2011 SESSION

11-1006
01/04

SENATE BILL ***163-FN***

AN ACT relative to the New Hampshire health benefit exchange.

SPONSORS: Sen. White, Dist 9; Sen. Barnes, Jr., Dist 17; Sen. Bradley, Dist 3; Sen. Bragdon, Dist 11; Sen. Groen, Dist 6; Sen. Sanborn, Dist 7; Rep. Hunt, Ches 7; Rep. Avard, Hills 20; Rep. Accornero, Belk 4

COMMITTEE: Commerce

ANALYSIS

This bill establishes the New Hampshire health benefit exchange as a public corporation. The bill also establishes the exchange board to provide procedures to facilitate the exchange's purpose which is to assist in the purchase and sale of qualified health plans and to meet the requirements of the Patient Protection and Affordable Care Act. The insurance commissioner is granted rulemaking authority for the purposes of the bill.

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Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

11-1006
01/04

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Eleven

AN ACT relative to the New Hampshire health benefit exchange.

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

1 1 New Chapter; New Hampshire Health Benefit Exchange. Amend RSA by inserting after
2 chapter 415-J the following new chapter:
3 CHAPTER 415-K
4 NEW HAMPSHIRE HEALTH BENEFIT EXCHANGE
5 415-K:1 Purpose and Intent. The purpose of this chapter is to establish a New Hampshire
6 health benefit exchange to facilitate the purchase and sale of qualified health plans in the individual
7 market in this state and to establish a small business health options program (SHOP exchange) to
8 assist qualified small employers in this state in enrolling their employees in qualified health plans
9 offered in the small group market. The intent of the exchange is to reduce the number of uninsured,
10 provide a transparent marketplace, provide consumer education, and assist individuals with access
11 to programs, premium assistance tax credits, and cost-sharing reductions. Further, the legislative
12 intent of this chapter is to preserve and not displace, the private, commercial delivery of health care
13 through health carriers and health insurance producers to the greatest degree possible with the least
14 disruption to the private, commercial delivery systems currently in place. Consistent with this
15 intent, nothing in this chapter shall preclude the establishment of separate, privately-run exchanges.
16 Furthermore, nothing in this chapter shall prohibit the sale of health coverage by health carriers or
17 health insurance producers in the private marketplace directly to the consumer without the use of a
18 health insurance exchange. It is not the intent of this chapter to displace or discontinue any health
19 carrier and health insurance producer delivery systems in the current marketplace to the greatest
20 degree lawful under the federal Patient Protection and Affordable Care Act (Public Law 111-148), as
21 amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152)
22 hereinafter known as "Act" and the greatest degree practical. In cases of competing interests
23 between the exchange and the private marketplace, it is the intent of this chapter to promote a "level
24 playing field" as much as is practical and lawful under the Act. In cases of competing interests
25 between New Hampshire legislative intent and the Act, the commissioners responsible for carrying
26 out the duties, rules, and implementation contemplated under this chapter are strongly encouraged
27 to seek rule exceptions and waivers from the federal entities able to grant such exceptions and
28 waivers whenever possible in order to preserve the state of New Hampshire's autonomy and
29 legislative intent to the greatest degree that is legal, practical, permissible, and possible.
30 415-K:2 Definitions. In this chapter:

I. “Act” means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any amendments thereto, or regulations or guidance issued under, those acts.

II. “Board” means the exchange board established under RSA 415-K:3.

III. “Commissioner” means the insurance commissioner.

IV. “Exchange” means the New Hampshire health benefit exchange established pursuant to RSA 415-K:3.

V.(a) “Health benefit plan” means a policy, contract, certificate, or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

(b) “Health benefit plan” shall not include:

(1) Coverage only for accident or disability income insurance, or any combination thereof;

(2) Coverage issued as a supplement to liability insurance;

(3) Liability insurance, including general liability insurance and automobile liability insurance;

(4) Workers’ compensation or similar insurance;

(5) Automobile medical payment insurance;

(6) Credit-only insurance;

(7) Coverage for on-site medical clinics; or

(8) Other similar insurance coverage, specified in federal regulations issued pursuant to Public Law No. 104-191, under which benefits for health care services are secondary or incidental to other insurance benefits.

(c) “Health benefit plan” shall not include the following benefits if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan:

(1) Limited scope dental or vision benefits;

(2) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or

(3) Other similar, limited benefits specified in federal regulations issued pursuant to Public Law No. 104-191.

(d) “Health benefit plan” shall not include the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided under any group health plan maintained by the same plan sponsor:

(1) Coverage only for a specified disease or illness; or

(2) Hospital indemnity or other fixed indemnity insurance.

(e) "Health benefit plan" shall not include the following if offered as a separate policy, certificate, or contract of insurance:

(1) Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act;

(2) Coverage supplemental to the coverage provided under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), 10 U.S.C. sections 1071-1110a; or

(3) Similar supplemental coverage provided under a group health plan.

VI. "Health care consumer" means an individual who is knowledgeable about the health care system, and has background or experience in making informed decisions regarding health, medical, and scientific matters.

VII. "Health carrier" or "carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits, or health services.

VIII. "Health coverage" means a policy, contract, certificate, or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services that meets the definition of health coverage in RSA 420-G:2, X.

IX. "Health insurance producer" or "producer" means an individual licensed, pursuant to RSA 402-J, to sell health insurance in the state. This is separate and distinct from "navigators" as defined in paragraph X. Unlike "navigators," a "health insurance producer" or "producer" may receive commissions or other remuneration for placing business through the exchange when acting in the capacity of a producer.

X. "Navigator" means a person or entity that shall:

(a) Distribute fair and impartial information concerning enrollment in qualified health plans, and the availability of premium tax credits under section 36B of the Internal Revenue Code of 1986 and cost-sharing reductions under section 1402 of the Act;

(b) Conduct public education activities to raise awareness of the availability of qualified health plans;

(c) Facilitate enrollment in qualified health plans;

(d) Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the Public Health Service Act (PHSA), or any other appropriate state agency or agencies, for any enrollee with a grievance, complaint, or question regarding a health plan, coverage, or a determination under such plan or coverage; and

(e) Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the exchange or exchanges.

XI. "Qualified dental plan" means a limited scope dental plan that has been certified in accordance with this chapter.

XII. "Qualified employer" means a small employer that elects to make its full-time employees eligible for one or more qualified health plans offered through the SHOP exchange, and at the option of the employer, some or all of its part-time employees, provided that the employer:

(a) Has its place of business in this state and elects to provide coverage through the SHOP exchange to all of its eligible employees, wherever employed; or

(b) Elects to provide coverage through the SHOP exchange to all of its eligible employees who are employed in this state.

XIII. "Qualified health plan" means a health plan that has in effect a certification that the plan meets the criteria for certification described in section 1311(c) of the Act.

XIV. "Qualified individual" means an individual, including a minor, who:

(a) Is seeking to enroll in a qualified health plan offered to individuals through the exchange;

(b) Resides in this state;

(c) At the time of enrollment, is not incarcerated, other than incarceration pending the disposition of charges; and

(d) Is, and is reasonably expected to be, for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States.

XV. "Secretary" means the Secretary of the federal Department of Health and Human Services.

XVI. "SHOP exchange" means the small business health options program.

XVII. "Small employer" means an employer that employed an average of not more than 50 employees during the preceding calendar year. For purposes of this paragraph:

(a) All persons treated as a single employer under subsections (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as a single employer;

(b) An employer and any predecessor employer shall be treated as a single employer;

(c) All employees shall be counted, including part-time employees and employees who are not eligible for coverage through the employer.

415-K:3 New Hampshire Health Benefit Exchange Established.

I. The New Hampshire health benefit exchange is hereby established as a corporate body, which shall be deemed to be an instrumentality of the state and a public corporation. This chapter shall not preclude the establishment of separate, privately-run exchanges or the distribution of health coverage outside of an exchange.

II. The exchange shall:

1 (a) Facilitate the purchase and sale of qualified health plans;
2 (b) Assist qualified employers in this state in facilitating the enrollment of their
3 employees in qualified health plans; and
4 (c) Meet the requirements of the Act and any regulations implemented under that Act.
5 415-K:4 Exchange Board.
6 I. The powers of the corporation shall be vested in the following members who shall serve
7 staggered 6-year terms:
8 (a) Three persons affiliated with an insurer admitted and authorized to write health
9 insurance in this state, 2 of whom shall represent domestic insurers, appointed by the commissioner.
10 (b) Two health insurance producers licensed to sell health insurance in New Hampshire,
11 appointed by the commissioner.
12 (c) Three public members who are not employed by or affiliated with an insurance
13 company or plan, group hospital, or other health care provider, and who can reasonably be expected
14 to qualify to purchase individual or group coverage through the exchange, appointed by the
15 commissioner. For the purposes of this subparagraph, public members includes small employers and
16 persons whose only affiliation with an insurance company or plan, group hospital service
17 corporation, or health maintenance organization are as an insured or person who has coverage
18 through a plan provided by such a corporation or organization and/or as a purchaser of such
19 coverage.
20 (d) The commissioner of the department of health and human services, or designee.
21 (e) The commissioner, or designee.
22 II. The members shall elect annually from among their number a chairperson. If a vacancy
23 occurs on the board, the commissioner shall fill the vacancy for the unexpired term with a person
24 who has the appropriate qualifications to fill that position on the board.
25 III. No member of the board of directors shall be liable for an act or omission performed in
26 good faith in the performance of powers and duties under this section, and a cause of action shall not
27 arise against a member for the action or omission.
28 415-K:5 Duties of the Board.
29 I. Within 6 months of appointment, the exchange's initial board shall submit to the
30 commissioner a plan of operation for the pool that will assure the fair, reasonable, and equitable
31 administration of the exchange.
32 II. In addition to the other requirements of this chapter, the plan of operation shall include
33 procedures for:
34 (a) Operation of the exchange.
35 (b) Selecting an administrator.
36 (c) Creating a fund, under management of the board, for administrative expenses.
37 (d) Handling and auditing of money and other assets of the pool.

1 (e) Developing and implementing a program to publicize the existence of the exchange,
2 the eligibility requirements for coverage under the exchange and for subsidies offered for individual
3 coverage offered through the exchange, enrollment procedures, and to foster public awareness of the
4 exchange.
5 (f) Developing and implementing procedures that require only licensed health insurance
6 producers to enroll individuals and employers in any qualified health plans offered through an
7 exchange in this state; and to assist individuals in applying for premium tax credits and cost-sharing
8 reductions for plans sold through an exchange, including an educational certification process for
9 insurance producers and navigators who wish to participate in the exchange to complete on an
10 annual basis.
11 (g) Developing a fair and equitable compensation plan for licensed insurance producers
12 that is consistent with the private market.
13 (h) Other matters as may be necessary and proper for the execution of the board's
14 powers, duties, and obligations under this chapter.
15 III. After notice and a hearing, the commissioner shall approve the plan of operation if it is
16 determined that the plan is suitable to assure the fair, reasonable, and equitable administration of
17 the exchange. The plan of operation shall take effect on the date it is approved by the commissioner.
18 IV. If the initial board fails to submit a suitable plan of operation before the 180th day
19 following its appointment, the commissioner, after notice and hearing, may adopt all necessary and
20 reasonable rules pursuant to RSA 541-A, to provide a plan for the exchange. The rules adopted
21 under this paragraph shall continue in effect until the initial board submits, and the commissioner
22 approves, a plan of operation under this section.
23 V. The board shall amend the plan of operation as necessary to carry out this section. The
24 commissioner shall approve amendments to the plan of operation before they become part of the
25 plan.
26 VI. It is the responsibility of the board to carry out the functions of the plan and employ and
27 set the compensation of any persons necessary to assist the board in carrying out its responsibilities
28 and functions.
29 VII. Not later than June 1 of each year, the board shall make an annual report to the
30 governor, the general court, the department of health and human services, and the commissioner.
31 The report shall summarize the activities of the exchange in the preceding calendar year.
32 415-K:6 Authority of the Commissioner.
33 I. The commissioner may require by rule, pursuant to RSA 541-A, additional duties of the
34 board and coordinate with other departments, including the office of Medicaid business and policy,
35 department of health and human services as needed to adopt other rules as are necessary and proper
36 to implement this chapter.

II. The commissioner shall perform the health plan certification functions for the exchange as required by the federal reform as part of the commissioner's existing health plan rate and form review responsibilities.

III. The commissioner may investigate the affairs of the exchange, examine the properties and records of the exchange and require the exchange to provide periodic reporting to the commissioner in relation to the activities undertaken by the exchange under this chapter.

415-K:7 Standards for Navigators.

I. The commissioner and the board shall jointly establish standards for navigators as outlined in Section 1311(i) of the Act, including provisions to ensure that any private or public entity that is selected as a navigator is qualified, licensed, and regulated by the state and the commissioner as a licensed health producer to engage in the navigator activities described in this section and to avoid conflicts of interest. Under such standards, a navigator shall not:

(a) Be a health insurance issuer; or

(b) Receive any consideration directly or indirectly from any health insurance issuer in connection with the enrollment of any qualified individuals or employees of a qualified employer in a qualified health plan through this exchange.

II. Although the navigator function is understood to be separate and distinct from a health insurance producer, the requirements for licensing, regulation, and continuing education shall be the same for both.

415-K:8 General Requirements.

I. The exchange shall make qualified health plans available to qualified individuals and qualified employers beginning with effective dates on or before January 1, 2014.

II. The exchange shall allow a health carrier to offer a plan that provides limited scope dental benefits meeting the requirements of section 9832(c)(2)(A) of the Internal Revenue Code of 1986 through the exchange, either separately or in conjunction with a qualified health plan, if the plan provides pediatric dental benefits meeting the requirements of section 1302(b)(1)(J) of the Act.

III. A policy of insurance offered through the exchange shall not impose a charge on an individual for termination of coverage if the individual enrolls in another type of minimum essential coverage because the individual has become newly eligible for that coverage or because the individual's employer-sponsored coverage has become affordable under the standards of section 36B(c)(2)(C) of the Internal Revenue Code of 1986.

415-K:9 Duties of the Exchange.

I. The exchange shall:

(a) Facilitate the purchase and sale of qualified health plans;

(b) Meet the requirements of this chapter and any rules adopted under this chapter;

(c) Implement procedures for the certification, recertification, and decertification, consistent with guidelines developed by the Secretary under section 1311(c) of the Act;

(d) Provide for the operation of a toll-free telephone hotline to respond to requests for assistance;

(e) Provide for enrollment periods, as provided under section 1311(c)(6) of the Act;

(f) Maintain an Internet website through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on such plans;

(g) Assign a rating to each qualified health plan offered through the exchange in accordance with the criteria developed by the Secretary under section 1311(c)(3) of the Act, and determine each qualified health plan's level of coverage in accordance with regulations issued by the Secretary under section 1302(d)(2)(A) of the Act;

(h) Use a standardized format for presenting health benefit options in the exchange, including the use of the uniform outline of coverage established under section 2715 of the PHSA;

(i) In accordance with section 1413 of the Act, inform individuals of eligibility requirements for the Medicaid program under title XIX of the Social Security Act, the Children's Health Insurance Program (CHIP) under title XXI of the Social Security Act or any applicable state or local public program and if through screening of the application by the exchange, the exchange determines that any individual is eligible for any such program, enroll that individual in that program;

(j) Establish and make available by electronic means a calculator to determine the actual cost of coverage after application of any premium tax credit under section 36B of the Internal Revenue Code of 1986 and any cost-sharing reduction under section 1402 of the Act;

(k) Establish a SHOP exchange through which qualified employers may access coverage for their employees, which shall enable any qualified employer to specify a level of coverage so that any of its employees may enroll in any qualified health plan offered through the SHOP exchange at the specified level of coverage;

(l) Subject to section 1411 of the Act, grant a certification attesting that, for purposes of the individual responsibility penalty under section 5000A of the Internal Revenue Code of 1986, an individual is exempt from the individual responsibility requirement or from the penalty imposed by that section because:

(1) There is no affordable qualified health plan available through the exchange, or the individual's employer, covering the individual; or

(2) The individual meets the requirements for any other such exemption from the individual responsibility requirement or penalty;

(m) Transfer to the federal Secretary of the Treasury the following:

(1) A list of the individuals who are issued a certification of exemption from the individual mandate that shall include the name and taxpayer identification number of each individual;

1 (2) The name and taxpayer identification number of each individual who was an
2 employee of an employer but who was determined to be eligible for the premium tax credit under
3 section 36B of the Internal Revenue Code of 1986 because:
4 (A) The employer did not provide minimum essential coverage; or
5 (B) The employer provided the minimum essential coverage, but it was
6 determined under section 36B(c)(2)(C) of the Internal Revenue Code to either be unaffordable to the
7 employee or not provide the required minimum actuarial value; and
8 (3) The name and taxpayer identification number of:
9 (A) Each individual who notifies the exchange under section 1411(b)(4) of the
10 federal Act that he or she has changed employers; and
11 (B) Each individual who ceases coverage under a qualified health plan during a
12 plan year and the effective date of that cessation;
13 (n) Provide to each employer the name of each employee of the employer described in
14 subparagraph (m)(2) who ceases coverage under a qualified health plan during a plan year and the
15 effective date of the cessation;
16 (o) Perform duties required of the exchange by the Secretary or the Secretary of the
17 Treasury related to determining eligibility for premium tax credits, reduced cost-sharing or
18 individual responsibility requirement exemptions;
19 (p) Select entities qualified to serve as navigators in accordance with section 1311(i) of
20 the Act, and standards developed by the Secretary. In order to be considered an entity qualified to
21 be a navigator, all individuals employed by or affiliated with the entity facilitating enrollment in
22 qualified health plans shall be health insurance producers licensed and regulated by the state. As
23 required by the Act, the exchange will award grants to enable navigators to:
24 (1) Conduct public education activities to raise awareness of the availability of
25 qualified health plans;
26 (2) Distribute fair and impartial information concerning enrollment in qualified
27 health plans, and the availability of premium tax credits under section 36B of the Internal Revenue
28 Code of 1986 and cost-sharing reductions under section 1402 of the Act;
29 (3) Facilitate enrollment in qualified health plans;
30 (4) Provide referrals to the insurance department or health insurance ombudsman
31 established under section 2793 of the PHSA, for any enrollee with a grievance, complaint or question
32 regarding his or her health benefit plan, coverage or a determination under that plan or coverage; and
33 (5) Provide information in a manner that is culturally and linguistically appropriate
34 to the needs of the population being served by the exchange;
35 (q) Review the rate of premium growth within the exchange and outside the exchange,
36 and consider the information in developing recommendations on whether to continue limiting
37 qualified employer status to small employers;

1 (r) Credit the amount of any free choice voucher to the monthly premium of the plan in
2 which a qualified employee is enrolled, in accordance with section 10108 of the Act, and collect the
3 amount credited from the offering employer;
4 (s) Consult with stakeholders relevant to carrying out the activities required under this
5 chapter, including, but not limited to:
6 (1) Health care consumers who are enrollees in qualified health plans;
7 (2) Individuals and entities with experience in facilitating enrollment in qualified
8 health plans;
9 (3) Representatives of small businesses and self-employed individuals;
10 (4) The office of Medicaid business and policy, department of health and human
11 services; and
12 (5) Advocates for enrolling hard to reach populations; and
13 (t) Meet the following financial integrity requirements:
14 (1) Keep an accurate accounting of all activities, receipts and expenditures and
15 annually submit to the Secretary, the governor, the commissioner and the general court a
16 comprehensive financial report;
17 (2) Fully cooperate with any investigation conducted by the Secretary pursuant to
18 the Secretary's authority under the Act and allow the Secretary, in coordination with the Inspector
19 General of the United States Department of Health and Human Services, to:
20 (A) Investigate the affairs of the exchange;
21 (B) Examine the properties and records of the exchange; and
22 (C) Require periodic reports in relation to the activities undertaken by the
23 exchange; and
24 (3) In carrying out its activities under this chapter, not use any funds intended for
25 the administrative and operational expenses of the exchange for staff retreats, promotional
26 giveaways, or excessive executive compensation.
27 II. The exchange may contract with an eligible entity for any of its functions described in
28 this chapter. An eligible entity includes, but is not limited to, an entity that has experience in
29 individual and small group health insurance, benefit administration or other experience relevant to
30 the responsibilities to be assumed by the entity, but a health carrier or an affiliate of a health carrier
31 is not an eligible entity.
32 III. The exchange may enter into information-sharing agreements with federal and state
33 agencies and other state exchanges to carry out its responsibilities under this chapter provided such
34 agreements include adequate protections with respect to the confidentiality of the information to be
35 shared and comply with all state and federal laws and regulations.
36 415-K:10 Health Benefit Plan Certification.
37 I. The commissioner may certify a health benefit plan as a qualified health plan if:

(a) The plan provides the essential health benefits package described in section 1302(a) of the Act;

(b) The premium rates and contract language have been approved by the commissioner;

(c) The plan provides at least a bronze level of coverage, as determined pursuant to RSA 415-K:8, unless the plan is certified as a qualified catastrophic plan, meets the requirements of the federal Act for catastrophic plans, and will only be offered to individuals eligible for catastrophic coverage;

(d) The plan's cost-sharing requirements do not exceed the limits established under section 1302(c)(1) of the Act, and if the plan is offered through the SHOP exchange, the plan's deductible does not exceed the limits established under section 1302(c)(2) of the Act.

(e) The health carrier offering the plan:

(1) Is licensed and in good standing to offer health insurance in this state;

(2) Offers at least one qualified health plan in the silver level and at least one plan in the gold level through each component of the exchange;

(3) Charges the same premium rate for each qualified health plan without regard to whether the plan is offered through the exchange and without regard to whether the plan is offered directly from the carrier or through an insurance producer;

(4) Does not charge any cancellation fees or penalties; and

(5) Complies with the regulations developed by the Secretary under 1311(d) of the Act and such other requirements as the exchange may establish.

(f) The plan meets the requirements of certification as adopted by rule pursuant to RSA 415-K:9 and by the Secretary under section 1311(c) of the Act, which include, but are not limited to, minimum standards in the areas of marketing practices, network adequacy, essential community providers in underserved areas, accreditation, quality improvement, uniform enrollment forms, and descriptions of coverage and information on quality measures for health benefit plan performance; and

(g) The exchange commissioner determines that making the plan available through the exchange is in the interest of qualified individuals and qualified employers in this state.

II. The commissioner shall not exclude a health benefit plan:

(a) On the basis that the plan is a fee-for-service plan; or

(b) Through the imposition of premium price controls by the exchange;

III. The commissioner shall require each health carrier seeking certification of a plan as a qualified health plan to:

(a) Submit a justification for any premium increase before implementation of that increase. The carrier shall prominently post the information on its Internet website. The commissioner shall take this information, along with the information and the recommendations provided by the exchange to the commissioner under section 2794(b) of the PHSA, into consideration when determining whether to allow the carrier to make plans available through the exchange;

(b)(1) Make available to the public, in the format described in subparagraph (2), and submit to the exchange, the Secretary, and the commissioner, accurate and timely disclosure of the following:

(A) Claims payment policies and practices;

(B) Periodic financial disclosures;

(C) Data on enrollment;

(D) Data on disenrollment;

(E) Data on the number of claims that are denied;

(F) Data on rating practices;

(G) Information on cost-sharing and payments with respect to any out-of-network coverage;

(H) Information on enrollee and participant rights under title I of the Act; and

(I) Other information as required under the Act.

(2) The information required in paragraph (1) shall be provided in plain language as that term is defined in section 1311(e)(3)(B) of the Act; and;

(c) Permit individuals to learn, in a timely manner upon the request of the individual, the amount of cost-sharing, including deductibles, copayments, and coinsurance, under the individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider. This information shall be made available to the individual through an Internet website and through other means for individuals without access to the Internet.

IV. The commissioner shall not exempt any health carrier seeking certification of a qualified health plan, regardless of the type or size of the carrier, from licensure or solvency requirements and shall apply the criteria of this section in a manner that assures a level playing field between or among health carriers participating in the exchange.

415-K:11 Funding; Publication of Costs.

I. The exchange may generate funding necessary to support its operations provided under this chapter.

II. The exchange shall publish the average costs of licensing, regulatory fees, and any other payments required by the exchange, and the administrative costs of the exchange, on an Internet website to educate consumers on such costs. This information shall include information on moneys lost to fraud, waste, abuse, and mismanagement within the exchange system.

415-K:12 Relation to Other Laws. Nothing in this chapter, and no action taken by the exchange pursuant to this chapter, shall be construed to preempt or supersede the authority of the commissioner to regulate the business of insurance within this state. Except as expressly provided to the contract in this chapter, all health carriers offering qualified health plans in this state shall comply fully with all applicable health insurance laws of this state and rules adopted and orders issued by the commissioner.

1 415-K:13 Severability. If any provision of this chapter or the application thereof to any person
2 or circumstance is held invalid, such invalidity shall not affect the provisions or application of this
3 chapter which can be given effect without the invalid provisions or applications, and to this end, the
4 provisions of this chapter are severable.
5 2 Effective Date. This act shall take effect 60 days after its passage.

LBAO
11-1006
Revised 02/07/11

SB 163 FISCAL NOTE

AN ACT relative to the New Hampshire health benefit exchange.

FISCAL IMPACT:

The Insurance Department states this bill will increase state revenues and state expenditures by indeterminable amounts in FY 2012 and each fiscal year thereafter. There will be no fiscal impact on county and local revenues or expenditures.

METHODOLOGY:

The Insurance Department states this bill provides for the creation of a public corporation to operate a health insurance exchange which would be responsible for performing several duties. The Department is unable to estimate the costs associated with performing all of the required duties under this bill. The Department states this bill also authorizes the health insurance exchange to generate funding necessary to fund its operations. The Department states as neither the amount of revenue required to be generated nor the mechanism for raising revenue is known, it is unable to determine this bill's fiscal impact on state revenues.