

Enacted state legislation for NH's 1332 waiver application

CHAPTER 221
HB 469 - FINAL VERSION

05/31/2017 2004s

2017 SESSION

17-0661

10/01

HOUSE BILL **469**

AN ACT establishing a continuous quality improvement program for pharmacies, relative to vaccines administered by pharmacists, and relative to the authority of the insurance department on federal health care reform.

SPONSORS: Rep. P. Schmidt, Straf. 19; Rep. Patten, Merr. 17

COMMITTEE: Health, Human Services and Elderly Affairs

AMENDED ANALYSIS

This bill:

I. Requires licensed pharmacies to establish continuous quality improvement programs to identify weaknesses in processes and systems and make appropriate corrections. [OMITTED in COPY]

II. Adds hepatitis A, hepatitis B, Tdap, MMR, and meningococcal vaccines to the list of vaccines which may be administered by certain licensed pharmacists and nullifies the provision of SB 65 of the 2017 regular legislative session which addresses the same matter. [OMITTED in COPY]

III. Adds provisions for the insurance department concerning federal health care reform, and repeals these provisions on July 1, 2020.

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Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

05/31/2017 2004s 17-0661

10/01

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Seventeen

AN ACT establishing a continuous quality improvement program for pharmacies, relative to vaccines administered by pharmacists, and relative to the authority of the insurance department on federal health care reform.

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

221:1 New Section; Continuous Quality Improvement. [OMITTED in COPY]

221:2 New Section; Vaccines Administered by Pharmacists; Vaccines Added. [OMITTED in COPY]

221:3 Nullification. The provisions of SB 65 of the 2017 regular legislative session, relative to vaccines administered by pharmacists, are hereby nullified and shall not take effect.

221:4 Individual Health Insurance Market; Contingency. RSA 404-G:12 is repealed and reenacted to read as follows:

404-G:12 Contingency.

I. Notwithstanding RSA 404-G:11, with the approval of the governor and the joint health care reform oversight committee, and after issuing public notice, conducting a hearing, and receiving public comment, the commissioner may request that the board of directors of the association develop a plan of operation to support the affordability of health insurance in the state's individual health insurance market. The proposal may include resumption of the risk adjustment program referenced in RSA 404-G:5, reopening of the high risk pool referenced in RSA 404-G:5-a, creation and operation of a reinsurance program, or such other program as the board finds will best support the availability and affordability of health insurance in the state. The commissioner shall approve the revised plan of operations if the commissioner finds that the plan will further the purpose of this chapter as stated in RSA 404-G:1, I, and is otherwise consistent with New Hampshire and federal law.

II. The board's proposal may include a recommendation that the state apply for a waiver under the Act (or any successor to the Act). If the approved plan includes application for an waiver, the commissioner shall proceed in accordance with RSA 420-N:6-a. If the waiver is approved by the federal government, the board shall prepare a revised plan of operations consistent with the terms of the waiver, and shall implement it upon approval by the commissioner.

221:5 Federal Health Care Reform 2010; Purpose and Scope. Amend RSA 420-N:1 to read as follows:

420-N:1 Purpose and Scope. The intent of this chapter is to preserve the state's status as the primary regulator of the business of insurance within New Hampshire and the constitutional integrity and sovereignty of the state of New Hampshire under the Tenth Amendment to the United States Constitution and part I, article 7 of the New Hampshire constitution and to create a legislative oversight committee to supervise the insurance commissioner's administration of the insurance reforms required under the Patient Protection and Affordable Care Act of 2009, Public Law 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, including any *successor legislation and any* federal regulations, interpretations, standards, or guidance issued thereunder (hereinafter "the Act").

221:6 Federal Health Care Reform 2010; Definition of Act. Amend RSA 420-N:2, I to read as follows:

I. "Act" means the Patient Protection and Affordable Care Act of 2009, Public Law 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, including any *successor legislation and any* federal regulations, interpretations, standards, or guidance issued thereunder.

221:7 New Section; Federal Health Care Reform 2010; Waiver. Amend RSA 420-N by inserting after section 6 the following new section:

420-N:6-a Waiver. With the approval of the governor and the joint health care reform oversight committee, and after issuing public notice, conducting a hearing, and receiving public comment, the commissioner is authorized to submit an application on behalf of the state to the United States Secretary of the Treasury, and if required, to the United States Secretary of Health and Human Services, to waive certain provisions of the Act, as provided in section 1332 of the Act, or any other applicable waiver provision. The commissioner is authorized to implement any federally approved waiver, including but not limited to overseeing the implementation of a revised plan of operations under RSA 404-G:12.

221:8 Individual Health Insurance Market; Contingency; 2020 Version. RSA 404-G:12 is repealed and reenacted to read as follows:

404-G:12 Contingency.

I. Notwithstanding RSA 404-G:11, if the commissioner determines that high risk pool enrollees will not have access to guaranteed issue coverage in the commercial marketplace, the commissioner may order the association to continue to provide coverage under the high risk pool authorized pursuant to RSA 404-G:5-b. Any such order by the commissioner shall be issued after consultation with the oversight committee on health and human services, established under RSA 126-A:13.

II. An order issued under paragraph I shall remain in effect until the earlier of the following:

(a) The date on which the commissioner determines that high risk pool enrollees have access to guaranteed issue coverage; or

(b) The effective date of any order executed by the commissioner pursuant to RSA 404-C addressing the availability of health insurance.

221:9 Federal Health Care Reform 2010; Purpose and Scope; Reference Deleted; 2020 Version. Amend RSA 420-N:1 to read as follows:

420-N:1 Purpose and Scope. The intent of this chapter is to preserve the state's status as the primary regulator of the business of insurance within New Hampshire and the constitutional integrity and sovereignty of the state of New Hampshire under the Tenth Amendment to the United States Constitution and part I, article 7 of the New Hampshire constitution and to create a legislative oversight committee to supervise the insurance commissioner's administration of the insurance reforms required under the Patient Protection and Affordable Care Act of 2009, Public Law 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, including any ~~[successor legislation and any]~~ federal regulations, interpretations, standards, or guidance issued thereunder (hereinafter "the Act").

221:10 Federal Health Care Reform 2010; Definition of Act; Reference Deleted; 2020 Version. Amend RSA 420-N:2, I to read as follows:

I. "Act" means the Patient Protection and Affordable Care Act of 2009, Public Law 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, including any ~~[successor legislation and any]~~ federal regulations, interpretations, standards, or guidance issued thereunder.

221:11 Repeal; 2020. RSA 420-N:6-a, relative to waivers under Federal Health Care Reform 2010, is repealed.

221:12 Effective Date.

I. Section 1 of this act shall take effect 60 days after its passage.

II. Section 2 of this act shall take effect January 1, 2018.

III. Sections 8-11 of this act shall take effect July 1, 2020.

IV. The remainder of this act shall take effect upon its passage.

Approved: July 10, 2017

Effective Date:

I. Section 1 effective September 8, 2017

II. Section 2 effective January 1, 2018

III. Sections 8-11 effective July 1, 2020

IV. Remainder effective July 10, 2017

TITLE XXXVII INSURANCE

CHAPTER 404-G INDIVIDUAL HEALTH INSURANCE MARKET

Section 404-G:1

404-G:1 Purpose of Provisions. – The purpose of this chapter is to:

I. Protect the citizens of this state who participate in the individual health insurance market by providing a mechanism to equitably distribute the excessive risk sometimes associated with this market and to enable insurers to better protect against the costs of covering high risk individuals.

II. Create a nonprofit, voluntary organization to facilitate the availability of affordable individual nongroup health insurance by establishing an assessment mechanism and an individual health insurance market mandatory risk sharing plan as a mechanism to distribute the risks associated within the individual nongroup market and to support the marketplace premium assistance program established in RSA 126-A:5, XXV.

III. Establish a high risk pool that will provide access to health insurance to all residents of the state who are denied health insurance for medical or health reasons. The premiums charged for coverage in the high risk pool shall be affordable and the coverage provided shall be reasonably comprehensive and comparable to coverage available outside of the high risk pool. It is the intent of the legislature that the high risk pool shall be adequately funded through an annual, and if necessary, a special assessment mechanism, that the high risk pool shall utilize cost containment measures, including, but not limited to, providing network based coverage, and that measures shall be taken to avoid inappropriate shifting of costs and risk to the high risk pool.

IV. Authorize the association to establish a federally qualified high risk pool pursuant to section 1101 of the Patient Protection and Affordable Care Act of 2009 (PL 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (PL 111-152).

Source. 1998, 340:6. 2001, 295:4, eff. July 1, 2001. 2010, 243:2, eff. July 1, 2010. 2016, 13:7, eff. Apr. 5, 2016.

Section 404-G:1-a

404-G:1-a Study and Biannual Report. – The commissioner shall evaluate the impact and effectiveness of RSA 404-G in effectuating the principles outlined in RSA 404-G:1, III. This review shall be based on data collected from carriers in the individual market and from the association, including but not limited to the following data elements: data on premiums and carrier profitability, carriers entering or exiting the market, products being sold, basis for high risk pool eligibility, and overall denial rate. The study shall be completed within 6 months of the availability of data on the first 2 years of operation of the high risk pool. Upon completion of the study, the commissioner shall make an initial report relative

to the findings of the study to the governor, the president of the senate and the speaker of the house of representatives and shall make biannual reports to such persons thereafter.

Source. 2001, 295:15, eff. July 1, 2001.

Section 404-G:2

404-G:2 Definitions. – In this chapter:

I. "Actively marketing" means actively marketing, issuing, and renewing all of the health coverages the respective carrier sells in the individual market to all individuals.

I-a. "Act" means the Patient Protection and Affordable Care Act of 2009 (PL 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (PL 111-152).

II. "Assessment" means the liability of the member insurer to the association.

III. "Association" means the entity created within this chapter which shall be the same association as that created under the order, defined in paragraph X.

IV. "Commissioner" means the insurance commissioner.

V. "Covered lives" shall include all persons who are:

(a) Covered under an individual health insurance policy issued or delivered in New Hampshire;

(b) Covered under a group health insurance policy that is issued or delivered in New Hampshire;

(c) Covered under a group health insurance policy evidenced by a certificate of insurance that is issued or delivered in New Hampshire;

(d) Protected, in part, by a group excess loss insurance policy where the policy or certificate of coverage has been issued or delivered in New Hampshire.

V-a. "Group excess loss insurance" means coverage purchased by an employer against the risk that any one claim made against the employer's health plan will exceed a specified dollar amount or coverage purchased by an employer against the risk that the employer's total liability for the health plan will exceed a specified amount.

VI. "Group health insurance" means health insurance coverage other than individual health insurance coverage.

VII. "Health insurance" means health insurance coverage issued in accordance with RSA 415, 420-A, or 420-B. For the purposes of this chapter, health insurance shall not include accident only, credit, dental, vision, Medicare supplement, Medicare Risk, Medicare+Choice, Managed Medicaid, long-term care, disability income, coverage issued as a supplement to a liability insurance, workers' compensation or similar insurance, automobile medical payment insurance, policies or certificates of specified disease, hospital confinement indemnity, limited benefit health insurance, coverage provided through the New Hampshire healthy kids association, and coverage provided through the Federal Employees' Program. Health insurance does include group excess loss insurance.

VIII. "Individual health insurance" means health insurance sold directly to an individual and not on a group remittance basis. Individual health insurance shall include franchise health insurance.

IX. "Insurer" means any entity licensed pursuant to RSA 402, RSA 420-A, or RSA 420-B.

X. "Order" means the insurance department findings and final order dated November 26, 1997, in the matter of the individual health insurance market in New Hampshire pursuant to RSA 404-C.

X-a. "Plan of operation" means the plan of operation of the risk sharing mechanism, the high risk pool, support for the program established in RSA 126-A:5, XXV, and the federally qualified high risk pool, including articles, bylaws and operating rules, procedures and policies adopted by the association.

X-b. "Pool" means the New Hampshire health insurance high risk pool.

X-c. "Program" means the marketplace premium assistance program established pursuant to RSA 126-A:5, XXV.

XI. "Writer" means a writing carrier.

Source. 1998, 340:6. 2001, 295:5, 6, eff. July 1, 2001. 2003, 276:1, 2, eff. July 1, 2003. 2008, 375:3, 4, eff. July 1, 2008. 2010, 243:3, 4, eff. July 1, 2010. 2016, 13:8, 9, eff. Apr. 5, 2016.

Section 404-G:3

404-G:3 Association's Powers and Duties. –

I. The association shall be a not-for-profit, voluntary corporation under RSA 292 and shall possess all general powers as derive from that status and such additional powers and duties as are approved by the commissioner or as specified below.

II. The board of directors of the association shall have the following powers:

(a) Enter into contracts as necessary or proper to administer the plan of operation.

(b) Sue or be sued, including taking any legal action necessary or proper for the recovery of any assessments for, on behalf of, or against members of the association or other participating person.

(c) Take legal action as necessary to avoid the payment of improper claims against the plan or to defend the coverage provided by or through the pool.

(d) Oversee the issuance of policies of insurance and certificates or evidences of coverage.

(e) Retain appropriate legal, actuarial, and other persons as necessary to provide technical assistance in the operation of the plan, policy development, and other contract design and in any other function within the authority of the plan.

(f) Borrow money to carry out the plan of operation.

(g) Provide for reinsurance of risks incurred.

(h) Perform any other functions within the authority of the association as may be necessary or proper to carry out the plan of operation.

(i) Perform additional powers as set forth in RSA 404-G:5-g.

III. The board of directors of the association shall have the following duties:

(a) Fulfill the plan of operation as approved by the commissioner.

(b) Issue policies of insurance to persons eligible for the high risk pool.

(c) Prepare certificate of eligibility forms and enrollment instruction forms.

(d) Determine and collect assessments for the risk sharing mechanism and for the high risk pool.

(e) Disburse assessment payments, as provided in the plan of operation for the high risk pool.

(f) Establish appropriate rates, rate schedules, rate adjustments, expense allowances, agent referral fees, claim reserve formulas and any other actuarial functions appropriate to the plan of operation for the high risk pool.

(g) Provide for and employ cost-containment measures and requirements, which shall include but

not be limited to, preadmission screening, second surgical opinion, concurrent utilization review, and individual case management for the purpose of making the benefit plan more cost effective.

(h) Develop a list of medical or health conditions the existence or history of which makes an individual eligible for participation in the high risk pool without first requiring application to a carrier for health coverage.

(i) In connection with the managed care or network based coverage options required pursuant to RSA 404-G:5-b, III, design, utilize, contract or otherwise arrange for the delivery of cost-effective health care services, including establishing or contracting for administration and operation of the pool with a carrier, a preferred provider organization, a health maintenance organization, or any other network provider arrangement.

IV. Neither the association nor its employees shall be liable for any obligations of the plan. No member or employee of the association shall be liable, and no cause of action of any nature may arise against them, for any act or omission related to the performance of their powers and duties under this chapter unless such act or omission constitutes willful or wanton misconduct. The association may provide in its bylaws or rules for indemnification of, and legal representation for, its members and employees.

Source. 1998, 340:6. 2001, 295:7, eff. July 1, 2001. 2010, 243:5, eff. July 1, 2010.

Section 404-G:4

404-G:4 Association Membership and Governance. –

I. The association shall be comprised of all writers of health insurance.

II. The initial board of directors of the association shall be the same as that set forth in the order. Except as provided in paragraph IV, each successor board shall consist of 9 individuals who are representative of categories of members of the association, health care providers, consumers who have purchased or are likely to purchase coverage from the pool, insurance brokers, small employers, and the commissioner who shall be an ex-officio member. In the initial and in each successor board, 3 directors shall be representative of and elected by qualified writers of group health insurance, 2 directors shall be representative of and elected by qualified writers of individual health insurance, one director shall be representative of the health care provider community and shall be appointed by the commissioner, one director shall be representative of consumers covered through the high risk pool and shall be appointed by the commissioner, one director shall be a representative of insurance brokers and shall be appointed by the commissioner, and one director shall be a representative of small employers and shall be appointed by the commissioner.

III. There shall be no more than one director representing any one qualified writer or its affiliate. For purposes of this section, the insurance activities of any elected director's affiliate shall be deemed to be insurance activities of the elected director.

IV. Qualified writers of individual or group health insurance shall be those that provide coverage for at least 500 covered lives or 5 percent of the total covered lives in the relevant market. A member's votes for individual or group market representatives shall be proportional to the member's assessment in that market.

V. If, at any board election subsequent to the establishment of the initial board, one or more elected group representatives are also qualified individual health insurance writers, then the membership of the board shall be altered by applying the provisions in subparagraphs (a) through (d) to such elected group representatives.

(a) If the elected group representative writing in the individual market is also an elected individual representative, then that member shall take a seat on the board as an individual representative and relinquish the group seat. The group writer with the next highest number of group votes shall take the relinquished group seat.

(b) If the elected group representative writing in the individual market is not also an elected individual representative, then up to 2 directors will be added to the board as follows:

(1) If the total size of the board-elect is 9 or 10, the elected group representative shall remain on the board, but neither as a group or an individual representative, and the group writer with the next highest number of group votes shall join the board as a group representative; but

(2) If the total size of the board-elect is 11, the elected group representative shall not remain on the board and the group writer with the next highest number of group votes shall take the relinquished group seat.

(c) The provisions in subparagraphs (a) and (b) shall be applied to elected group representatives in the order of the number of votes received.

(d) The seats added to the board pursuant to subparagraph (b) shall not survive the term of the seat-holder.

VI. Members of the board of directors shall be elected to terms of one year.

VII. The board of directors shall take action by affirmative vote representing a simple majority of the entire board.

VIII. The board shall elect officers in accordance with the bylaws of the association. The bylaws of the association shall also govern the place and frequency of meetings of directors and their reimbursement for expenses incurred.

Source: 1998, 340:6. 2001, 295:8, July 1, 2001.

Section 404-G:4-a

404-G:4-a Report Required. – The association shall submit an annual report to the commissioner, in a manner and form determined by the commissioner, listing the association membership base, providing a count of covered lives by member, identifying changes in association membership and covered lives, describing the collection of assessments, listing payment delinquencies, and containing such other related information as the commissioner may require.

Source. 2008, 375:5, eff. July 1, 2008.

Section 404-G:5

404-G:5 Plan of Operation. – The board of directors of the association shall adopt a plan of operation which shall be the same plan of operation as that adopted pursuant to the order. Any amendments to the current plan of operation shall be approved by the commissioner. The plan of operation shall provide substantially the following:

I. Description of risks to be shared. Sharing shall be implemented through a risk adjustment and subsidization mechanism whereby writers in the group market will subsidize losses of writers in the individual market. The mechanism shall include parameters which will limit its costs and ensure proper claims management by the nongroup writers.

II. Subsidy determination for the risk sharing mechanism. For a given calendar year, the subsidy calculations for the risk sharing mechanism shall be based on the experience of the prior year. Only individual health insurance writers who are actively marketing individual health insurance, in accordance with the provisions of RSA 420-G, during the calendar year in which the subsidy is distributed shall be eligible for a subsidy. For companies that utilize health status factors, only individuals whose coverage is written at the maximum allowable health status factors under RSA 420-G and whose coverage was issued prior to July 1, 2002 shall be eligible for a subsidy. For companies that do not utilize varied health status factors, all individuals whose coverage is written under RSA 420-G and whose coverage was issued prior to July 1, 2002 shall be eligible for a subsidy. The subsidy determination process shall recognize and compensate writers based on the risk characteristics of coverage eligible for consideration in the subsidy relative to standards established by the association board. Nothing in this chapter shall preclude the commissioner from approving a subsidy mechanism that fully compensates individual health insurers for all costs incurred on subsidy-eligible coverages in excess of the premiums collected from subsidy-eligible coverages.

III. Assessment determination.

(a) Assessment liabilities shall commence on the effective date of this chapter.

(b) Assessments shall be calculated based on the number of covered lives. The number of covered lives shall be determined each month during the calendar year. The assessment shall be calculated as the number of covered lives times a specified amount. The specified amount shall be fixed throughout the calendar year and shall be determined by the board no later than the first day of November preceding the calendar year for which the amount is to be used. The amount shall be subject to approval by the commissioner. The board shall provide a basis for recommending the specified amount, including a projection of the calculated subsidy and consideration of any prior year shortfalls or overages. For the calendar years 1999 and 2000, the specified amount shall be 18 cents per covered life per month, provided, however, that the board may petition the commissioner for approval of a greater specified amount. The commissioner shall approve such amount if he or she finds, after consideration of the:

(1) Board's subsidy determination process;

(2) Number of subsidy-eligible lives;

(3) Size of the entire non-group market;

(4) Morbidity experience of the subsidy-eligible lives; and

(5) Morbidity experience of the entire non-group market; that the amount petitioned by the board is no greater than is necessary to fulfill the purposes of this chapter. For the purpose of making this determination, the commissioner may, at the expense of the association, seek independent actuarial certification of the need for the increase.

(c) Each covered life should be included in the assessment only once. The board shall adopt procedures by which affiliated carriers calculate their assessment on an aggregate basis and procedures to ensure that no covered life is counted more than once.

IV. Administrative matters. The plan of operation shall further provide for all of the following:

(a) Responsibility for the handling and accounting of funds and other assets of the association.

(b) The financial and other records required to be kept, including the annual report to be submitted to the commissioner.

(c) Such other administrative provisions as are necessary or proper for the execution of the powers and duties of the association.

Source. 1998, 340:6. 2001, 295:9, eff. July 1, 2001.

Section 404-G:5-a

404-G:5-a Plan of Operation for the High Risk Pool. –

I. The board of directors for the association shall adopt a plan of operation for the high risk pool. The high risk pool shall be funded in part through an assessment mechanism whereby writers of health insurance contribute an amount sufficient to cover the expenses and losses of the pool not covered by premiums.

II. The plan of operation for the high risk pool shall establish:

(a) Procedures for handling and accounting for the assets and moneys of the plan;

(b) Procedures for selecting and retaining a pool administrator;

(c) Procedures to establish and maintain public awareness of the plan, including its eligibility requirements and enrollment procedures;

(d) Procedures to create a fund, under management of the board, for administrative expenses;

(e) Procedures for handling, accounting and auditing of assets, moneys and claims of the pool;

(f) Requirements for keeping financial and other records;

(g) Regular times and places for meetings of the board; and

(h) Procedures by which applicants and participants can submit utilization review determinations and grievances to the pool administrator. The procedures shall ensure that utilization review determinations and grievances will be processed properly and in accordance with all statutory and regulatory requirements.

III. The assessment for the high risk pool shall be based on the number of covered lives times a specified assessment rate. The association shall specify the basis used to set the assessment rate.

IV. The association shall establish a regular assessment rate which shall be:

(a) Calculated on a calendar year basis;

(b) Established no later than November 1 in the year preceding the calendar year for which the carrier's experience shall be used to calculate the assessment;

(c) Anticipated to be sufficient to meet the high risk pool's funding needs and the association's share of the costs of the program, as defined in subparagraph (d); and

(d) For the period of January 1, 2017 through December 31, 2018, an amount not to exceed 50 percent of the remainder amount, as defined in RSA 126-A:5-c, I(b), less the amount made available to

the program pursuant to RSA 404-G:11, VI. The association shall transfer all amounts collected pursuant to this subparagraph and the amount made available to the program pursuant to RSA 404-G:11, VI to the New Hampshire health protection trust fund, established pursuant to RSA 126-A:5-b.

V. In addition to the regular assessment rate, the association may establish a special assessment rate. Notwithstanding RSA 420-G:4, a writer of health insurance may increase the premiums charged by the amount of the special assessment. Any assessment may appear as a separate line item on a policyholder's bill.

(a) The association shall only establish a special assessment if the association determines that its funds are or will become insufficient to pay the high risk pool's expenses in a timely manner.

(b) The association shall only assess, through the special assessment, at a rate necessary to fund the deficiency ascertained in subparagraph (1) above.

VI. The regular assessment rate, and any special assessment rate, shall be subject to the approval of the commissioner. The commissioner shall approve the rate if she or he finds that the amount is required to fulfill the purposes of the high risk pool. For the purpose of making this determination, the commissioner may, at the expense of the association, seek independent actuarial certification of the need for the proposed rate.

VII. The association shall impose and collect assessments from its members.

VIII. If the assessment exceeds the amount actually needed, the excess shall be held and invested and, with the earnings and interest thereon, be used to offset future net losses.

IX. Each covered life should be included in the assessment only once. The association shall adopt procedures by which affiliated carriers calculate their assessment on an aggregate basis and procedures to ensure that no covered life is counted more than once.

X. The initial assessment rate to fund the high risk pool shall be 60 cents per covered life per month, and shall take effect on policies or certificates issued or renewed on or after July 1, 2001.

Source. 2001, 295:10, eff. July 1, 2001. 2016, 13:10, eff. Apr. 5, 2016.

Section 404-G:5-b

404-G:5-b High Risk Pool. –

I. There is hereby created the New Hampshire high risk pool. This pool shall operate subject to the supervision and control of the association and shall offer policies of insurance on or after July 1, 2002. The pool shall offer health care coverage consisting of 4 benefit plans, 2 of which shall be either managed care or network based plans.

II. The plans to be issued by the pool, including schedules of benefits, exclusions and other limitations shall be established by the association subject to the approval of the commissioner. In establishing the plans, the association shall take into consideration the levels of health insurance coverage provided in the state and medical economic factors as may be deemed appropriate and shall promulgate benefit levels, deductibles, coinsurance factors, exclusions and limitations determined to be generally reflective of and commensurate with comprehensive, major medical health insurance coverage provided in the state. The association shall, utilizing standard morbidity assumptions, annually place a value on all plans presently being written or issued in the individual market. The association shall average these values,

weighed according to each plan's written premium volume, or some other suitable proxy, and utilizing the same standard morbidity assumptions, shall develop 2 coverage options: Option A and Option B.

III. The value of Option A developed by the association shall be 10 percent higher than the average value computed under paragraph II and the value of Option B shall be 10 percent lower than the average value computed under paragraph II. The association shall also provide either a managed care or network based version of Option A and a managed care version of Option B for a total of 4 plan choices.

III-a. The association, subject to the approval of the commissioner, may from time to time offer such plans, in addition to the 4 plans required under paragraphs II and III, as its board of directors determines would be helpful to advance the purposes of this chapter.

IV. The insurance plans developed by the association shall comply with all applicable insurance laws and rules, except as provided herein.

V. (a) The pool shall be payer of last resort of benefits whenever any other benefit or source of third-party payment is available. The pool shall have a right of subrogation for any other health insurance coverage and by all hospital and medical expense benefits paid or payable under any workers' compensation coverage, automobile medical payment or liability insurance whether provided on the basis of fault or nonfault, and by any hospital or medical benefits paid or payables under or provided pursuant to any state or federal law or program.

(b) The pool shall have a cause of action against an eligible person for the recovery of the amount of benefits paid that are not for covered expenses. Benefits due from the plan may be reduced or applied as a set-off against any amount recoverable under this paragraph.

VI. The high risk pool shall be funded by premiums charged for coverage and by assessments which the association shall calculate based on the number of covered lives times a specified amount. The high risk pool shall not be funded with state general fund revenue. The high risk pool shall never cease writing policies to eligible individuals.

Source. 2001, 295:10. 2004, 187:11, eff. July 31, 2004.

Section 404-G:5-c

404-G:5-c High Risk Pool Administrator. –

I. The board shall select a high risk pool administrator through a competitive bidding process to administer the pool. The board shall evaluate bids submitted based on criteria established by the board which shall include:

(a) The high risk pool administrator's proven ability to handle health insurance coverage to individuals;

(b) The efficiency and timeliness of the high risk pool administrator's claim processing procedures;

(c) An estimate of total charges for administering the pool;

(d) The high risk pool administrator's ability to apply effective cost containment programs and procedures and to administer the pool in a cost efficient manner; and

(e) The financial condition and stability of the high risk pool administrator.

II. (a) The high risk pool administrator shall serve for a period of at least 3 years and shall be subject to removal for cause; and

(b) At least one year prior to the expiration of each period of service by a high risk pool administrator, the association shall invite eligible entities, including the current high risk pool administrator to submit bids to serve as the high risk pool administrator. Selection of the high risk pool administrator for the succeeding period shall be made at least 6 months prior to the end of the current period.

III. The high risk pool administrator shall perform such functions relating to the plan as may be assigned to it, including:

(a) The determination of eligibility;

(b) The payment of claims and the development of procedures to ensure that each claim is promptly paid;

(c) The establishment of a premium billing procedure for collection of premium from persons covered under the pool;

(d) The acceptance of payments of premiums from insureds;

(e) The development of procedures to ensure that medical utilization reviews and grievance determinations are conducted in a fair and timely manner and in accordance with all statutory and regulatory requirements; and

(f) Other necessary functions to assure timely payment of benefits to covered persons under the pool.

IV. The high risk pool administrator shall submit regular reports to the association and the commissioner regarding the operation of the pool. The frequency, content and form of the report shall be specified in the contract between the association and the high risk pool administrator.

V. Following the close of each calendar year, the high risk pool administrator shall determine net written and earned premiums, the expense of administration, and the paid and incurred losses for the year and report this information to the association and the commissioner on a form prescribed by the commissioner.

VI. The high risk pool administrator shall be paid as provided in the contract between the association and the high risk pool administrator.

VII. The association shall submit the contract between itself and the high risk pool administrator to the commissioner for approval.

VIII. The association may select more than one administrator for the high risk pool.

IX. The association may use the same administrator for both the high risk pool and the federally qualified high risk pool. Notwithstanding the provisions of subparagraph II(b), the association may extend the term of the current contract with the existing high risk pool administrator without a competitive bidding process until January 1, 2014.

Source. 2001, 295:10, eff. July 1, 2001. 2010, 243:6, eff. July 1, 2010.

Section 404-G:5-d

404-G:5-d Premiums. –

I. Premiums charged for the policies issued by the plan shall be based on the standard risk rate calculated pursuant to paragraph II of this section.

II. The standard risk rate shall be calculated using the average rate, based on the lowest allowable health status factor, for health benefit plans or policies which are presently available in New Hampshire and adjusted for the difference in the actuarial value of the pool's plans relative to these available plans using the factors derived pursuant to RSA 404-G:5-a, II.

III. Premium rates for coverage under the plan may not be less than 125 percent and may not exceed 150 percent of the standard risk rate pursuant to paragraph II of this section. The association shall charge high risk pool enrollees a premium charge based on the average rate for the plan adjusted for the attained age of the high risk pool enrollee. The adjustment for attained age shall conform to the provisions of RSA 420-G.

IV. All premium rates and rate schedules shall be submitted to the commissioner for approval.

Source. 2001, 295:10, eff. July 1, 2001.

Section 404-G:5-e

404-G:5-e Eligibility. –

I. An individual who is a New Hampshire resident shall be eligible for coverage through the high risk pool if:

(a) The individual has applied to a carrier of individual health insurance for coverage that is substantially similar to the coverage that is available through the pool, and the carrier has refused to write or issue that coverage to that individual;

(b) The individual has applied to a carrier of individual health insurance for coverage that is substantially similar to the coverage that is available through the pool, and such application has been accepted, but at a premium rate exceeding the eligibility rate set by the association from time to time and submitted to the commissioner for approval with the premium rates, which eligibility rate shall not be less than 125 percent and shall not exceed 150 percent of the standard risk rate calculated pursuant to RSA 404-G:5-d, II;

(c) The individual has a history of any medical or health condition that is on a list adopted by the association;

(d) The individual is an "eligible individual" as defined in section 2741(b) of the Public Health Service Act;

(e) The individual has been certified as eligible for either federal trade adjustment assistance or for pension benefit guarantee corporation, as prescribed by the federal Trade Adjustment Assistance Reform Act of 2002 and the association, in accordance with procedures set forth in its plan of operation, is offering coverage in the high risk pool to such eligible persons at the time of the individual's application; or

(f) The individual has received an offer of coverage from a carrier of individual health insurance that contains a rider or endorsement excluding coverage for a specified condition pursuant to RSA 420-G:5, II.

II. The association shall promulgate a list of medical or health conditions for which a person shall be eligible for plan coverage without applying for health insurance coverage. Persons who can demonstrate the existence or history of any medical or health conditions on the list promulgated by the association

shall not be required to provide evidence of a notice of rejection or refusal. The list shall be effective on the first day of the operation of the pool and may be amended from time to time as may be appropriate.

III. Each resident dependent of a person who is eligible for pool coverage shall also be eligible for pool coverage. If the primary insured is a child, resident family members shall also be eligible for pool coverage.

IV. New Hampshire residents who are insured through an individual policy shall be eligible for pool coverage only if the rate assessed by the individual carrier exceeds the pool rate.

V. An individual shall not be eligible for coverage under the pool if:

(a) The individual is eligible for employer sponsored health coverage, including continuation of group coverage, as either an employee or an eligible dependent; or

(b) The individual is eligible for publicly funded health insurance coverage, including Medicare or Medicaid; or

(c) The individual's premiums are paid for or reimbursed by the health care provider or the individual's premiums are paid by any government sponsored program or government agency, except if the person is eligible under subparagraphs I(d) or (e). Nothing in this subparagraph shall be construed to prevent the association from receiving or using non-assessment funds, including but not limited to federal, state, foundation, or other grants or donations from any source to further the purposes of this chapter.

VI. Coverage shall cease:

(a) On the date a person is no longer a resident of this state;

(b) On the date a person requests coverage to end;

(c) Upon the date a person dies;

(d) On the date state law requires cancellation of the policy; or

(e) After the second of 2 successive inquiries made by the plan concerning the person's place of residence to which the person does not reply, provided the person has 90 days to respond to each inquiry.

Source. 2001, 295:10. 2002, 207:42. 2003, 201:3; 276:12, 13. 2004, 187:2, eff. July 31, 2004. 2007, 289:38, eff. Jan. 1, 2008. 2011, 189:2, eff. Aug. 13, 2011.

Section 404-G:5-f

404-G:5-f Application of Provisions of the Insurance Code. –

I. The pool shall be subject to examination and regulation by the insurance department.

II. All the provisions of title 37 shall apply to the pool to the extent applicable and not inconsistent with the express provisions of this chapter, except for the following: RSA 400-A:29, RSA 400-A:31 through 400-A:35, RSA 404-B, RSA 404-D, RSA 404-H, RSA 408-B, and RSA 420-K. For the purposes of this chapter, the pool shall be deemed an insurer, pool coverage shall be deemed individual health insurance, and pool coverage contracts shall be deemed policies.

Source. 2001, 295:10. 2002, 207:43, eff. July 15, 2002. 2007, 255:10, eff. Jan. 1, 2008.

Section 404-G:5-g

404-G:5-g Federally Qualified High Risk Pool. –

I. The association shall negotiate and submit to the commissioner for approval a contract with the United States Department of Health and Human Services to create a federally qualified high risk pool pursuant to the Act. This pool shall be known as the "federally qualified high risk pool" and the contract shall be known as the "federally qualified high risk pool contract." The eligibility requirements, premiums, benefits, and all other elements of the federally qualified high risk pool and its operations shall be governed solely by federal law and regulation and the federally qualified high risk pool contract. Individuals covered by insurance under the federally qualified high risk pool shall not be covered lives for the purposes of this chapter. The federally qualified high risk pool shall be funded solely by federal moneys and premiums charged for coverage under it, and shall not be funded with state general fund revenue or any assessments under this chapter. All federal moneys received by the association for the federally qualified high risk pool shall be used solely for the federally qualified high risk pool.

II. In addition to the powers and duties enumerated elsewhere in this chapter, the board of directors of the association shall have the following powers and duties with respect to the federally qualified high risk pool:

(a) Make application, subject to review and approval of the commissioner, to establish and operate a federally qualified high risk pool; and

(b) Enter into contract with the Secretary of the United States Department of Health and Human Services, subject to review and approval of the commissioner, to establish and operate a federally qualified high risk pool under section 1101 of the Act.

III. The board of directors of the association shall adopt a plan of operation for the federally qualified high risk pool. This plan of operation shall include the federally qualified high risk pool contract, all federal rules and guidance issued with respect to federally qualified high risk pools, and any other provisions deemed necessary by the board to operate the federally qualified high risk pool.

Source. 2010, 243:7, eff. July 1, 2010.

Section 404-G:6

404-G:6 Commissioner's Powers and Duties. – In addition to duties and powers enumerated elsewhere in this chapter:

I. The commissioner shall upon request of the board of directors, serve a demand upon the member insurer to pay an assessment within a reasonable time; the failure of the member insurer to promptly comply with such demand shall not excuse the association from the performance of its powers and duties under this chapter.

I-a. The commissioner shall annually review the report required under RSA 404-G:4-a on association membership, covered lives, and the payment of assessments to ensure that all insurers that should be members of the association are participating in the association and that all association members have accurately reported covered lives and paid the proper assessment. The association shall remedy any problem identified by the commissioner with respect to membership in the association, reporting of

covered lives, or payment of the assessment.

II. The commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any member insurer which fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative, the commissioner may levy a forfeiture on any member insurer which fails to pay an assessment when due. Such forfeiture shall not exceed 5 percent of the unpaid assessment per month, but no forfeiture shall be less than \$100 per month. Any amounts so collected shall be credited to the assessment fund administered by the association.

III. Any action of the board of directors or the association may be appealed to the commissioner by any member insurer if the appeal is taken within 30 days of the final action being appealed. If a member company is appealing an assessment, the amount assessed shall be paid to the association and available to meet association obligations during the pendency of an appeal. If the appeal on the assessment is upheld, the amount paid in error or excess shall be returned to the member company from available funds of the association. Any final action or order of the commissioner shall be subject to judicial review, pursuant to RSA 541.

IV. The commissioner may adopt rules as necessary to carry out the purposes of this chapter.

V. The powers of the commissioner enumerated in this chapter shall be in addition to those established under RSA 404-C.

Source. 1998, 340:6, eff. Aug. 25, 1998. 2008, 375:6, eff. July 1, 2008.

Section 404-G:7

404-G:7 Examination and Annual Report. – The association shall be subject to examination by the commissioner. The board of directors shall submit to the commissioner each year, not later than 120 days after the association's fiscal year, a financial report in a form approved by the commissioner and a report of its activities during the proceeding fiscal year. The report shall summarize the activities of the risk sharing mechanism and the high risk pool in the preceding calendar year, including the net written and earned premiums, enrollment, the expense of administration, and the paid and incurred losses. The association's fiscal year shall be the calendar year.

Source. 1998, 340:6. 2001, 295:11, eff. July 1, 2001.

Section 404-G:8

404-G:8 Tax Exemption. – The association shall be exempt from payment of all fees and all taxes levied by this state or any of its subdivisions, except taxes levied on real property.

Source. 1998, 340:6, eff. Aug. 25, 1998.

Section 404-G:9

404-G:9 Immunity for Members and Employees. – There shall be no liability on the part of and no cause of action of any nature shall arise against any member insurer or its agents or employees, the

association or its agents or employees, members of the board of directors, or the commissioner or the commissioner's representatives, for any action or omission by them in the performance of their powers and duties under this chapter.

Source. 1998, 340:6, eff. Aug. 25, 1998.

Section 404-G:10

404-G:10 Severability. – If any provisions of this chapter or the application thereof to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the chapter which can be given effect without the invalid provisions or applications, and to this end the provisions of this chapter are severable.

Source. 1998, 340:6, eff. Aug. 25, 1998.

Section 404-G:11

404-G:11 Termination of Activities and Dissolution. – Notwithstanding the provisions of RSA 404-G:1- RSA 404-G:7, the association shall undertake the winding down and cessation of the risk sharing subsidy mechanism, the high risk pool and the federally qualified high risk pool, and the dissolution of the association, as follows:

I. The risk sharing subsidy mechanism described in RSA 404-G:5 shall cease. The final subsidies shall be determined based on calendar year 2013 experience and paid to eligible carriers in 2014.

II. The risk adjustment and subsidization established by the commissioner through Ins 1908 with respect to individual health policies to children under age 19 shall cease. The final subsidies shall be determined based on calendar year 2013 experience and disbursed in accordance with the association's disbursement plan as approved by the commissioner.

III. The high risk pool under RSA 404-G:5-b shall cease in accordance with the following:

(a) Health care coverage provided by the pool shall cease at the close of business on December 31, 2013;

(b) On or before November 1, 2013, the association, through the high risk pool administrator, shall notify all individuals currently enrolled in the pool of the year-end termination of coverage;

(c) The association may renew coverage for existing enrollees or enroll new individuals in the high risk pool until December 1, 2013; provided, that at the time of renewal or application, such enrollees are given notice that pool coverage will terminate on December 31, 2013;

(d) Insurance laws and regulations providing for guaranteed renewal and guaranteed premiums for a period of 12-months, and any similar insurance laws or regulations, shall not apply to the high risk pool to the extent that they are inconsistent with this section;

(e) No individual shall be eligible for coverage through the high risk pool on or after January 1, 2014; and

(f) The association may extend the contract of the existing high risk pool administrator without a competitive bidding process through the period of time required to wind down the operations of the

high risk pool.

IV. Coverage under the federally qualified high risk pool described in RSA 404-G:5-g shall cease as of the close of business on December 31, 2013, and the pool shall dissolve in accordance with the Act and as directed by, and under the contract of the association with, the Secretary of the United States Department of Health and Human Services.

V. The board of directors of the association shall prepare and submit to the commissioner for approval within 60 days of the effective date of this section, a plan of termination which shall be an amendment to the plans of operation described in RSA 404-G:5 and RSA 404-G:5-a. The plan of termination shall provide for such administrative measures as are necessary or desirable to terminate the risk sharing subsidy mechanism, under 19 subsidy mechanism, high risk pool and federally qualified high risk pool, and such provisions shall not be inconsistent with this section.

VI. Following the cessation of coverage on December 31, 2013, the association shall take such actions as are necessary and desirable to wind down its affairs under this chapter in accordance with the plan of termination. The association shall retain all of its powers and duties, including, but not limited to, its power to establish and collect regular and special assessments under RSA 404-G:5 and RSA 404-G:5-a, and the immunity provided by RSA 404-G:9 and the bylaws of the association. Any excess funds remaining after the satisfaction of all of the association's liabilities shall be used for the program and for the association's reasonable costs for collecting its share of the remainder amount.

VI-a. No later than October 1, 2016, the board of directors shall prepare and submit to the commissioner and the commissioner of health and human services for approval an amendment to the plan of termination that provides for the continuation of the association for the limited purpose of compliance with the provisions of RSA 404-G:5-a, IV(d).

VII. When the association has completed the winding down of its affairs under this chapter and satisfied in full all of its liabilities, then it shall submit to the commissioner for approval a plan of dissolution. Upon approval of the plan of dissolution, the association shall file a certificate of dissolution with the secretary of state, whereupon the association shall cease to exist.

Source. 2013, 200:1, eff. July 9, 2013. 2016, 13:11, eff. Apr. 5, 2016.

Section 404-G:12

404-G:12 Contingency. –

I. Notwithstanding RSA 404-G:11, if the commissioner determines that high risk pool enrollees will not have access to guaranteed issue coverage in the commercial marketplace on January 1, 2014, the commissioner may order the association to continue to provide coverage under the high risk pool authorized pursuant to RSA 404-G:5-b. Any such order by the commissioner shall be issued no later than December 1, 2013, after consultation with the oversight committee on health and human services, established under RSA 126-A:13.

II. An order issued under paragraph I shall remain in effect until the earlier of the following:

(a) The date on which the commissioner determines that high risk pool enrollees have access to guaranteed issue coverage; or

(b) The effective date of any order executed by the commissioner pursuant to RSA 404-C addressing the availability of health insurance.

Source. 2013, 200:2, eff. July 9, 2013.

**TITLE XXXVII
INSURANCE**

**CHAPTER 420-N
FEDERAL HEALTH CARE REFORM 2010**

Section 420-N:1

420-N:1 Purpose and Scope. – The intent of this chapter is to preserve the state's status as the primary regulator of the business of insurance within New Hampshire and the constitutional integrity and sovereignty of the state of New Hampshire under the Tenth Amendment to the United States Constitution and part I, article 7 of the New Hampshire constitution and to create a legislative oversight committee to supervise the insurance commissioner's administration of the insurance reforms required under the Patient Protection and Affordable Care Act of 2009, Public Law 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, including any federal regulations, interpretations, standards, or guidance issued thereunder (hereinafter "the Act").

Source. 2011, 264:1. 2012, 231:1, eff. June 18, 2012.

Section 420-N:2

420-N:2 Definitions. – In this chapter:

I. "Act" means the Patient Protection and Affordable Care Act of 2009, Public Law 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, including any federal regulations, interpretations, standards, or guidance issued thereunder.

II. "Commissioner" means the insurance commissioner.

III. "Oversight committee" means the joint health care reform oversight committee established in RSA 420-N:3.

Source. 2011, 264:1, eff. July 1, 2011.

Section 420-N:3

420-N:3 Joint Health Care Reform Oversight Committee Established. –

I. There is established a joint health care reform oversight committee consisting of 6 members as follows:

(a) Three members of the senate, appointed by the senate president.

(b) Three members of the house of representatives, appointed by the speaker of the house of representatives.

II. The terms of the members shall be for the biennium and shall be coterminous with their membership in the general court. The oversight committee shall elect a chairperson from its membership. The oversight committee shall meet at the call of the chairperson who may call a meeting

as often as necessary. The oversight committee shall require 4 members for a quorum.

III. The committee shall provide legislative oversight, policy direction, and recommendations for legislation with respect to the Act as it determines appropriate. The committee shall also review existing rules, bulletins, or policies adopted pursuant to 2010, 243 and may require the repeal of such rules, bulletins, or policies.

IV. The committee shall make a report, together with any recommendations for legislation, to the president of the senate, the speaker of the house of representatives, the chairpersons of the house commerce and consumer affairs and the health, human services and elderly affairs committees and the senate commerce and health and human services committees by December 1, 2011 and annually thereafter.

Source. 2011, 264:1, eff. July 1, 2011.

Section 420-N:4

420-N:4 Implementation of the Act. –

I. The oversight committee established under RSA 420-N:3 shall determine all policies within the state of New Hampshire regarding implementation of the Act, as directed by this chapter and by any future law enacted by the general court with respect to implementation of the Act.

II. Before establishing any standard for enforcing or implementing the Act, and before initiating any rulemaking proceeding relating to the Act, the commissioner shall obtain approval for the standard or rule from the oversight committee.

III. The commissioner shall make periodic reports as requested by the oversight committee on the provisions of the Act that have taken legal effect in New Hampshire and on the status of the commissioner's implementation and enforcement efforts under the Act.

IV. The commissioner shall not implement or enforce any provision of the Act that has been ruled unconstitutional or invalid by the United States Supreme Court.

Source. 2011, 264:1, eff. July 1, 2011.

Section 420-N:5

420-N:5 Authority of the Commissioner. – Only with such prior approvals from the oversight committee as are required under RSA 420-N:4, the commissioner shall have authority to:

I. Make, adopt, and amend rules and regulations pursuant to RSA 541-A for, or as an aid to, the administration of any provision of the Act relating to insurance;

II. Apply for any public or private grant funds available under the Act;

III. Apply for any waiver available under any specific provision of the Act;

IV. Adopt and apply standards consistent with the Act for form and rate review of insurance products and any other regulatory oversight functions performed by the department; and

V. Enforce the consumer protections and market reforms set forth in the Act that relate to insurance. This shall not include the medical assistance program under RSA 167.

Source. 2011, 264:1, eff. July 1, 2011.

Section 420-N:5-a

[RSA 420-N:5-a repealed by 2014, 201:2, effective January 1, 2019.]

420-N:5-a Public Information Sessions and Comment Period Required. –

On or before June 15 of each year, and before the commissioner approves insurance products to be sold on a federally-facilitated exchange in New Hampshire, the commissioner shall hold at least 2 public information sessions, in different regions of the state concerning the proposed provider networks of insurance products proposed to be sold on the federally-facilitated exchange for the following calendar year. Notwithstanding any other provision of law, information regarding the proposed network of hospitals and essential community providers as defined in 45 CFR 156.235 included under any such insurance plan shall be made available to the public at or before these information sessions. This information shall be shared orally at the public information sessions and in writing on the department's Internet website. The commissioner shall provide public notice of these information sessions in compliance with RSA 91-A, and shall, to the extent practicable, make audio and video footage of these information sessions available through the department's Internet website. The commissioner shall accept public comments on the proposed networks for at least 2 weeks following the conclusion of the public information sessions, and shall enable members of the public to register their comments in writing through the department's website. If an insurance carrier amends its proposed network submission on or before August 1 of the year preceding the plan's inclusion in the federally-facilitated exchange, the commissioner shall only be required to make any such amendments available to the public on the insurance department's website. Nothing in this section shall be construed to prohibit an insurance carrier from making changes to the proposed network at any time if the insurance carrier meets network adequacy requirements under RSA 420-J:7.

Source. 2014, 201:1, eff. Aug. 10, 2014.

Section 420-N:6

420-N:6 Consistency. – [Repealed 2012, 231:3, I, eff. June 18, 2012.]

Health Exchange

Section 420-N:7

420-N:7 Prohibition on State-Based Health Exchange; Guidelines for Interaction With Federally-Facilitated Health Exchange. –

I. No New Hampshire state agency, department, or political subdivision shall plan, create, participate in or enable a state-based exchange for health insurance under the Act, or contract with any private

entity to do so.

II. State agencies or departments may interact with the federal government with respect to the creation of a federally-facilitated exchange for New Hampshire.

III. Subject to the requirements of this chapter with respect to oversight committee approval, state agencies or departments may operate specific functions of a federally-facilitated exchange consistent with this subdivision to enable the continuation of traditional areas of state regulation and authority.

IV. State agency activities relating to any federally-facilitated exchange for New Hampshire shall be consistent with the following objectives:

(a) Promoting preservation of the private, commercial delivery of health coverage through carriers and producers to the greatest degree possible under the Act and minimizing interference with the operation of commercial markets.

(b) Minimizing overhead and administrative expenses.

(c) Promoting competition and consumer choice, for example by advocating for allowing all health and dental plans that meet the minimum requirements necessary to be certified as qualified plans under the Act to be offered in the exchange.

(d) Preserving to the greatest extent possible the state's insurance regulatory authority and the state's flexibility in determining Medicaid eligibility standards and program design and operation.

Source. 2012, 231:2, eff. June 18, 2012.

Section 420-N:8

420-N:8 Federally-Facilitated Exchange; Authority of the Commissioner. –

I. In the event a federally-facilitated exchange is established for New Hampshire, the commissioner shall retain authority with respect to insurance products sold in New Hampshire on the federally-facilitated exchange to the maximum extent possible by law as provided in title XXXVII, including but not limited to producer and insurer licensing, form and rate approval, reinsurance and other risk-sharing mechanisms, network adequacy, industry assessments, internal grievance standards, external review, and unfair trade practices.

II. Any person who sells, solicits, or negotiates insurance within the meaning of RSA 402-J:3 through a federally-facilitated exchange shall be licensed as a producer under RSA 402-J; provided, that nothing in this subdivision shall prohibit the sale of health coverage by an exchange or health carrier directly to the consumer without the use of a producer. This paragraph shall not be interpreted to require that all navigators as defined under the Act be licensed as producers, but rather that any individual who in fact performs a producer function be licensed, whether or not that person is employed by a navigator.

III. The commissioner may establish standards and training requirements for navigators on a federally-facilitated exchange consistent with section 1311(i) of the Act and regulations implemented under the Act, including provisions to ensure that any private or public entity that is selected as a navigator avoids conflicts of interest and is appropriately qualified to engage in navigator activities.

IV. The commissioner shall, consistent with the requirements of the Act, allow producers to enroll individuals, employers, or employees in qualified health plans offered through a federally-facilitated exchange in this state, including enrollment using Internet websites.

V. The commissioner may adopt rules, pursuant to RSA 541-A and in accordance with RSA 420-N:4, II, as necessary to perform the duties specified in this section and to protect against adverse selection by creating a level playing field between a federally-facilitated exchange and the commercial health insurance market.

Source. 2012, 231:2, eff. June 18, 2012.

Section 420-N:9

420-N:9 Federally-Facilitated Exchange; Authority of the Health and Human Services Commissioner.

I. The commissioner of health and human services shall have authority to establish New Hampshire eligibility standards, enrollment procedures, and outreach mechanisms for persons who are enrolled through a federally-facilitated exchange in this state in the Medicaid program under title XIX of the Social Security Act or the Children's Health Insurance Program (CHIP) under title XXI of the Social Security Act.

II. The commissioner of health and human services may establish navigator guidelines for New Hampshire consistent with section 1311(i) of the Act, and regulations implemented under the Act, to ensure that navigators are qualified to reach and assist the Medicaid-eligible and other populations served by a federally-facilitated exchange in New Hampshire.

III. The commissioner of health and human services may adopt rules, pursuant to RSA 541-A and subject to oversight committee approval under RSA 161:11, as necessary to fulfill the purposes of this subdivision.

Source. 2012, 231:2, eff. June 18, 2012.

Section 420-N:10

420-N:10 Health Exchange Advisory Board. –

I. There is hereby created a health exchange advisory board for the purpose of advising the commissioner and the commissioner of health and human services regarding the interests of New Hampshire businesses and consumers with respect to any federally-facilitated exchange that may be created for New Hampshire. The board shall consist of 12 members, as follows:

(a) Two persons representing health insurance carriers, appointed by the commissioner.

(b) One person representing dental carriers, appointed by the commissioner.

(c) One person representing producers, appointed by the commissioner.

(d) One person representing Medicaid recipients, appointed by the commissioner of health and human services.

(e) One person representing health care providers and health care facilities in New Hampshire, appointed by the commissioner of health and human services.

(f) One person who is an advocate for enrolling hard to reach populations, including individuals with a mental health or substance abuse disorder, appointed by the commissioner of health and human

services.

(g) One person who is a public health expert, appointed by the commissioner of health and human services.

(h) Four public members appointed by the governor, with consent of the executive council, who are not employed by or affiliated with a carrier, a producer, or a health care provider, other than incidentally as a covered person or purchaser of health coverage or health care, as follows:

(1) One person who can reasonably be expected to purchase individual coverage through the exchange with the assistance of a premium tax credit and who can reasonably be expected to represent the interests of consumers purchasing individual coverage through the exchange;

(2) One person representing an employer that can reasonably be expected to purchase group coverage through an exchange and who can reasonably be expected to represent the interests of employers;

(3) One person representing navigators or entities likely to be licensed as navigators; and

(4) One person employed by an employer who can reasonably be expected to purchase group coverage through an exchange and who can reasonably be expected to represent the interests of such employees.

II. Members of the board may serve up to 2 3-year terms. Of the initial members, 4 members shall serve an initial term of one year, 4 members shall serve an initial term of 2 years, and 4 members shall serve an initial term of 3 years in order to achieve staggered terms.

III. The board shall elect a chairperson annually from among its members. If a vacancy occurs on the board, the vacancy for the unexpired term shall be filled in accordance with the above procedures with a person who has the appropriate qualifications to fill that position on the board.

IV. Initial appointments shall be made within 30 days of the effective date of this subdivision, and subsequent appointments shall be made within 30 days of any vacancy.

V. Meetings of the board shall be held at the call of the chairperson or when 5 members so request.

VI. The board shall be a public body subject to RSA 91-A, and its meetings shall be considered public proceedings.

Source. 2012, 231:2, eff. June 18, 2012.

CHAPTER 126-A
DEPARTMENT OF HEALTH AND HUMAN SERVICES

Section 126-A:5

RSA 126-A:5, XXV. (a) Consistent with the time frames in this paragraph, there is hereby established the marketplace premium assistance program. This will be a premium assistance program for newly eligible adults and their eligible spouse and dependents, if applicable, until December 31, 2018 and shall be administered by the department of health and human services. In order to receive medical assistance from the program, newly eligible adults who are ineligible for the HIPPA program shall choose from any qualified health plans (QHPs) offered on the federally-facilitated exchange if cost effective; provided, however, that any newly eligible adult who had coverage under an alternative benefit plan (ABP) offered by a managed care organization (MCO) under paragraph XIX during the voluntary bridge to marketplace premium assistance program established under RSA 126-A:5, XXIV shall be automatically enrolled at the beginning of open enrollment in a comparable QHP by that same MCO if one is available, unless such newly eligible adult subsequently chooses a different QHP during the enrollment period. If a comparable QHP is not offered by the newly eligible adult's MCO then the newly eligible adult may choose from any QHPs, if cost effective. Provider payments shall be in an amount which shall be no less than before the effective date of this paragraph.

(b) On or before December 1, 2014, the commissioner shall submit to CMS any necessary waiver application to implement the provisions of this paragraph, including provisions to address individuals determined to be medically frail after completion of a health questionnaire screening process. To the greatest extent practicable the waiver shall incorporate measures to promote continuity of health insurance coverage and personal responsibility, including but not limited to: co-pays, deductibles, disincentives for inappropriate emergency room use, and mandatory wellness programs. Prior to submitting the waiver to CMS the commissioner shall present the waiver to the fiscal committee of the general court for approval. The program shall not begin until such waivers have been approved by CMS.

(c) If the waiver to implement the marketplace premium assistance program is approved on or before March 31, 2015 then, coverage under the voluntary bridge to marketplace premium assistance program established in RSA 126-A:5, XXIV shall terminate on December 31, 2015. Enrollment in the marketplace premium assistance program shall begin on October 15, 2015 and coverage shall begin on January 1, 2016. Coverage shall end on December 31, 2018. The cost of the medical assistance provided under the marketplace premium assistance program shall be paid solely from non-general fund sources, including federal funds as provided under 42 U.S.C. section 1396d(y).

(d) If the waiver to implement the marketplace premium assistance program is not approved on or before March 31, 2015 then the program shall not begin and coverage under the voluntary bridge to marketplace premium assistance program established in RSA 126-A:5, XXIV shall terminate on June 30, 2015.

(e) A determination of eligibility for the marketplace premium assistance program shall be a qualifying event under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Individuals who participate in the marketplace premium assistance program shall:

(1) Provide all necessary information regarding financial eligibility, residency, citizenship or immigration status, and insurance coverage to the department of health and human services in

accordance with rules, or interim rules, adopted under RSA 541-A;

(2) Inform the department of any changes in financial eligibility, residency, citizenship or immigration status, and insurance coverage within 10 days of such change; and

(3) At the time of enrollment acknowledge that the marketplace premium assistance program is subject to cancellation upon notice.

(f) The commissioner may adopt rules or interim rules, pursuant to RSA 541-A, as necessary to implement any changes to the Medicaid program consistent with any waivers or state plan amendments submitted under this paragraph.

(g) Nothing in this paragraph shall limit the existing and traditional regulatory authority of the New Hampshire insurance department under Title XXXVII with respect to private health insurance coverage in which persons are enrolled in this program under this paragraph. In developing the program under this paragraph including drafting any necessary plan amendments or waiver requests, the commissioner shall consult with the New Hampshire insurance department as necessary to ensure that each program is designed to operate seamlessly with private insurance coverage and is consistent with all applicable insurance regulatory standards.

[Paragraph XXVI repealed by 2014, 3:12, IV, effective December 31, 2018.]

Section 126-A:5-b

[RSA 126-A:5-b repealed by 2014, 3:12, V, effective December 31, 2018.]

126-A:5-b The New Hampshire Health Protection Trust Fund. –

I. There is hereby established the New Hampshire health protection trust fund which shall be accounted for distinctly and separately from all other funds and shall be non-interest bearing. The trust fund shall be administered by the commissioner of the department of health and human services and shall be used solely to provide coverage for the newly eligible Medicaid population as provided for under RSA 126-A:5, XXIV-XXVI and RSA 126-A:67 in qualified health plans on the federal marketplace and pay for the administrative costs for the program. The commissioner may accept any gifts, grants, donations, or other funding from any source and shall deposit all such revenue received into the fund. No state general fund appropriations shall be deposited into the fund. All moneys in the trust fund shall be nonlapsing and shall be continually appropriated to the commissioner of the department of health and human services for the purposes of the trust fund. The trust fund shall be authorized to pay and/or reimburse:

(a) The cost of the employee share of premiums, co-insurance, co-payments, deductibles, and supplemental cost-sharing, plus the cost of any wrap-around services that are determined by the department to be cost effective to licensed health insurance carriers and/or private employers for coverage under employer sponsored health insurance as provided in RSA 126-A:5, XXIII.

(b) The cost of medical services, including without limitation, premiums and wrap-around benefits for those newly eligible adults who obtain health coverage through the voluntary bridge to marketplace premium assistance program as provided in RSA 126-A:5, XXIV.

(c) The cost of premiums, co-insurance, co-payments, deductibles, and supplemental cost-sharing plus the cost of any wrap-around services to licensed health insurance carriers on the federally facilitated exchange under the marketplace premium assistance program as provided in

RSA 126-A:5, XXV.

(d) Any other costs that are fully reimbursable by the federal government pertaining to the health insurance premium payment (HIPP) program, the voluntary bridge to marketplace premium assistance program, and the marketplace premium assistance program for the newly eligible as established under 126-A:5, XXIII-XXVI and RSA 126-A:67.

II. The commissioner of health and human services, as the administrator of the trust fund, shall have the sole authority to:

(a) Apply for federal funds to support the programs established under RSA 126-A:5, XXIII-XXV and RSA 126-A:67.

(b) Notwithstanding any provision of law to the contrary, accept and expend federal funds as may be available for HIPP, the voluntary bridge to marketplace premium assistance program, and the premium assistance program. The commissioner shall notify the bureau of accounting services, by letter, with a copy to the fiscal committee of the general court and the legislative budget assistant.

(c) Make payments and reimbursements from the trust fund as outlined in this section.

III. The commissioner shall submit a report to the governor and the fiscal committee of the general court detailing the activities and operation of the trust fund annually within 90 days of the close of each state fiscal year.

Source. 2014, 3:3, eff. Mar. 27, 2014. 2016, 13:5, eff. Apr. 5, 2016.