notice must be provided to employees by the date that is the later of: (i) the first day of the first Plan Year after February 4, 2010; or (ii) May 1, 2010. So, for Plan Years beginning March 1, 2010, April 1, 2010 or May 1, 2010 the notice must be provided by May 1, 2010. For Plans with a Plan Year that begins ON January 1, 2011 the initial Employer CHIP Notice must be sent no later than January 1, 2011. (More information can be found in the March 1, 2010 BAS Client Alert)

INDUSTRY TRENDS

SCREENING FOR DIABETES HIGHLY COST EFFECTIVE, STUDY FINDS

SOURCE: American Diabetes Association

Though some professional organizations recommend routine screening for type 2 diabetes, research now confirms it not only helps prevent or delay illness, it is also highly cost effective, according to a study commissioned by the American Diabetes Association.

Using a highly detailed mathematical model, the study concluded that early screening could greatly reduce diabetes-related complications at reasonable cost and also substantially reduce mortality.

"This study confirmed for us what we have long believed to be true but have never been able to show in clinical trials," said John Buse, MD, PhD, former President, Medicine and Science of the American Diabetes Association and an author of the paper.

Because there are few symptoms in the early stages of development, diabetes can go undiagnosed for up to 10 years, while rising blood glucose levels begin to cause damage to the body. This can lead to costly and potentially devastating complications such as heart disease and stroke, kidney failure, blindness, and problems with the nerves, especially in the lower extremities, leading to risk of amputations. However, if blood glucose levels are properly controlled, people with diabetes can successfully prevent or delay complications of the disease.

For this reason, the American Diabetes Association has long recommended that adults be screened for diabetes starting by at least age 45 with the test repeated every three years. Younger adults with diabetes risk factors, such as obesity or family history, should begin screenings earlier. However, there have been no randomized, controlled trials to support this recommendation because such trials would be prohibitively expensive, requiring thousands of people without diabetes to be followed for decades.

Each of the screening strategies reduced rates of heart attacks and diabetes-related complications (such as blindness, amputation and kidney failure) and most reduced death rates. Compared to no screening, most of the strategies were highly cost effective.

"Clearly there is value to diabetes screening starting between the age of 30 and 45, as recommended by the American Diabetes Association, in terms of the quality of a person's life due to earlier diagnosis and the ability to prevent complications," said Buse. "This model now suggests for us that there is a financial value to diabetes screening as well."

ILLINOIS HOSPITALS MAKE THE GRADE

Source: Illinois Statehouse News

Illinois residents now have the opportunity to evaluate the quality of their community hospitals with the Department of Public Health's latest Hospital Report Card.

The report looks at mortality rates, surgical care quality and customer satisfaction at every hospital statewide from July 2008 to July 2009. The report represents a combination of data collected by two federal agencies: the U.S. Department of Health and Human Services and the Centers for Medicare & Medicaid Services.

Illinois met most national averages evaluating the quality of its medical care. In fact, the state's handling of cases involving heart failure had a success rate of nearly 90 percent—five points better than national averages.

However, there is room for improvement in patient care. Sixty-three percent of Illinois patients described their hospital visit as "highly satisfactory," on par with national averages.

Some hospitals, however, face a larger gap between the quality of clinical care and patient satisfaction.

The Illinois Hospital Association, which represents more than 200 hospitals and healthcare facilities, also praised the reports and the department for its collaborative work with hospitals. "We've been very supportive of helping consumers be more informed, to be able to obtain the information they need to make healthcare decisions," association spokesman Danny Chun said.

The full report is available at:
<http://www.healthcarereportcard.illinois.gov>

Note: BAS recognizes the complexity of the Health Care Reform Law and will continue to review and analyze information as it becomes available through the various regulatory agencies who issues guidance. BAS will continue to inform Clients and Brokers as information is released and draft amendments where applicable

3 SIMPLE STEPS

If you are a small employer (business or tax-exempt) that provides health insurance coverage to your employees, determine if you may qualify for the **Small Business Health Care Tax Credit** by following these three simple steps:

1

Determine the total number of your employees (not counting owners or family members):

Full-time employees: _____
(enter the number of employees who work at least 40 hours per week)

+

Full-time equivalent of part-time employees: _____
(Calculate the number of full-time equivalents by dividing the total annual hours of part-time employees by 2080.)

= total employees

If the total number of employees is fewer than 25 **GO TO STEP 2**

2

Calculate the average annual wages of employees (not counting owners or family members):

Take the total annual wages paid to employees: _____

÷

Divide it by the number of employees from STEP 1: _____
(total wages ÷ number of employees)

= average wages

If the result is less than \$50,000, **AND**

3

You pay at least half of the insurance premiums for your employees at the single (employee-only) coverage rate, then

»» you may be able to claim the Small Business Health Care Tax Credit.
Find out more information at **IRS.gov**



**Medicaid and the Children’s Health Insurance Program (CHIP)
Offer Free Or Low-Cost Health Coverage To Children And Families**

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer’s health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer’s plan. This is called a “special enrollment” opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of April 16, 2010. You should contact your State for further information on eligibility –

ALABAMA – Medicaid	CALIFORNIA – Medicaid
Website: http://www.medicaid.alabama.gov Phone: 1-800-362-1504	Website: http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 1-866-298-8443
ALASKA – Medicaid	COLORADO – Medicaid and CHIP
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Medicaid Website: http://www.colorado.gov/ Medicaid Phone: 1-800-866-3513 CHIP Website: http:// www.CHPplus.org CHIP Phone: 303-866-3243
ARIZONA – CHIP	
Website: http://www.azahcccs.gov/applicants/default.aspx Phone: 1-877-764-5437	
ARKANSAS – CHIP	FLORIDA – Medicaid
Website: http://www.arkidsfirst.com/ Phone: 1-888-474-8275	Website: http://www.fdhc.state.fl.us/Medicaid/index.shtml Phone: 1-866-762-2237

GEORGIA – Medicaid	MONTANA – Medicaid
Website: http://dch.georgia.gov/ Click on Programs, then Medicaid Phone: 1-800-869-1150	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Telephone: 1-800-694-3084
IDAHO – Medicaid and CHIP	NEBRASKA – Medicaid
Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 1-800-926-2588 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588	Website: http://www.dhhs.ne.gov/med/medindex.htm Phone: 1-877-255-3092
INDIANA – Medicaid	NEVADA – Medicaid and CHIP
Website: http://www.in.gov/fssa/2408.htm Phone: 1-877-438-4479	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
IOWA – Medicaid	CHIP Website: http://www.nevadacheckup.nv.org/ CHIP Phone: 1-877-543-7669
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	
KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: https://www.khpa.ks.gov Phone: 800-766-9012	Website: http://www.dhhs.state.nh.us/DHHS/MEDICAIDPROGRAM/default.htm Phone: 1-800-852-3345 x 5254
KENTUCKY – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-800-356-1561
LOUISIANA – Medicaid	CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
Website: http://www.la.hipp.dhh.louisiana.gov Phone: 1-888-342-6207	
MAINE – Medicaid	NEW MEXICO – Medicaid and CHIP
Website: http://www.maine.gov/dhhs/oms/ Phone: 1-800-321-5557	Medicaid Website: http://www.hsd.state.nm.us/mad/index.html Medicaid Phone: 1-888-997-2583
MASSACHUSETTS – Medicaid and CHIP	CHIP Website: http://www.hsd.state.nm.us/mad/index.html Click on Insure New Mexico CHIP Phone: 1-888-997-2583
Medicaid & CHIP Website: http://www.mass.gov/MassHealth Medicaid & CHIP Phone: 1-800-462-1120	
MINNESOTA – Medicaid	NEW YORK – Medicaid
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 800-657-3739	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MISSOURI – Medicaid	NORTH CAROLINA – Medicaid
Website: http://www.dss.mo.gov/mhd/index.htm Phone: 573-751-6944	Website: http://www.nc.gov Phone: 919-855-4100

NORTH DAKOTA – Medicaid	UTAH – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604	Website: http://health.utah.gov/medicaid/ Phone: 1-866-435-7414
OKLAHOMA – Medicaid	VERMONT – Medicaid
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://ovha.vermont.gov/ Telephone: 1-800-250-8427
OREGON – Medicaid and CHIP	VIRGINIA – Medicaid and CHIP
Medicaid & CHIP Website: http://www.oregonhealthykids.gov Medicaid & CHIP Phone: 1-877-314-5678	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
PENNSYLVANIA – Medicaid	WASHINGTON – Medicaid
Website: http://www.dpw.state.pa.us/partnersproviders/medicalassistance/doingbusiness/003670053.htm Phone: 1-800-644-7730	Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-877-543-7669
RHODE ISLAND – Medicaid	WEST VIRGINIA – Medicaid
Website: www.dhs.ri.gov Phone: 401-462-5300	Website: http://www.wvrecovery.com/hipp.htm Phone: 304-342-1604
SOUTH CAROLINA – Medicaid	WISCONSIN – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dhs.wisconsin.gov/medicaid/publications/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	WYOMING – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.health.wyo.gov/healthcarefin/index.html Telephone: 307-777-7531

To see if any more States have added a premium assistance program since April 16, 2010, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565