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INSURANCE DEPARTMENT**

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**BULLETIN
DOCKET NO. INS NO. 12-015-AB**

TO: All licensed HMOs providing Medicaid Managed Care Coverage

FROM: Roger Sevigny 

DATE: April 4, 2012

RE: Applicability of New Hampshire Insurance Laws to Medicaid HMOs

In 2011, the New Hampshire General Court enacted a law requiring the New Hampshire Department of Health and Human Services (“DHHS”) to “employ a managed care model for administering the Medicaid program.” 2011 N.H. Laws chapter 125:1, codified at RSA 126-A:5, XIX(a). Consistent with options laid out in the statute, the DHHS commissioner chose to proceed under the “traditional capitated managed care organization contract” model. See RSA 126-A:5, XIX(a). Accordingly, in the request for proposals issued for Medicaid Care Management contracts on October 17, 2011 (“RFP”)¹, DHHS required that responding entities be licensed as Health Maintenance Organizations (“HMOs”). RFP at 29, 97. In view of the July 2012 target date for implementing the first phase of Medicaid Care Management, the New Hampshire Insurance Department (“Department”) is issuing this bulletin to address the applicability of certain state insurance laws to Medicaid HMOs.

Managed care in New Hampshire is governed by RSA chapter 420-B, which relates to HMOs, and RSA chapter 420-J, which relates to managed care generally. Certain other insurance law provisions, such as RSA chapter 420-G, the New Hampshire Portability, Availability and Renewability of Health Coverage Act and RSA chapter 417, the Unfair Insurance Trade Practices Act, also apply to managed care entities. See RSA 420-B:20, III, listing insurance law provisions applicable to HMOs. However, not all of the statutory requirements applicable to HMOs generally are applicable to Medicaid coverage that is made available by the state to eligible persons through a state contract with an HMO. For example, insurance laws concerning employer-based coverage that require coverage of particular categories of persons or that give covered persons rights in the face of cancellation or termination of a policy do not apply to enrolled participants in a Medicaid HMO. In addition, while the Department regulates HMOs

¹ The RFP is available at <http://www.dhhs.state.nh.us/business/rfp/documents/12-DHHS-CM-01.pdf>.

and other entities participating in the business of insurance,² the specific terms of Medicaid coverage offered through an HMO are governed by state and federal Medicaid requirements and the State Medicaid plan.³ Thus, the general rule that federal law requirements take precedence over state-specific requirements that conflict with the federal requirements may come into play.⁴

Given the complexity of the issues and the lack of specific guidance on the relationship between Medicaid and state insurance law requirements in the context of managed care, the purpose of this bulletin is to identify and provide information regarding certain requirements of Title XXXVII that do or do not apply to Medicaid managed care entities and the coverage they provide. This bulletin is not, however a comprehensive treatment of all laws,⁵ and the Department may issue further guidance in the future as questions arise with respect to provisions not addressed in this preliminary analysis.

I. Medicaid HMOs are subject to all licensing and solvency requirements.

The General Court clearly intended that the organizations offering Medicaid HMOs be licensed and regulated by the Department. The statute specifies that the Medicaid managed care model will be one of “full risk to the vendors,” which places their operations squarely within the realm of insurance. RSA 126-A:5, XIX(a). The law also defines a managed care organization as “an entity that is authorized by law to provide covered health services on a capitated risk basis.” RSA 126-A:5, XIX(c)(3). Only by obtaining an HMO license from the Department under RSA 420-B will an entity satisfy the statutory requirement that it be “authorized by law” to provide services on a capitated basis.

Licensing and solvency requirements focus on the HMO entity, rather than the care provided or persons covered. As Medicaid managed care entities are required by RSA 126-A:5, XIX to bear risk, it is necessary and appropriate that the Department regulate them just like any other HMO entity. Accordingly, the entities must be fully licensed under RSA chapter 420-B, and must comply with all provisions of that statute governing financial status and solvency. These include the following specific provisions of RSA 420-B:

- RSA 420-B:1 – Definitions
- RSA 420-B:2 – Certificate of Authority
- RSA 420-B:3 – Application for Certificate of Authority

² Under the McCarran-Ferguson Act, state law regulation of the core “business of insurance,” particularly with respect to the relationship of an insurer and its insured, takes precedence over federal requirements, unless the federal law in question specifically relates to the business of insurance and specifically supersedes the state law. See, e.g., Solis v. The Home Insurance Co., 2012 WL 254234 (D.N.H. January 27, 2012).

³ Generally speaking, “[t]o qualify for federal funds, States must submit to a federal agency . . . a state Medicaid plan that details the nature and scope of the State's Medicaid program. It must also submit any amendments to the plan that it may make from time to time. And it must receive the agency's approval of the plan and any amendments. Before granting approval, the agency reviews the State's plan and amendments to determine whether they comply with the statutory and regulatory requirements governing the Medicaid program.” Douglas v. Independent Living Center, 132 S.Ct. 1204, 1208 (Feb. 22, 2012).

⁴ See, e.g., Bartlett v. Mutual Pharmaceutical Company, 659 F.Supp.2d 279 (D.N.H. 2009).

⁵ In particular, this bulletin is not intended to provide specific information regarding state or federal laws applicable to the state's Medicaid program, which is administered by DHHS.

- RSA 420-B:4 – Jurisdictional Power of Attorney
- RSA 420-B:5 – Issuance of Certificate of Authority
- RSA 420-B:5-a – Renewal of Certificate of Authority
- RSA 420-B:5-b – New License Required for Changed Conditions
- RSA 420-B:6 – Pre-Certificate Activities
- RSA 420-B:7 – Powers of Health Maintenance Organizations
- RSA 420-B:9 – Reports to the Commissioner
- RSA 420-B:10 – Examinations
- RSA 420-B:13 – Sanctions
- RSA 420-B:14 – Procedures and Appeals
- RSA 420-B:15 – Investments
- RSA 420-B:16 – Fees
- RSA 420-B:21 - Regulation
- RSA 420-B:25 – Capital Requirements

In sum, these entities will be fully licensed as HMOs and once licensed will be free to offer non-Medicaid products in New Hampshire.

In view of the analysis above, the following chapters of Title XXXVII relating to solvency, made applicable to all HMOs under RSA 420-B:20, III, are also applicable to Medicaid HMOs:

- RSA chapter 401-B, regarding holding companies
- RSA chapter 402-C, regarding insurance company rehabilitation and liquidation
- RSA chapter 404-F, regarding risk-based capital

II. Medicaid HMOs are subject to the premium tax and Department assessment

HMOs are subject to both the premium tax and the assessment for the Department's administration fund. Specifically, RSA 420-B:17 provides that "[e]very organization doing business pursuant to this chapter shall be subject to the premium tax requirements of RSA 400-A:31 and 32." Similarly, RSA 420-B:20, III includes on its list of applicable provisions RSA 400-A:39, which requires insurers, including HMOs, to pay a pro rata share of the Department's operating costs. RSA 400-A:39, IV. Both the premium tax and the Department assessment are calculated based on a company's gross direct premiums. See RSA 400-A:31. There is no exception for Medicaid HMOs.

By contrast, Medicaid HMOs are exempt from the high risk pool assessment under RSA chapter 404-G and the vaccine association assessment under RSA chapter 126-Q. Both of these assessments rely on the definition of "health insurance" in RSA 404-G:2, VII. This provision excludes "Managed Medicaid" from the definition of health insurance and thereby precludes any high risk pool or vaccine association assessment based on Medicaid covered lives.

III. Insurance Laws With Limited or No Applicability to Medicaid Coverage

A. External Review

By statute, New Hampshire's external review provisions, which govern appeals from a carrier's decision to deny coverage for a particular service, are not applicable to determinations made by a health carrier with respect to Medicaid services. Such decisions "shall not be reviewed under this chapter, but shall be reviewed pursuant to the review processes provided by applicable federal or state law." RSA 420-J:5-a, II. Thus, the following provisions are inapplicable to Medicaid HMOs:

- RSA 420-J:5-a – Right to External Review
- RSA 420-J:5-b – Standard External Review
- RSA 420-J:5-c – Expedited External Review
- RSA 420-J:5-e – General Provisions Regarding External Review

B. Advertising

With respect to advertising, the HMO law requires prior approval by the Department of "[a]ll advertising intended for use in this state whether through written, radio, or television medium . . . except that the commissioner may waive prior approval for any such materials which the department of health and human services has approved for use in the medicaid program." RSA 420-B:8, VI. Consistent with this language, the Department will waive prior approval of Medicaid HMO advertising materials that have been approved by DHHS (see RFP Section 3.5.6).

C. Rate Review

Medicaid HMOs must file their proposed rates with the Department, but it will be considered an "information only" filing that does not require approval by the Department. Specifically, RSA 420-B:8, I requires all HMOs to submit their proposed rates for review by the Department under N.H. Code of Admin. Rules Ins ("Ins") Part 4100 governing rate filings. The actuarial memorandum a regulated entity must include in its rate submission for purposes of Ins 4100 must contain a projected medical loss ratio ("MLR") as part of its explanation of why a proposed rate is reasonable.

In the Department's view, the rate filing is dual-purpose. It pertains to the regulated entity in that the Department must ensure that the rates are sufficient to allow the entity to remain solvent. However, it pertains to the product in that the rates must be reasonable in view of the coverage provided under the policy. Because the Department must regulate all aspects of the Medicaid HMO entities' financial status, these entities must comply with the rate filing requirement. However, due to the unique nature of the Medicaid "product," there is no applicable MLR standard in the Ins 4100 rules, because this product does not fall into any of the categories in the rules (individual, small group, large group, stop loss and products exempted under RSA 420-G:2, IX). Thus, the filing will be made for informational purposes only, and will not require Department approval.

D. Eligibility

Any New Hampshire Care Management coverage must, at a minimum, meet all applicable federal Medicaid standards. Medicaid has its own eligibility requirements. See RFP Section 2.1.3 (Eligibility for the Medicaid Program), listing requirements and their sources in state and federal law. Given the complex and unique nature of the Medicaid eligibility determination and the fact that these standards differ substantially from continuation of coverage requirements specific to employer-based coverage, the Department concludes that the following requirements of RSA 415:18⁶ are inapplicable to Medicaid HMOs:

- RSA 415:18, VII-a – Coverage During Labor Disputes
- RSA 415:18, XVI – State Continuation
- RSA 415:18, XVII – Termination of Coverage

Similarly, the following provisions of RSA chapter 420-B are inapplicable because they are designed solely for the private insurance market and do not apply to Medicaid coverage:

- RSA 420-B:8-aa – Dependent Coverage⁷
- RSA 420-B:8-c, 8-d - Cancellation/Nonrenewal
- RSA 420-B:8-i – Incontestability
- RSA 420-B:12, IV – Prohibition on excluding part-time employees

IV. Other Laws

With the exception of the provisions specifically discussed above, the Department retains its general authority under RSA chapters 415-A, 417, 420-B, 420-G and 420-J. The Department's intention is to regulate fully the functions and activities of Medicaid HMOs as entities engaged in the business of insurance. At the same time, however, the Department acknowledges that the Medicaid coverage these entities offer must comply with all applicable Medicaid requirements, and that provisions of insurance law that relate to the coverage rather than the licensed entity may not be applicable to the extent they directly conflict with Medicaid-specific requirements. Any issues that arise under any specific provision will be decided on a case-by-case basis, and regulated entities are encouraged to contact the Department to discuss their specific questions.

If you have questions about this bulletin, please contact the Department's Life, Accident and Health Legal Counsel Jennifer Patterson at (603) 271-2261 or Jennifer.patterson@ins.nh.gov.

⁶ Under RSA 420-B:20, III, these three requirements apply to HMOs.

⁷ This provision requires dependent coverage up to age 26, but specifically excludes individuals with Medicaid coverage. RSA 420-B:8-aa, I(d).