SB 413-FN-A – VERSION ADOPTED BY BOTH BODIES

03/06/14 0651s
03/06/14 0889s
03/13/14 1167EBA

2014 SESSION

14-2857
01/10

SENATE BILL ***413-FN-A***

AN ACT relative to access to health insurance coverage.

SPONSORS: Sen. Morse, Dist 22; Sen. Larsen, Dist 15; Sen. Bradley, Dist 3; Sen. Gilmour, Dist 12; Sen. Odell, Dist 8; Sen. D'Allesandro, Dist 20

COMMITTEE: Health, Education and Human Services

ANALYSIS

This bill establishes the New Hampshire health protection program. This bill also establishes the New Hampshire health protection trust fund which is to be administered by the commissioner of the department of health and human services for the purposes of paying certain costs associated with the programs established in the bill and to accept any federal moneys for such programs. The commissioner of the department of health and human services 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Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

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STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Fourteen

AN ACT relative to access to health insurance coverage.

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

1 Statement of Purpose. The state of New Hampshire shall develop the New Hampshire health protection program to provide a coordinated strategy to access private insurance coverage for uninsured, low-income citizens with income up to 133 percent of the federal poverty level (FPL) using available, cost-effective health care coverage options for Medicaid newly eligible individuals at the earliest practicable date. The strategy shall promote the improvement of overall health through access to private insurance coverage options and draw appropriate levels of federal funding available through a Medicaid Section 1115 demonstration waiver. Increasing access to private health insurance will increase provider reimbursement rates and reduce the burden of uncompensated care in New Hampshire.

2 New Paragraphs; Department of Health and Human Services; Changes to State Medicaid Program. Amend RSA 126-A:5 by inserting after paragraph XXII the following new paragraphs:

XXIII.(a) The commissioner shall provide access to the health insurance premium payment (HIPP) program established by the department pursuant to section 1906 of the Social Security Act of 1935 to Medicaid newly eligible adults from 0 – 133 percent of the federal poverty level (FPL) who are eligible for medical assistance under section 1902(a)(10)(A)(i)(VIII) of the Social Security Act of 1935, as amended, 42 U.S.C. section 1396a(a)(10)(A)(i) ("newly eligible adults") and their spouse and dependents if applicable until December 31, 2016 to maximize the use of private insurance and available federal assistance. All newly eligible adults who have access to qualified employer sponsored insurance either directly as an employee or indirectly through another individual who is eligible for qualified employer sponsored insurance, shall be required to participate in the HIPP program in order to receive medical assistance, if eligible and determined by the department to be cost effective as required by the federal Centers for Medicare and Medicaid Services (CMS).

(b) The commissioner shall seek any necessary waivers or submit a state plan amendment to implement the provisions of this paragraph, including provisions to address individuals determined to be medically frail after completion of a health questionnaire screening process. Prior to submitting the state plan amendment or waiver to CMS the commissioner shall present the state plan amendment or waiver to the fiscal committee of the general court for approval.

Participation in the HIPP program by newly eligible adults shall not begin until such waivers or state plan amendments have been approved by CMS.

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

(1) Provide all necessary information regarding financial eligibility, residency, citizenship or immigration status, and insurance coverage to the department of health and human services in accordance with rules or interim rules, adopted under RSA 541-A;

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

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

(d) The New Hampshire mandatory HIPP program under this paragraph shall be implemented as soon as is practicable after the waiver or state plan amendment is approved. The cost of the medical assistance provided under the HIPP program shall be paid solely from federal funds provided under 42 U.S.C. section 1396d(y).

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

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

XXIV.(a) There is hereby established the voluntary bridge to marketplace premium assistance program in order to provide medical assistance for newly eligible adults and their spouse and dependents, if applicable, who are ineligible for the HIPP program established in RSA 126-A:5, XXIII. This program shall be administered by the department of health and human services and subject to subparagraph XXV(c) shall terminate on March 31, 2015. In order to receive medical assistance through the program, newly eligible adults shall choose health insurance coverage either from qualified health plans (QHPs) offered on the federally-facilitated exchange if cost effective or an alternative benefit plan (ABP) offered by one of the managed care organizations (MCO) awarded contracts as vendors to implement Medicaid managed care under RSA 126-A:5, XIX(a). For the purposes of this paragraph, alternative benefit plan is defined as the Medicaid benchmark or

benchmark equivalent coverage in section 1937 of the Social Security Act. Provider payments shall be in an amount which shall be no less than before the effective date of this paragraph.

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

(c) A determination of eligibility for the voluntary bridge to marketplace premium assistance program or discontinuation of benefits, including at the conclusion of the voluntary bridge to marketplace premium assistance program, shall be a qualifying event under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Individuals who participate in the voluntary bridge to marketplace premium assistance program shall:

(1) Provide all necessary information regarding financial eligibility, residency, citizenship or immigration status, and insurance coverage to the department of health and human services in accordance with rules, or interim rules, adopted under RSA 541-A;

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

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

(d) Enrollment for the voluntary bridge to marketplace premium assistance program under this paragraph shall begin May 1, 2014 or as soon thereafter as is practicable. Coverage under the voluntary bridge to marketplace premium assistance program under this paragraph shall be implemented commencing July 1, 2014 or as soon thereafter as is practicable. The cost of the medical assistance provided under the voluntary bridge to marketplace premium assistance program shall be paid solely from federal funds as provided under 42 U.S.C. section 1396d(y).

(e) For coverage under the voluntary bridge to marketplace premium assistance program, the commissioner shall negotiate an amendment to its existing managed care contracts to provide new private insurance plans which will qualify for this program. Alternative benefit plans shall reimburse at rates that are sufficient to ensure improved access to and quality of care. Such plans shall maximize to the extent allowable wellness programs, cost-sharing mechanisms, and disincentives for inappropriate emergency room use.

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

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

XXV.(a) Consistent with the time frames in this paragraph, there is hereby established the marketplace premium assistance program. This will be a premium assistance program for newly eligible adults and their eligible spouse and dependents, if applicable, who are ineligible for the HIPP program established in RSA 126-A:5, XXIII until December 31, 2016 and shall be administered by the department of health and human services. In order to receive medical assistance from the program, newly eligible adults who are ineligible for the HIPP program shall choose from any qualified health plans (QHPs) offered on the federally-facilitated exchange if cost effective; provided, however, that any newly eligible adult who had coverage under an alternative benefit plan (ABP) offered by a managed care organization (MCO) under paragraph XIX during the voluntary bridge to marketplace premium assistance program established under RSA 126-A:5, XXIV shall be automatically enrolled at the beginning of open enrollment in a comparable QHP by that same MCO if one is available, unless such newly eligible adult subsequently chooses a different QHP during the enrollment period. If a comparable QHP is not offered by the newly eligible adult's MCO then the newly eligible adult may choose from any QHPs, if cost effective. Provider payments shall be in an amount which shall be no less than before the effective date of this paragraph.

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

(c) If the waiver to implement the marketplace premium assistance program is approved on or before March 31, 2015 then, coverage under the voluntary bridge to marketplace premium assistance program established in RSA 126-A:5, XXIV shall terminate on December 31, 2015.

Enrollment in the marketplace premium assistance program shall begin on October 15, 2015 and coverage shall begin on January 1, 2016. Coverage shall end on December 31, 2016. The cost of the medical assistance provided under the marketplace premium assistance program shall be paid solely from federal funds as provided under 42 U.S.C. section 1396d(y).

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

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

(1) Provide all necessary information regarding financial eligibility, residency, citizenship or immigration status, and insurance coverage to the department of health and human services in accordance with rules, or interim rules, adopted under RSA 541-A;

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

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

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

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

XXVI. Any unemployed individual who qualifies for the voluntary bridge to marketplace premium assistance program established in paragraph XXIV or the marketplace premium assistance program established in paragraph XXV shall be referred to the department of employment security for the purpose of helping the unemployed individual find employment.

3 New Section; New Hampshire Health Protection Trust Fund. Amend RSA 126-A by inserting after section 5-a the following new section:

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

I. There is hereby established the New Hampshire health protection trust fund which shall be accounted for distinctly and separately from all other funds and shall be non-interest bearing.

The trust fund shall be administered by the commissioner of the department of health and human services and shall be used solely to provide payment and reimbursement for medical and other medical-related services for the newly eligible Medicaid population as provided for under RSA 126-A:5, XXIII – XXVI and RSA 126-A:67. All moneys in the trust fund shall be nonlapsing and shall be continually appropriated to the commissioner of the department of health and human services for the purposes of the trust fund. The trust fund shall be authorized to pay and/or reimburse:

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

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

(c) The cost of premiums, co-insurance, co-payments, deductibles, and supplemental cost-sharing plus the cost of any wrap-around services to licensed health insurance carriers on the federally facilitated exchange under the marketplace premium assistance program as provided in RSA 126-A:5, XXV.

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

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

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

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

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

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

4 New Subparagraph; New Hampshire Health Protection Trust Fund. Amend RSA 6:12, I(b) by inserting after subparagraph (316) the following new subparagraph:

(317) Moneys deposited in the New Hampshire health protection trust fund established under RSA 126-A:5-b.

5 New Subdivision; Statewide Section 1115 Demonstration Waiver. Amend RSA 126-A by inserting after section 66 the following new subdivision:

Statewide Section 1115 Demonstration Waiver

126-A:67 Statewide Section 1115 Demonstration Waiver.

I. On or before June 1, 2014, the commissioner, after consultation with stakeholders including state, county, and local officials and health care providers, shall submit a statewide section 1115 demonstration waiver to enhance designated state health programs and transform the Medicaid care delivery system. The section 1115 demonstration waiver will promote the improvement of overall health through increased access to private insurance coverage options and will integrate and align New Hampshire's Medicaid care management program, the provision of coverage to the newly eligible under this chapter, existing Medicaid waivered programs, and other department initiatives in a manner that improves public health, and improves the quality of care and access to care for all Medicaid and CHIP beneficiaries. The waiver shall be used to allow the state maximum flexibility to redesign Medicaid including establishing premium assistance programs that are customized to transform the state's reform goals. To the greatest degree possible programs funded under the demonstration waiver shall complement the mental health settlement and shall be designed to promote innovation, reform delivery systems, and reduce the number of uninsured patients who seek treatment from health care providers.

II. Prior to submitting the waiver to CMS, the commissioner shall present the waiver to the fiscal committee of the general court for approval. The waiver shall be approved by the CMS by December 1, 2014.

6 New Section; Ambulatory Services. Amend RSA 415 by inserting after section 24 the following new section:

415:25 Qualified Health Plans; Ambulatory Services.

I. Each qualified health plan (QHP) on the federally-facilitated exchange shall, as a condition of participation, (1) offer to each federally-qualified health center, as defined in section 1905(l)(2)(B) of the Social Security Act, 42 U.S.C. section 1396d(l)(2)(B), providing services in geographic areas served by the plan, the opportunity to contract with such plan to provide to the plan's enrollees all ambulatory services that are covered by the plan that the center offers to provide; and (2) reimburse each such center for such services as provided in section 1302(g) of the Patient Protection and Affordable Care Act, Public Law 111-148, as added by section 10104(b)(2) of such Act.

II. In this section "ambulatory services" means health care services provided on an outpatient basis.

7 Department of Health and Human Services; Contracting; Transfer Among Accounts.

I. Notwithstanding any law to the contrary, the department shall be authorized, subject to the prior approval of governor and council, to enter into sole source contracts with qualified consultants and vendors (a) for services in connection with obtaining waivers and state plan amendments and (b) to implement the health coverage programs for newly eligible under RSA 126-A:5, XXIII-XXVI and RSA 126-A:67.

II. Notwithstanding RSA 9:17-a or any other provision of law to the contrary, except as provided in RSA 9:17-c and 2013, 143:1, organization note on accounting unit 05-95-48-481510-5942 nursing services – county participation, for the biennium ending June 30, 2015, the commissioner of the department of health and human services is hereby authorized to transfer funds within and among all accounting units within the department, as the commissioner deems necessary and appropriate to address present or projected budget deficits, or to respond to changes in federal laws, regulations, or programs, and otherwise as necessary for the efficient management of the department, with the exception of class 60 transfers; provided, that any transfer of $75,000 or more shall require prior approval of the fiscal committee of the general court and the governor and council.

8 Appropriation; Health Care Reform Commission. Amend 2013, 144:130 to read as follows:

144:130 Appropriation. The sum of $200,000 is hereby appropriated to the department of health and human services for the fiscal year ending June 30, 2014, for the purpose of providing administrative support to the commission established in RSA 126-A:66 as inserted by section 129 of this act. Contracts for administrative support or consulting services shall not require governor and council approval. ***Any unspent balance of the appropriation made under this section shall be extended and shall not lapse until November 1, 2014, and shall be for the use of the department of health and human services in preparing or submitting any necessary waivers or state plan amendments pursuant to RSA 126-A:5, XXIII – XXV and RSA 126-A:67.*** The governor is authorized to draw a warrant for said sum out of any money in the treasury not otherwise appropriated.

9 Department of Health and Human Services; Medicaid Breast and Cervical Cancer Program. Enrollment in the Medicaid breast and cervical cancer program, under 42 U.S.C. section 1396a(aa), shall be suspended effective July 1, 2014 or upon the approval of any waivers or state plan amendments necessary to implement RSA 126-A:5, XXIII and XXIV whichever is later. Any individual covered under the Medicaid breast and cervical cancer program prior to the date the program is suspended shall continue to be covered for the program unless his or her medical treatment has concluded, or until the next redetermination of his or her eligibility by the department, whichever event occurs later. After the date the program is suspended the individual's eligibility for assistance shall be determined by the department pursuant to RSA 126-A:5, XXIII-XXV. Commencing on the date the program is suspended, administrative rule He-W 641.09 shall be limited in its application to only those individuals enrolled in the Medicaid breast and cervical cancer program receiving treatment prior to the date the program is suspended. If, at any time after

July 1, 2014 the assistance authorized in RSA 126-A:5, XXIII-XXV is no longer offered or fails to gain the necessary federal approvals, then the commissioner of the department of health and human services shall reinstate Medicaid coverage and open enrollment for those individuals eligible under this program.

10 Applicability; Eligibility.

I. If at any time the federal match rate applied to medical assistance for newly eligible adults under RSA 126-A:5, XXIII-XXV between July 1, 2014 – December 31, 2016 is less than 100 percent as set forth in 42 U.S.C. section 1396d(y)(1), then RSA 126-A:5, XXIII, XXIV, and XXV shall immediately be repealed upon notification by the commissioner of the department of health and human services to the secretary of state and the director of legislative services.

II Any state plan amendment or waiver required under 126-A:5, XXIII-XXV that is submitted to the Centers for Medicare and Medicaid Services (CMS), shall comply with 42 U.S.C. section 18001, et seq., as amended by 42 U.S.C. section 1305, et seq., 42 U.S.C. section 7, et seq. and any applicable regulations by CMS governing eligibility for newly eligible adults regarding citizenship, referral requirements for employment or seeking employment, and allowable income resource restrictions.

11 Severability. With the exception of section 10 of this act, if any provision of this act or the application thereof to any person or circumstances is held invalid, such invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to this end the provisions of this act are declared to be severable.

12 Repeal. The following are repealed:

I. RSA 126-A:5, XXIII, relative to health insurance premium payment (HIPP) program.

II. RSA 126-A:5, XXIV, relative to the bridge to marketplace premium assistance program.

III. RSA 126-A:5, XXV, relative to the marketplace premium assistance program.

IV. RSA 126-A:5, XXVI, relative to unemployed individuals who qualify for the voluntary bridge to marketplace premium assistance program and the marketplace premium assistance program.

V. RSA 126-A:5-b, relative to New Hampshire health protection trust fund.

VI. RSA 6:12, I(b)(317), relative to the New Hampshire health protection trust fund.

VII. RSA 415:25, relative to qualified health plans on the federally-facilitated exchange.

VIII. 2013, 144:129 and 131, relative to the Medicaid expansion commission and the repeal of the commission.

IX. 2013, 144:130, as amended by section 8 of this act, relative to an appropriation.

13 Effective Date.

I. Section 12, paragraphs I-VII of this act shall take effect December 31, 2016.

II. Section 12, paragraph IX of this act shall take effect November 1, 2014.

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

LBAO
14-2857
Amended 03/21/14

SB 413-FN-A FISCAL NOTE

AN ACT relative to access to health insurance coverage.

FISCAL IMPACT:

The Departments of Health and Human Services and Insurance state this bill, **as amended by the Senate (Amendments #2014-0651s and #2014-0889s)**, will increase state expenditures and revenue by indeterminable amounts in FY 2014, FY 2015, FY 2016 and FY 2017. The Departments of Corrections and Administrative Services state this bill may decrease state expenditures by an indeterminable amount in FY 2015, FY 2016 and FY 2017. The New Hampshire Association of Counties and New Hampshire Municipal Association state this bill may decrease county and local expenditures by indeterminable amounts in FY 2015, FY 2016 and FY 2017. There will be no fiscal impact on county or local revenues.

METHODOLOGY:

The Department of Health and Human Services makes the following assumptions concerning the fiscal impact of this bill:

- The bill would become effective in March 2014 allowing coverage to begin no later than July 1, 2014.
- Cost estimates are based on coverage for an additional 50,000 individuals.
- Start up and operating costs are included for the FY 2014-2015 biennium only.
- Program assumptions include:
    - The Bridge to Marketplace program will begin no later than July 1, 2014. Commencement will align with the amendments to the Medicaid Managed Care contracts.
    - The Bridge to Marketplace program will continue until December 31, 2015 if the State receives federal approvals for Premium Assistance by March 31, 2015. If not, the Bridge to Marketplace program will end on June 30, 2015.
    - The mandatory Health Insurance Premium Program (HIPP) will begin July 1, 2014, serve approximately 15,000 individuals and, along with the Bridge to Marketplace Program, will ensure that all newly eligible individuals with access to cost effective employer sponsored insurance are covered by private insurance.
    - Premium Assistance Programs will provide all newly eligible persons, except those determined to be medically frail, with coverage funded 100% by the federal government for calendar years 2014, 2015 and 2016.

- The Department will coordinate the HIPP and Premium Assistance Medicaid waivers along with other section 1115 waiver requests to the Centers for Medicare and Medicaid Services (CMS) in order to align the expansion program with other Departmental initiatives.
- Consultant costs will support obtaining all required waivers from CMS. In order to begin coverage by July 1, 2014, the contracts for consultants, enrollment, systems and other operational requirements will be done on a sole-source basis, subject to prior approval of governor and council.

- Existing positions within the Department will be transferred, reclassified, recruited and filled as needed to support the program. The Division of Personnel will provide the necessary support to enable the personnel actions to be completed in a timely manner as needed.

The Department estimates the operational costs for FY 2014 and FY 2015 as follow:

Total Operational Costs (Amounts In thousands)	**FY 2014 Start up**	**FY 2014 Ongoing**	**FY 2015 Ongoing**
Division of Client Services. (Average 55% federal funds, systems costs are 90% federal)			
Eligibility Determination 50 Family Services Specialists (1 employee per 1,000 clients)	$0	$553	$3,437
Eligibility Determination 6 Family Service Supervisors (1 supervisor per 8 employees)	$0	$77	$473
Scanning/Mail Unit Personnel (6.5 employees)	$0	$57	$357
Training Unit Personnel (3 employees)	$0	$34	$213
Call Center Personnel (3 employees)	$0	$33	$206
Office Space - One-time retrofit costs.	$400	$0	$0
Office Space (250 square feet per employee @ $3,000)	$0	$31	$186
Equipment & other operating costs (Current expense, phone, travel, supplies and other costs)	$247	$49	$335
New Heights System changes - 90% federal funds (Two testing staff, HIPP programming, and system upgrades)	$1,083	$44	$263
Office of Information Services - MMIS system changes ($5 million to Xerox for implementation, $500,000 to Cognosante for testing support, and unknown costs for Pharmacy Benefit Manager) 90% federal funds.	$5,500	$0	$0
Office of the Commissioner - Consultant costs to obtain HIPP, Premium Assistance, and other section 1115 (b) waivers from CMS. 50% federal funds.	$2,000	$0	$0
Office of Medicaid and Business Policy			
HIPP Contractor. Due to short timeline, consultant will determine cost effectiveness calculations under a sole-source contract. 50% federal funds.	$0	$100	$300
Maximus contract - Care management enrollment contract. Four months in FY 2014. Assumes 50,000 enrollees. 50% federal funds.	$0	$100	$300
Milliman actuarial contract. $366k (Already in current budget.)	$0	$0	$0

External Quality Review Organization (EQRO) contract. $250k (Already in current budget.)	$0	$0	$0
Consulting, staffing and training. Additional healthcare analytic functions: develop a database, performance measures and report on improved health outcomes, cost effectiveness and comparison with other groups. 50% federal funds.	$0	$250	$250
Office of Business Operations. Based on experience with current program assumes one mailing per month. 50% federal funds.	$0	$0	$120
Bureau of Behavioral Health. Two additional staff and training/ education costs beginning June 1, 2014. 50% federal funds.	$0	$14	$174
Bureau of Drug & Alcohol Services. Two additional staff and training/ education costs beginning June 1, 2014. Staff will implement and oversee the Substance Abuse Disorder Benefit. 50% federal funds.	$0	$14	$174
Bureau of Elderly & Adult Services. Costs include: 5 additional Medical Consultant III positions, labor grade 24, to establish long-term care eligibility, 8 contract nurses to do medical eligibility assessments, and 5 Adult Protective Service Worker IIs, labor grade 21. 50% federal funds.	$0	$215	$972
Program Integrity Unit.			
Special Investigations Unit investigates cases of fraud and abuse seeking cost recovery for all DHHS programs. An increase of 50,000 clients will require additional staff. Health benefits are 100% federal and recoveries would be remitted to the federal government. 50% federal funds.	$0	$0	$167
Third Party Liability - Accident and Trauma Recoveries. The unit consists of two full-time employees and recovers Medicaid costs in cases where clients are involved in accidents and receive cash settlements. An increase of 50,000 clients will require additional staff. Since benefits are 100% federal, recoveries would be remitted to the federal government. 50% federal funds.	$0	$0	$53
Administrative Appeals Unit - Medicaid Legal Services Unit. The Appeals Unit issues written legal decisions on appeals from departmental actions. The Medicaid Legal Services Unit represents and defends the department at the appeals. DHHS general counsel provides guidance to Medicaid programs. Medicaid enrollment is currently 150,000. An increase of 50,000 will increase hearings proportionately. Need: 2 Hearings Officers, 1 Medical Services Consultant, and 2 Attorneys. Associated equipment and operating costs will be absorbed within the existing budget. 50% federal funds.	$0	$0	$250
Operating Costs:	**$9,230**	**$1,571**	**$8,230**
Federal Funds:	**$7,280**	**$845**	**$4,480**
General Funds:	**$1,950**	**$726**	**$3,750**
Total Funds by Fiscal Year		**FY 2014**	**FY 2015**
Total:		**$10,801**	**$8,230**
Federal Funds:		**$8,125**	**$4,480**
General Funds:		**$2,676**	**$3,750**

In addition, the Department indicates federal funds would replace state expenditures for the Breast and Cervical Cancer Program (BCCP) and for certain medical costs paid by the Department of Corrections. The BCCP, which is currently funded 65% with federal Medicaid funds and 35% with state general funds, would be transitioned to 100% federal funds reducing general fund expenditures by $1.07 million in FY 2015 and by similar amounts in the future years. The Department indicates there would be savings to the Department of Corrections as certain hospital inpatient costs would be eligible for federal Medicaid reimbursement. (See the Department of Correction's response for estimated savings). In addition, the Department assumes county and local costs associated with the detention and treatment of persons affected by mental health and substance use disorders will decrease over time as a result of the new mental health and substance use disorder benefits. These benefits are required to be included in the coverage programs authorized by the bill. The Department states there would be an increase in insurance premium tax revenue to the State general fund as more individuals would be covered by managed care or private health plans. (See the Insurance Department's response for the insurance premium tax revenue estimate). Finally, the Department assumes, as the number of uninsured individuals decreases, uncompensated care provided by hospitals will decrease resulting in an increase in hospital revenues and Medicaid Enhancement Tax collections in FY 2016 and the first half of FY 2017. The amount of any additional MET revenue cannot be estimated at this time.

The Department states the cost of the health benefits would be paid with 100% federal funds through December 31, 2016. Federal funds for payment of health benefits would be credited to, and disbursed from, the New Hampshire Health Protection Trust Fund established by the bill. For an estimate of the federally funded benefit amounts, the Department refers to the DHHS spreadsheet: "Summary Impacts of ACA on NH Medicaid Program: Update for Mental Health Parity and Additional Equity Act" dated 9/16/2013, which was presented to the Commission to study the Expansion of Medicaid Eligibility in New Hampshire. The spreadsheet is based on the reports issued by the Lewin Group in November 2012, January 2013, and September 2013. "Block B" of the spreadsheet provided an estimated impact of serving the additional population assuming an effective date of January 1, 2014. The summary estimated additional federal funds of $289.6 million in FY 2015, and $337.4 million in FY 2016 would pay for health coverage for the newly eligible population. These amounts provided a reasonable estimate based on certain assumptions and timing and also provide an awareness of the scale of the program. Due to differences in timing and assumptions, the amounts should not be considered a precise projection of the federal cost of benefits under this bill. No state general funds will be used to pay for the health benefits.

The Insurance Department assumes as of July 1, 2014, additional individuals would be eligible for health coverage and it would take 90 days to enroll all individuals who are potentially eligible. Coverage would continue through December 31, 2016 when the program terminates. The Department estimates the following impact on insurance premium tax collections:

(In millions $)	**Calendar Year 2014**	**Calendar Year 2015**	**Calendar Year 2016**	**Calendar Year 2017**
Premium Base Change	$53.6	$146.6	$167.0	$0.0
Premium Tax Change	**Fiscal Year 2015**	**Fiscal Year 2016**	**Fiscal Year 2017**	**Fiscal Year 2018**
Estimated Tax:	$1.07	$2.93	$3.34	$0.0
True Up:	$1.07	$1.86	$0.41	($3.34)
Increase / (Decrease) in Premium Tax Revenue:	$2.14	$4.79	$3.75	($3.34)

The Department of Corrections assumes up to 90% of inmates would be eligible for Medicaid coverage if the State chooses to cover prisoners. The Department estimates, based on estimated inpatient medical costs of $750,959 incurred in FY 2013, $675,863 may be reimbursable by Medicaid. The Department states 36.5% of 2,650 inmates, (approximately 965) generated community-based health claims. The Department indicates in FY 2012, 61 Medicaid applications were processed by one Nurse Coordinator. In order to process an additional 904 applications, the Department assumes a minimum of three additional Correctional Counselor/Case Managers would be needed. These individuals would be supervised by the Nurse Coordinator. The Department estimates the annual fiscal impact, based on FY 2013 information, as follows:

FY 2013 Inpatient charges:	$750,959
Percentage eligible for Medicaid:	90%
Amount potentially Medicaid reimbursable ($750,959 x 90%):	$675,863
Three additional Correctional Counselor/Case Managers Salary and Benefits: ($90,000 x 3 positions)	($270,000)
Potential decrease in state expenditures:	$405,863

The Department of Administrative Services states the Health Insurance Premium Program (HIPP) would not have a fiscal impact on the state employee and retiree health benefit program since it offsets the employee's cost of coverage. The State, as the employer, would remain responsible for funding the cost of the underlying health benefits. The Department states, because the State is a public employer it is not clear if state coverage would be included in the definition of private employer-sponsored insurance. The Department indicates the fiscal impact of the Voluntary Bridge to Marketplace Premium Assistance Program is indeterminable. The Department assumes there could be savings in the event a state employee declined state employee coverage and opted for coverage under the Voluntary Bridge to Marketplace Premium

Assistance Program. The Department indicates, in order for an employee to be eligible, the State's coverage would have to be deemed not cost effective or not included in the definition of private employer -sponsored coverage. The Department is not able to provide an estimate of the number of state employees who may meet the criteria for this program. The Department states the fiscal impact of the Marketplace Premium Assistance Program on the state employee and retiree health benefit program would be similar to that of the Voluntary Bridge to Marketplace Premium Assistance Program and cannot be determined.

The New Hampshire Municipal Association states this bill creates a program to provide assistance to low income residents in purchasing health insurance. The Association states it is likely that by helping previously uninsured individuals to obtain insurance, the bill will reduce the need of some individuals for public assistance, and thus will reduce municipal welfare expenditures. The Association states it is not able to estimate the amount of such reductions and states there will be no impact on municipal revenue.

The New Hampshire Association of Counties states this bill may have a fiscal impact on county corrections costs. The Association states, to the extent an individual incarcerated in a county correctional facility is able to access Medicaid coverage for overnight hospitalization costs, county expenditures for medical costs may decrease. The Association is not able to determine the actual fiscal impact because it is unable to determine the number of individuals who may be incarcerated and need hospitalization services.

The Department of Information Technology states this bill will have no direct fiscal impact on its operating budget. The Department states the Departments of Health and Human Services and Insurance will work with contracted vendors to develop and implement any system requirements.

This bill amends the appropriation to the Health Care Reform Commission in Chapter 144:130, Laws of 2013, providing the unspent balance of approximately $103,000 shall not lapse until November 1, 2014 and shall be used by the Department in preparing or submitting the necessary waivers or state plan amendments required by the bill.

This bill does not establish any new positions.