HB 668-FN – AS AMENDED BY THE HOUSE

13Mar2013... 0627h

2013 SESSION

13-0439
01/09

HOUSE BILL ***668-FN***

AN ACT relative to group and individual health insurance market rules.

SPONSORS: Rep. Schlachman, Rock 18

COMMITTEE: Commerce and Consumer Affairs

ANALYSIS

This bill makes changes to the statute applicable to health insurance carriers offering major medical health insurance coverage in the group and individual markets in New Hampshire.

This bill is a request of the insurance department.

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Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

HB 668-FN – AS AMENDED BY THE HOUSE

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13-0439
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STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Thirteen

AN ACT relative to group and individual health insurance market rules.

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

1 Definitions. Amend RSA 420-G:2, II-a to read as follows:

II-a. "Composite billing" means a method of calculating premium rates for small employer groups in which each enrolled employee's rate varies only by the enrolled employee's family composition ***and the enrolled member's tobacco use***. ***The composite rates would consist of rates that vary by family composition and a rating add-on for each member that uses tobacco.***

2 New Paragraphs; Definitions; Employee. Amend RSA 420-G:2 by inserting after paragraph VI the following new paragraphs:

VI-a. "Employee" means "employee" as described under section 3(6) of the Employee Retirement Income Security Act of 1974, 29 U.S.C., section 1002(6).

VI-b. "Essential health benefits" means the categories of coverage identified in 42 U.S.C. section 18022(b)(1) and as further defined and implemented by the United States Secretary of Health and Human Services from time to time.

3 New Paragraph; Definitions; Grandfathered Health Plans. Amend RSA 420-G:2 by inserting after paragraph VII-a the following new paragraph:

VII-b. "Grandfathered health plan" or "grandfathered coverage" means coverage provided by a group health plan, or a group or individual health insurance issuer, that was initially issued on or before March 23, 2010, in which at least one individual, though not necessarily the same individual, has been enrolled at all times since March 23, 2010, and that meets all other requirements for being considered a grandfathered health plan under 45 C.F.R., section 147.140.

4 Definitions. Amend RSA 420-G:2, XII-a to read as follows:

XII-a. "List billing" means a method of calculating premium rates for small employer groups in which each enrolled employee's rate varies [~~only~~] by the enrolled employee's attained age [~~and~~]**,** the enrolled employee's family composition***, and tobacco use by the enrolled employee and the employee's covered family***.

5 Definitions; Modified Experience Rating. Amend RSA 420-G:2, XIII-a to read as follows:

XIII-a. "Modified experience rating" means a rating methodology to apply only to individual [~~policies~~] ***grandfathered health plans*** sold in the nongroup market, which modifies community rating to allow for limited consideration of health status, as detailed in RSA 420-G:4, I(a).

6 Definitions Added. Amend RSA 420-G:2, XV-a to read as follows:

XV-a. ***"Qualified health plan" means a health plan that meets all requirements for certification set forth under 42 U.S.C. section 18021 and any applicable rules or regulations.***

XV-b. "Rating period" means the time period for which the premium rate charged by a health carrier to an individual or a small employer for a health benefit plan is in effect.

XV-c. "SHOP exchange" means the Small Business Health Options Program established for New Hampshire under 42 U.S.C. section 13031(b).

7 Definitions; Small Employer. Amend RSA 420-G:2, XVI(a) to read as follows:

(a) "Small employer" means a business or organization which employed on average, one and up to 50 employees[~~, including owners and self employed persons,~~] on business days during the previous calendar year. A small employer is subject to this chapter whether or not it becomes part of an association, multi-employer plan, trust, or any other entity cited in RSA 420-G:3 provided it meets this definition.

8 Definitions. RSA 420-G:2, XVI(a) is repealed and reenacted to read as follows:

(a) "Small employer" means a business or organization which employed on average, one and up to 100 employees on business days during the previous calendar year. A small employer is subject to this chapter whether or not it becomes part of an association, multi-employer plan, trust, or any other entity cited in RSA 420-G:3 provided it meets this definition.

9 Premium Rates. Amend RSA 420-G:4, I to read as follows:

I. Health carriers providing [~~health~~] ***grandfathered*** coverage to individuals and small employers under this chapter shall be subject to the following:

(a) All premium rates charged shall be guaranteed for a rating period of at least 12 months, and shall not be changed for any reason, including but not limited to a change in the group's case characteristics.

(b) Market rate shall be established by each health carrier for all of its ***grandfathered*** health [~~coverages~~] ***plans*** offered to individuals and, separately, for all of its ***grandfathered*** health [~~coverages~~] ***plans*** offered to small employers.

(c) Health carriers shall calculate health coverage plan rates for each of the [~~coverages or~~] ***grandfathered*** health [~~benefit~~] plans written by that carrier. Variations in health coverage plan rates shall be solely attributable to variations in expected utilization or cost due to differences in coverage design and/or the provider contracts or other provider costs associated with specific coverages and shall not reflect differences due to the nature of the groups or eligible persons assumed to select particular health coverages.

(d) In establishing the premium charged, health carriers providing ***grandfathered*** coverage to individuals shall calculate a rate that is derived from the health coverage plan rate through the application of rating factors that the carrier chooses to utilize for age, health status, and tobacco use. Such factors may be utilized only in accordance with the following limitations:

(1) The maximum premium differential for age as determined by ratio shall be 4 to 1. The limitation shall not apply for determining rates for an attained age of less than 19.

(2) The maximum differential due to health status shall be 1.5 to 1 and the maximum rate due to tobacco use shall be 1.5 to 1. Rate limitations based on health status do not apply to rate variations based on an insured's status as a tobacco user.

(3) Permissible rating characteristics shall not include changes in health status after issue.

(e) In establishing the premium charged, health carriers offering ***grandfathered*** coverage to small employers shall calculate premium rates that are derived from the health coverage plan rate by making adjustments to reflect one or more case characteristics. Such adjustments from the health coverage plan rate may be made only in accordance with the following limitations:

(1) In establishing the premium rates, health carriers offering ***grandfathered*** coverage to small employers may use only age, group size, and industry classification as case characteristics. No consideration shall be given to health status, claim experience, duration of coverage, geographic location, or any other characteristic of the group.

(2) Carriers making adjustments from the health coverage plan rate for age may do so only by using the following age brackets:

0 - 18
19 - 24
25 - 29
30 - 34
35 - 39
40 - 44
45 - 49
50 - 54
55 - 59
60 - 64
65 +

(3) The maximum premium rate differential after adjusting for all case characteristics as determined by ratio shall be 3.5 to 1. This limitation shall not apply for determining premium rates for covered persons whose attained age is less than 19.

(4) In establishing the premium rates, health carriers offering coverage to small employers may make further adjustments based on family composition.

(5) The small employer health carrier shall set premium rates for small employers after consideration of case characteristics of the small employer group as well as family composition. No small employer health carrier shall inquire regarding health status or claims experience of the

small employer or its employees or dependents until after the premium rates have been agreed upon by the carrier and the employer.

(6) Carriers may calculate premium rates using either list billing or composite billing. Carriers shall use the same billing method in all succeeding rating periods unless the small employer agrees to allow the carrier to change the methodology.

(7) [Repealed.]

(f) Each rating factor that a carrier chooses to utilize ***for grandfathered coverage*** in the individual market shall be reflective of claim cost variations that correlate with that factor independently of claim cost variations that correlate with any of the other allowable factors.

(g) The same rating methodology shall apply to [~~newly covered individuals and to~~] individuals renewing at each annual renewal date, or to [~~new small employers and~~] small employers renewing at each annual renewal date or anniversary date. Rating methodology shall not be construed to include health carrier incentives to individual subscribers or members to participate in wellness and fitness programs provided such incentives are [~~approved by the insurance department~~] ***consistent with sections 2702 and 2705 of the federal Public Health Act, and any regulations adopted thereunder***.

(h) The commissioner shall not approve any filing if such filing is excessive, inadequate, or contrary to the intent of this chapter.

I-a. Health carriers providing health coverage to individuals and small employers under this chapter, other than grandfathered coverage, shall be subject to the following:

(a) All premium rates charged shall be guaranteed for a rating period of at least 12 months, and shall not be changed for any reason, including, but not limited to, a change in the group's case characteristics.

(b) Market rate shall be established by each health carrier for all of its health coverages offered to individuals and, separately, for all of its health coverages offered to small employers.

(c) Health carriers shall calculate health coverage plan rates for each of the coverages or health benefit plans written by that carrier. Variations in health coverage plan rates shall be solely attributable to variations in expected utilization or cost due to differences in coverage design and/or the provider contracts or other provider costs associated with specific coverages and shall not reflect differences due to the nature of the groups or eligible persons assumed to select particular health coverages.

(d)(1) In establishing the premium charged, health carriers providing coverage to individuals or small groups shall vary the premium rate with respect to the particular plan or coverage involved only by:

(A) Whether the plan or coverage covers an individual or family;

(B) Geographic rating area, as established by the commissioner pursuant to RSA 420-G:14, I(a)(1);

(C) Age, except that the maximum premium differential for age as determined by ratio shall be 3 to 1 for adults; and

(D) Tobacco use, except that the maximum differential rate due to tobacco use shall be 1.5 to 1.

(2) With respect to family coverage under an individual or small group health insurance policy, the rating variations permitted under subparagraphs (1)(A) and (D) shall be applied based on the portion of the premium that is attributable to each family member covered under the plan.

(3) Carriers must adjust each health coverage plan or premium rate for age, based on the portion of the premium that is attributable to each family member covered under the plan or certificate, using the uniform age rating factors established by the commissioner pursuant to RSA 420-G:14, I(a)(2).

(e) Each rating factor that a carrier uses shall be reflective of claim cost variations that correlate with that factor independently of claim cost variations that correlate with any of the other allowable factors.

(f) For small employers, carriers shall calculate premium rates for employee and dependent coverage on a list bill basis and shall provide the employer with a billing statement that shows premiums on both a list bill and a composite bill basis.

(g) The same rating methodology shall apply to newly covered individuals and to individuals renewing at each annual renewal date, or to new small employers and small employers renewing at each annual renewal date or anniversary date. Rating methodology shall not be construed to include health carrier incentives to individual subscribers or members to participate in wellness and fitness programs provided such incentives are consistent with sections 2702 and 2705 of the federal Public Health Act, and any regulations adopted thereunder.

(h) The commissioner shall not approve any filing if such filing is excessive, inadequate, or contrary to the intent of this chapter.

10 New Section; Coverage of Essential Health Benefits. Amend RSA 420-G by inserting after section 4-c the following new section:

420-G:4-d Coverage of Essential Health Benefits. All health coverage offered by health carriers to individuals or small employers shall include coverage for the essential health benefits. This section shall not apply to grandfathered health coverage.

11 Medical Underwriting. Amend RSA 420-G:5, I and II to read as follows:

I. Health carriers providing [~~health~~] ***grandfathered*** coverage [~~for individuals~~] may ***in the individual market only,*** perform medical underwriting, including the use of health statements or

screenings or the use of prior claims history, to the extent necessary to establish or modify premium rates as provided in RSA 420-G:4. ***Health carriers shall not perform medical underwriting for any other type of coverage in the individual and small group markets. Health carriers providing coverage in the large group market may perform medical underwriting.***

II. [~~Health carriers providing health coverage for individuals may refuse to write or issue coverage to an individual because of his or her health status.~~] Regardless of claim experience, health status, or medical history, health carriers providing health coverage for ***individuals or*** small employers shall not refuse to write or issue any of their available coverages or health benefit plans to any ***individual or*** small employer group that elects to be covered under that plan and agrees to make premium payments and meet the other requirements of the plan***, except that this requirement shall not apply to grandfathered coverage in the individual market***.

12 Guaranteed Issue. Amend RSA 420-G:6, III to read as follows:

III. Health carriers shall actively market, issue, and renew all of the health coverages they sell in the ***individual and*** small employer market to all ***individuals and*** small employers ***in that market, except that this requirement shall not apply to grandfathered individual coverage. Health carriers offering health coverage to small employers shall permit small employers to purchase health coverage at any point during the year, with the small employer's health coverage consisting of the 12-month period beginning with the small employer's effective date of coverage.***

III-a. A health carrier shall not rescind health coverage issued to an individual or with respect to an individual covered under health coverage issued to a small or large employer, including a group to which the individual belongs or family coverage in which the individual is included, after the individual is covered under the plan, unless:

(a) The individual, or a person seeking coverage on behalf of the individual, performs an act, practice, or omission that constitutes fraud; or

(b) The individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage.

III-b. For the purposes of subparagraph III-a(a), a person seeking coverage on behalf of an individual does not include a producer, or an employee or authorized representative of the health carrier.

13 Guaranteed Issue. Amend RSA 420-G:6, V(d)-(g) to read as follows:

(d) Failure ***of an employer sponsoring group coverage*** to meet the minimum employee participation number or percentage requirement of the health coverage.

[~~(e) The small employer is no longer actively engaged in the business that it was engaged in on the effective date of the health coverage.~~

~~(f) The employer medically underwrites or otherwise violates a provision of this chapter.~~

~~(g)~~] ***(e)*** The health carrier is ceasing to offer health coverage in such market, in accordance with paragraph VII.

14 Guaranteed Issue. Amend RSA 420-G:6, V-a to read as follows:

V-a. Health carriers shall not underwrite insureds at time of renewal ***of an individual grandfathered health plan*** unless an insured has applied for an increase in his or her coverage***, and provided that such increase in coverage does not result in the coverage ceasing to be a grandfathered health plan***.

15 Preexisting Conditions. Amend RSA 420-G:7, I and II to read as follows:

I. [A heal~~th carrier providing health coverage to large employers may impose a preexisting condition exclusion period, but only if it is at least as favorable to covered persons as the following:~~

~~(a) No preexisting condition exclusion shall extend beyond a period of 9 consecutive months after the date of enrollment of the person's health coverage; and~~

~~(b) Such preexisting condition exclusion period may only apply to a condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received during the 3 months immediately preceding the enrollment date of health coverage.~~] ***A health carrier issuing health coverage to small or large employers shall not impose any preexisting condition exclusion with respect to such coverage. A health carrier issuing individual health coverage that is not a grandfathered health plan shall not impose any preexisting condition exclusion with respect to such coverage. A health carrier issuing individual health coverage under a grandfathered health plan may impose a preexisting condition exclusion only as permitted by this section.***

II. A health carrier providing health coverage [~~to individuals or small employers~~] ***in the individual market under a grandfathered plan*** may impose a preexisting condition exclusion period, but only if it is at least as favorable to covered persons as the following:

(a) No preexisting condition exclusion period shall extend beyond a period of 9 consecutive months after the date [~~of enrollment~~] of the person's ***enrollment in the grandfathered*** health [~~coverage~~] ***plan***.

(b) Such preexisting condition exclusion period may only apply to a condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was received or recommended during the 3 months immediately preceding the date [~~of enrollment~~] of the person's ***enrollment in the grandfathered*** health [~~coverage~~] ***plan***.

16 Preexisting Conditions. Amend RSA 420-G:7, V and the introductory paragraph of paragraph VI to read as follows:

V. Health carriers shall provide written certification of the period of creditable coverage which accumulated while a person was under the health coverage plan, and shall also state any waiting period which was imposed prior to receiving health coverage.

[~~(a)~~] The written certification shall be provided at the time a person ceases to be covered under a health coverage plan, and on a request made on behalf of the person made not later than 24 months after the date of the cessation of coverage.

[~~(b) A health carrier, which elects to credit coverage under the method set forth in rules pursuant to paragraph IV that enrolls a person with a certificate of creditable coverage, may request of the entity that issued the certificate the additional information required under the rules. The issuing entity shall promptly disclose such information to the health carrier, but may charge the reasonable costs of disclosing such information.~~]

VI. A health carrier providing health coverage [~~to large or small employer groups~~] ***under a grandfathered health plan for which a preexisting condition exclusion period is allowed*** shall not:

17 Open Enrollment. RSA 420-G:8 is repealed and reenacted to read as follows:

420-G:8 Open Enrollment.

I. Each small employer group shall have an annual employee open enrollment period 60 days in length, occurring prior to the small employer group's anniversary date. During open enrollment, employees or eligible dependents may apply to the small employer for health coverage or make a change in their membership status becoming effective upon the small employer group's anniversary date, subject to providing the health carrier 30-days notice.

(a) A health carrier shall not refuse any small employer employees or eligible dependents applying for health coverage during the open enrollment period.

(b) Employees or eligible dependents coming on at the time of an open enrollment period shall have the same premiums as the rest of the small employer group shall have upon the new or renewal effective date.

II. A small employer employee who has met any employer imposed waiting period and is otherwise eligible for health coverage, who declines a small employer's health coverage plan during the initial offering or subsequent open enrollment period, shall be a late enrollee and shall not be allowed on the plan until the next open enrollment period.

III. A large employer employee, who has met any employer imposed waiting period and is otherwise eligible for health coverage, may enroll within 31 days of becoming eligible and shall not be required to submit evidence of insurability based on medical conditions. If a person does not enroll at this time, that person is a late enrollee. Each large employer group shall have an open enrollment period during which late enrollees may enroll and shall not be required to submit evidence of insurability based on medical conditions.

IV. Paragraphs II and III notwithstanding, an eligible employee or eligible dependent shall not be considered a late enrollee if:

(a) The person was covered under public or private health coverage at the time the person was able to enroll; and

(1) Has lost public or private health coverage as a result of termination of employment or eligibility, the termination of the other plan's coverage, death of a spouse, or divorce; and

(2) Requests enrollment within 30 days after termination of such health coverage; or

(b) Is employed by an employer that offers multiple health coverages and the person elects a different plan during an open enrollment period; or

(c) Was ordered by a court to provide health coverage for an ex-spouse or a minor child under a covered employee's plan and the request for enrollment is made within 30 days after issuance of such court order.

V.(a) If individual coverage offered by a health carrier or a large or small employer group's health coverage plan offers dependent coverage and the individual is enrolled in such coverage or the employee is enrolled or has met any applicable waiting period and is eligible to be enrolled, but for a failure to do so during a previous open enrollment period, a person who becomes a dependent of the individual or employee through marriage, birth, adoption or placement for adoption, and the employee if not otherwise enrolled, shall be provided with a special enrollment period.

(b) If an individual has minimum essential coverage through individual coverage offered by a health carrier or as an employee through a large or small employer group's health coverage plan, and the individual loses such coverage for any reason other than failure to pay premiums or a basis on which rescission is permitted pursuant to RSA 420-G:6, IV, the individual shall be provided with a special open enrollment period under any other individual health coverage or any large or small employer group health coverage plan for which the individual becomes eligible.

(c) The special enrollment period shall be at least 60 days in length and shall begin on the later of:

(1) The date dependent health coverage is made available; or

(2) The date of the marriage, birth, adoption, placement for adoption, or loss of minimum essential coverage, as the case may be.

(d) If the person seeks enrollment during such special enrollment period, the health coverage shall become effective:

(1) In the case of marriage or loss of minimum essential coverage, on or before the first day of the first month following the completed request for enrollment;

(2) In the case of birth, as of the date of birth; or

(3) In the case of adoption or placement for adoption, the date of such adoption or placement for adoption.

VI. Health carriers offering individual health coverage shall have initial and annual open enrollment periods as follows:

(a) For health coverage that becomes effective on or after January 1, 2014, but before January 1, 2015, there shall be an initial open enrollment period beginning on October 1, 2013 and extending through March 31, 2014.

(b) For health coverage that becomes effective on or after January 1, 2015, there shall be an annual open enrollment period beginning on October 15th and extending through December 7th of the calendar year preceding the year in which the health coverage becomes effective.

18 Participation Requirements. Amend RSA 420-G:9, I and II to read as follows:

I. For coverage purchased outside of the SHOP exchange, a health carrier may not require more than the minimum participation percentage of the employees eligible for health coverage in a small employer group to participate in the health carrier's health coverage plan. The minimum participation percentage shall be 75 percent when the health carrier's plan is the sole health coverage plan being sponsored by the employer group, and 37.5 percent when the health carrier's plan is not the sole health coverage plan being sponsored by the employer group.

I-a. For coverage purchased in the SHOP exchange, the exchange shall not require more than the minimum participation percentage of the employees eligible for health coverage in a small employer group to participate in the SHOP exchange, equal to 75 percent. No health carrier shall apply any other participation test.

II. For the purpose of calculating whether or not a small employer group's enrollment meets a carrier's minimum participation requirements:

(a) Any full-time or part-time employees who are covered as a dependent on another person's health coverage ***or are enrolled in a governmental plan such as Medicare, Medicaid, or TRICARE*** shall be excluded from the count.

(b) ***Any full-time or part-time employees who have been found eligible for a premium tax credit and are enrolled in a qualified health plan purchased through an exchange shall be excluded from the count.***

(c) The total number of full-time employees and part-time employees who are otherwise eligible for health coverage shall be counted.

19 New Paragraph; Participation Requirements. Amend RSA 420-G:9 by inserting after paragraph IV the following new paragraph:

V. The requirements under this section shall be the only participation requirements. Minimum employer contributions, or other criteria, shall not be permitted.

20 Rulemaking. Amend RSA 420-G:14, I to read as follows:

I.***(a)*** The commissioner [~~may~~] ***shall*** adopt rules, under RSA 541-A, [~~necessary to the proper administration of this chapter.~~] ***relative to establishing:***

(1) Uniform age rating levels that are consistent with 45 C.F.R. 147.102.

(2) Special enrollment periods designed to allow employees to purchase individual coverage on the exchange during their employer's open enrollment period, even

if the employer's open enrollment period does not coincide with the open enrollment period in the individual market.

(b) The commissioner may adopt further rules, pursuant to RSA 541-A, necessary to the proper administration of this chapter.

21 Preexisting Conditions. RSA 415-A:5, III is repealed and reenacted to read as follows:

III. Health carriers issuing policies subject to RSA 420-G shall not impose any preexisting condition exclusion that is inconsistent with that chapter.

22 Coverage for Clinical Trials. RSA 415:18-l, I-III are repealed and reenacted to read as follows:

I. In this section:

(a) "Clinical trials" mean Phase I, Phase II, Phase III, and Phase IV clinical trials.

(b) "Cooperative group" means a formal network of facilities that collaborate on research projects and have an established National Institute of Health (NIH) approved peer review program operating within the group.

(c) "FDA" means the federal Food and Drug Administration.

(d) "Member" means the policyholder, subscriber, insured, or certificate holder, or a covered dependent of a policyholder, subscriber, insured, or certificate holder.

(e) "NIH" means the National Institutes of Health.

(f) "Non-routine patient care cost" means:

(1) The cost of an investigational new drug or device that is not approved for market for any indication by the FDA.

(2) The cost of a non-health care service that a member may be required to receive as a result of the treatment being provided for the purposes of the clinical trial.

(3) The costs of services that are clearly inconsistent with widely accepted and established regional or national standards of care for a particular diagnosis.

(4) Costs associated with managing the research associated with the clinical trial.

(5) Non-covered costs under the member's policy, plan, or contract.

(g) "Routine patient care cost" means the cost of any medically necessary health care service that is incurred as a result of the treatment being provided to a member of a health plan. Routine costs are those for which the health plan regularly reimburses its members, health care providers, or health care institutions subject to the terms and conditions of the member's policy and the provider's service agreement with the insurer.

II. A policy, plan, or contract subject to this section shall provide coverage for all medically necessary routine patient care costs incurred as a result of a treatment being provided in accordance with a clinical trial to the extent such costs would be covered for noninvestigational treatments if the treatment is being provided or the studies are being conducted in a phase I, phase II, phase III, or

phase IV clinical trial for cancer or the treatment is being provided for any other life-threatening condition.

III. The coverage required under paragraph II shall be required if:

(a) The treatment is being provided to the member in a clinical trial approved by:

(1) One of the National Institutes of Health;

(2) The Centers for Disease Control and Prevention;

(3) The Agency for Healthcare Research and Quality;

(4) The Centers for Medicare and Medicaid Services;

(5) An NIH cooperative group or an NIH center or a cooperative group or center of any of the entities described in subparagraphs (1) through (4) or the Department of Defense or the Department of Veterans Affairs;

(6) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants;

(7) The FDA in the form of an investigational new drug application or exemption;

(8) The federal Department of Veterans Affairs or Defense or the federal Department of Energy; provided that the treatment meets the requirement of 42 U.S.C., section 30099-8(d)(2); or

(9) An institutional review board of an institution in this state that has a multiple assurance contract approved by the Office of Protection from Research Risks of the NIH.

(b) The member is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition; and either (1) the referring provider is a participating provider and has concluded that the member's participation in such clinical trial would be appropriate based upon the member meeting the conditions described in this subparagraph; or (2) the member provides medical and scientific information establishing that the member's participation in such clinical trial would be appropriate based upon the member meeting the conditions described in this subparagraph.

23 Coverage for Clinical Trials. Amend RSA 415:18-l, V to read as follows:

V. The provisions of this section shall apply to ***individual and*** group hospital and medical expense policies subject to RSA 415, health service corporations under RSA 420-A, health maintenance organizations under RSA 420-B, and managed care organizations under RSA 420-J.

24 Coverage for Clinical Trials. Amend RSA 415:18-l, VIII to read as follows:

VIII. The provisions of this section shall not apply to a policy, plan, or contract paid for under the federal Medicare program [~~nor~~]***,*** the state children's health insurance program***, or to a plan that meets the definition of a grandfathered health plan under RSA 420-G:2, VII-b***.

25 Reference Change. Amend RSA 420-G:4-c, II to read as follows:

II. A carrier shall offer a limited open enrollment period [~~consistent with the requirements of RSA 420-G:8, I-a~~] during which time an employee having a cafeteria plan under RSA 275:43-c may purchase small employer group health coverage. A carrier may apply its rating factor for group size

of one to the premium charged for coverage sold to an employee on an individual basis through a payroll deduction, but shall not apply participation requirements under RSA 420-G:9, I to coverage purchased by an employee through a cafeteria plan established pursuant to RSA 275:43-c.

26 New Section; Prohibition on Lifetime or Annual Limits; Coverage of Preventative Health Services. Amend RSA 420-G by inserting after section 3 the following new section:

420-G:3-a Prohibition on Lifetime or Annual Limits; Coverage of Preventative Health Services.

I. All health coverage offered by health carriers to individuals, small employers, or large employers shall:

(a) Not contain lifetime or annual limits, in accordance with 42 U.S.C. section 300gg-11(a); and

(b) Provide coverage for preventative health services, without any cost-sharing requirements, in accordance with 42 U.S.C. section 300gg-13.

II. This section shall not apply to grandfathered health coverage.

27 New Section; Consistency. Amend RSA 420-N by inserting after section 6 the following new section:

420-N:6-a Consistency. In order to prevent a default to federal regulation and to preserve the state's status as the sole regulator of the business of insurance within the state, the oversight committee shall have the authority to find, with respect to any specific provision within Title XXXVII, that the provision is inconsistent with and prevents the application of the Act and to authorize the commissioner, on a provisional basis, to implement a specific provision of the Act. The commissioner's authority to implement this provision shall extend only until such time as the general court can take legislative action to amend Title XXXVII as it deems appropriate.

28 Report Required. The commissioner shall issue a report to the speaker of the house of representatives, the president of the senate, the house and senate committees having jurisdiction over commerce issues, and the governor no later than December 1, 2013 with respect to considerations and possible approaches to the creation of geographic rating areas for the individual and small group markets and with respect to the possibility of requiring that carriers applying a tobacco rating factor in the individual market make available a tobacco cessation wellness program, participation in which would fully offset any increase in premium due to the tobacco rating factor.

29 Repeal. The following are repealed:

I. RSA 420-G:4-b, relative to New Hampshire HealthFirst.

II. RSA 420-G:7, IV, relative to alternative method of crediting coverage.

30 Effective Date.

I. Sections 27 and 28 of this act shall take effect 60 days after its passage.

II. Section 8 of this act shall take effect January 1, 2016.

III. The remainder of this act shall take effect January 1, 2014.

LBAO
13-0439
Revised 03/27/13
Amended 03/18/13

HB 668 FISCAL NOTE

AN ACT relative to group and individual health insurance market rules.

FISCAL IMPACT:

The Insurance Department states this bill, **as amended by the House (Amendment #2013-0627h)**, will have no fiscal impact on state, county, or local revenue and expenditures in FY 2014 and each year thereafter.

METHODOLOGY:

The Insurance Department states this bill makes changes to the statute applicable to health insurance carriers offering major medical insurance coverage in the group and individual markets to align the statute with the federal Affordable Care Act. The changes in this bill will occur under federal law regardless of whether this bill is adopted or not. The Department states the bill will have no fiscal impact on state, county, or local revenue and expenditures.