ANNUAL REPORT

Joint Health Care Reform Oversight Committee

HB 601, Chapter 264, Laws of 2011
RSA 420-N

November 21, 2012

MEMBERS

Rep. John Hunt, Chairman
Rep. Andrew Manuse, Clerk
Rep. Richard Barry
(replaced Kathleen Taylor)

Sen. Sharon Carson
(replaced Sen. Raymond White)
Sen. David Boutin
Sen. Molly Kelly
(replaced Sen. Matthew Houde)

BACKGROUND AND CHARGE

The 2010 Health Insurance Reform Oversight Committee was established with the adoption of SB 455 (Chapter 243, Laws of 2010; RSA 420-L). Pursuant to this chapter, the Insurance Commissioner was required to make periodic reports to the initial Oversight Committee relative to the department's federal insurance reform implementation plans and initiatives. This committee met in September and in October of 2010, but did not issue a report. A sunset clause included in the 2010 law repealed the oversight committee on July 1, 2011.

A new Joint Health Care Reform Oversight Committee ("the Oversight Committee") was established in 2011, effective July 1, 2011, with the adoption of HB 601 (Chapter 264, Laws of 2011; RSA 420-N). Pursuant to RSA 420-N:3, III, the Oversight Committee is responsible for providing legislative oversight, policy direction, and recommendations for legislation with respect to the Patient Protection and Affordable Care Act of 2009, as it determines appropriate. The Oversight Committee is also required to review existing rules, bulletins, or policies adopted pursuant to Chapter 243, Laws of 2010 and may require the repeal of such rules, bulletins, or policies.

The Oversight Committee has met with representatives from the state Departments of Insurance and Health and Human Services to receive reports on ongoing developments on both the state and federal levels with regard to the Patient Protection and Affordable Care Act of 2009 (ACA). This report summarizes the discussions and actions taken by the Oversight Committee this year.

SUMMARY OF MEETINGS

The Oversight Committee met five times in 2012. The primary action taken in 2012 was the selection of a benchmark plan for New Hampshire.

March 20 - Discussion of Selecting Benchmark for EHBs

Staff from the NH Insurance Department presented information on the Essential Health Benefits (EHB) requirements under the Patient Protection and Affordable Care Act of 2012 (ACA). Under this act, all insurance plans sold in the individual and small group market must meet EHB coverage criteria starting on January 1, 2014. This requirement does not apply to large group or self-insured plans. Purchasers of covered health insurance plans that do not meet EHB criteria will be considered inadequate and will be subject to penalty.

A US Department of Health and Human Services bulletin on EHBs that was issued on December 16, 2011 requires states to choose from ten identified plans currently offered in the state. Because one plan fits into more than one designated category, there are actually eight potential New Hampshire plans to choose from. The benefits offered by the selected plan will serve as the benchmark for the individual and small group market plans in the state. This applies only to benefits that were offered as of January 1, 2012. States are required to select a benchmark plan by the end of September 2012. If no benchmark is selected, the default plan will be the largest insured commercial non-Medicaid plan offered in the state (for NH this is HMO Blue New England).

Potential NH benchmark plans:

3 largest federal employee health plans:

- Government Employee Health Association (GEHA)
- Blue Cross Blue/Shield Basic
- Blue Cross Blue/Shield Standard

3 largest NH state employee plans (only 2 exist)

- HMO Blue New England
- Blue Choice New England (POS)

3 largest NH small group plans

- HMO Blue New England
- Matthew Thornton Blue
- Access Blue New England

Largest insured commercial non-Medicaid HMO plan

- HMO Blue New England

Staff from the NH Department of Health and Human Services discussed the application of the ACA to the Medicaid program. There is a choice between three plans for the Medicaid benchmark. They are all included in the list of plans that are options for the EHB for the individual and small group plans. The plan selected for the Medicaid program is not required to be the same as the plan for the individual and small group plans, though there is an advantage to selecting the same plan.

May 29 – DHHS rule change necessary to comply with ACA, Comparison of Potential Benchmark Plans

A representative from the Department of Health and Human Services presented a proposed new administrative rule. Under §6407 of the ACA, all written orders from a physician for home health services or durable medical equipment must include documentation that the ordering physician has had face-to-face contact with the patient. The intent of this requirement is to reduce fraud, waste and abuse. The department intends to amend several rules to ensure compliance with this requirement as the rules come up for adoption. Rules addressing private duty nurse providers are currently under review and the department proposed new language for He-W 540.06 to require private duty nurse providers to document face-to-face encounters between an ordering physician and a patient.

The committee voted to approve the pursuit of this rule change on a vote of 3-1.

Representatives from the Insurance Department presented a comparison of benefits covered by the potential benchmark plans for New Hampshire. New Hampshire mandates not included in any of the federal plans include coverage for bone marrow testing for donations, certain dental procedures for children, nonprescription enteral formulas, early intervention therapy for children, and the treatment of certain autism disorders. Coverage for scalp hair prostheses is covered under two of the three federal plans. State benefits not included in the selected plan must be subsidized by the state. If one of the New Hampshire small group plans is selected as the benchmark, the state-mandated benefits would be in the plan and would not require a state subsidy.

The committee requested a cost comparison between Matthew Thornton Blue, GEHA and HMO Blue New England for their next meeting.

The committee also discussed whether the provisions included in HB 627 (2012) were necessary. A Committee of Conference on HB 627 was scheduled to be held after the Oversight Committee meeting. The bill amended the duties of the oversight committee to explicitly charge the committee to "determine the "essential benefits" package which will be available to insured persons in the state of New Hampshire under the Act".

July 25 – Supreme Court Decision on the ACA; Health Care Reform Key Decisions Points; Partnership Agreements for Exchanges; Potential Benchmark Plan for NH

NH Insurance Department staff distributed information on the June 28 US Supreme Court ruling on the challenge to the constitutionality of the ACA. It was noted that the sole provision of the Act that was struck down permitted the federal government to withhold funds for a state's entire Medicaid program if the state refused to participate in the Medicaid expansion included in the ACA.

There was also discussion about the timeline for key decisions relative to the ACA. Two deadlines that the committee focused on were September 30, 2012 for the decision on the state's EHB Benchmark and November 16 for the decision on whether the enter a Plan Management partnership for the federally-facilitated exchange (FFE).

The committee discussed RSA 400-A:14-a (adopted in 2011). This law prohibits a requirement for New Hampshire residents to obtain individual insurance coverage and prohibits charging a "penalty, assessment, fee or fine" against a resident who fails to obtain such coverage.

The staff presented information comparing the state's role in partnership agreements for FFEs and fully federal plan management. Legislation adopted earlier in 2012 prohibits a state-based health insurance exchange in New Hampshire. The new law also stipulates permissible state agency activity and the authority of the Insurance Commissioner when a federally-facilitated exchange is operating in the state. (RSA 420-N:7 and RSA 420-N:8)

A provision of the ACA allows states to enter into partnership agreements. Under these agreements, the state manages some functions within an FFE. The Insurance Department staff noted that the new law prohibiting state-based exchanges directs the department to maintain the regulatory functions that it currently performs and therefore would permit a plan management partnership in New Hampshire since it would not involve the department in any exchange functions. The department also noted that a strictly federal exchange with no partnership agreement would lead to dual and overlapping regulatory authority, a high potential for confusion among consumers and carriers, and make it difficult for the department to perform its traditional regulatory functions.

The committee discussed the advantages and disadvantages of entering into a partnership agreement.

The Insurance Department staff presented information comparing three plans – GEHA, Matthew Thornton Blue and HMO Blue New England. The committee requested an actuarial analysis of the three plans for the next meeting.

September 12 – Actuarial Analysis of Three Benchmark Plans

The Commissioner of the Department of Insurance introduced actuaries from Compass Health Analytics who presented a report that they had prepared comparing the relative pricing of

the three potential benchmark plans identified by the committee. The three plans compared were: GEHA, Matthew Thornton Blue and HMO Blue New England. The actuaries determined that the differences in benefit levels between the three plans was small, with the exception of the fact that the GEHA plan includes dental coverage. Similarly, the differences in pricing between the plans is small, except for the dental coverage. Mathew Thornton Blue is the lowest cost plan of the three, by a slight amount.

Staff from the Department of Health and Human Services provided an update on mandated increases in PCP Medicaid payment levels beginning in 2013. These increases are 100% federally funded.

September 19 - Discussion and Vote to Select Benchmark Plan for NH

Staff from the Department of Health and Human Services provided members with an update on the Balancing Incentive Program (BIP). The purpose of this program is to balance Medicaid spending so that expenditures on home and community-based care is roughly equivalent to spending for institutional care.

After some discussion of the potential benchmark plans for New Hampshire, the Oversight Committee voted to select Matthew Thornton Blue as the benchmark plan for New Hampshire, vote, 5-1.

Action taken in 2012

1. approved including He-W 540.06, relative to records of private duty nurse providers, in DHHS are proposed rules, vote 3-1, *May 29, 2012*

2. voted to select Matthew Thornton Blue (Anthem Blue Cross/Blue Shield) as the benchmark plan for New Hampshire, vote, 5-1, *September 19, 2012*

3. sent a letter to US Health and Human Services Secretary Kathleen Sebelius, notifying her of the selection of Matthew Thornton Blue, *September 25, 2012*