SB 228-FN - AS AMENDED BY THE HOUSE

03/14/2019 0841s
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2019 SESSION

19-1100
01/04

SENATE BILL *228-FN*

AN ACT relative to multiple-employer welfare arrangements.

SPONSORS: Sen. Feltes, Dist 15

COMMITTEE: Commerce

ANALYSIS

This bill makes changes to the law governing multiple-employer arrangements.

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Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.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

In the Year of Our Lord Two Thousand Nineteen

AN ACT relative to multiple-employer welfare arrangements.

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

1 Statement of Purpose. The purpose of this act is to provide legislative authorization for initiatives to improve the health coverage available through this state's individual and small employer markets, including authorizing new forms of multiple employer welfare arrangements contingent on the establishment of the legal validity of the United States Department of Labor's Association Health Plan Rule codified at 29 C.F.R. section 2510.3-5(b), authorizing the insurance commissioner to apply for a waiver on an expedited basis under section 1332 of the Affordable Care Act to create a market stabilization mechanism for the individual market, and creating a legislative commission on the status of health coverage markets for individuals and small employers. The general court hereby seeks to help individuals and small businesses obtain more affordable health care coverage and new coverage options while preserving protections for higher risk individuals and groups and while protecting against adverse impacts on New Hampshire's existing individual and small group health insurance markets.

2 Title. This act shall be known as the Individual and Small Business Health Care Reform Act of 2019.

3 Multiple-Employer Welfare Arrangements; Definitions. RSA 415-E:1 is repealed and reenacted to read as follows:

415-E:1 Definitions. In this chapter:

I. "Bona fide association" means a bona fide pathway I association or a bona fide pathway II association.

II. "Bona fide pathway I association" means a group or association that satisfies the criteria established by the United States Department of Labor prior to the adoption in 2018 of 29 C.F.R. section 2510.3-5, including the guidance provided in the United States Department of Labor publication entitled “MEWAS, Multiple-Employer Welfare Arrangements under the Employee Retirement Income Security Act (ERISA): A Guide to Federal and State Regulation, Revised August 2013” and including published United States Department of Labor ERISA Advisory Opinion Letters.

III. “Bona fide pathway II association” means a group or association that meets the requirements of 29 C.F.R. section 2510.3-5(b).

IV. "Commissioner" means the insurance commissioner of the state of New Hampshire.

V. “Eligible employee” means a full-time or part-time employee who meets the requirements for eligibility for group coverage set forth in RSA 415:18, I(q).

VI. Employee welfare benefit plan” has the same meaning as in 29 U.S.C. section 1002(1).

VII. “Fully insured health benefit plan” means a policy, contract, certificate, or agreement to provide, deliver, arrange for, pay for, or reimburse any of the costs of health services, that is offered or issued to bona fide association by a health insurer licensed to do business in New Hampshire and that bears the risk under the plan.

VIII. "Fund balance" means the total assets in excess of total liabilities, except that assets pledged to secure debts not reflected on the books of the multiple-employer welfare arrangement shall not be included in the fund balance. Fund balance shall include other contributed capital, retained earnings, and surplus notes.

IX. "Insolvency termination" means the termination of an arrangement where the fund balance as of the termination date is inadequate.

X. “Insurer” means any insurer, nonprofit hospital or medical service corporation, health maintenance organization, or managed care organization, including but not limited to an insurer offering health coverage as defined in RSA 420-G:2, IX.

XI. "Multiple-employer welfare arrangement (MEWA)" or “association” means an employee welfare benefit plan or any other arrangement which is established or maintained for the purpose of offering or providing health benefits to the eligible employees of 2 or more employers, or to their beneficiaries, and shall include a MEWA as defined in the Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1001 et seq. (ERISA). This shall include plans established by any political subdivision of the state or religious organization, but shall not include any plan or arrangement established or maintained under or pursuant to one or more agreements deemed collective bargaining agreements under section 3(40)(A)(i) of (ERISA). For the purposes of this chapter, 2 or more trades or businesses, whether or not incorporated, shall be deemed a single employer if such trades or businesses are under common ownership or within the same control group as defined under section 3(40)(B) of ERISA.

4 Multiple-Employer Welfare Arrangements; Applicability; General Eligibility. Amend RSA 415-E:2, I and II to read as follows:

I. No person shall[~~, after April 1, 1992,~~] operate a multiple-employer welfare arrangement unless such arrangement is approved by the commissioner. [~~No person shall, after April 1, 1992, operate a multiple-employer welfare arrangement in existence prior to April 1, 1992, unless such arrangement has submitted for approval in compliance with RSA 415-E:4, or otherwise meets the special requirements of paragraph III of this section.~~] ***A foreign or domestic MEWA or association shall be subject to the jurisdiction of this state if it provides a health benefit plan that covers the employees of at least one employer that maintains a work location in New Hampshire, which is the primary workplace of at least one New Hampshire resident, including any self-employed New Hampshire resident who is qualified to enroll in the plan.***

II. This chapter shall not apply to a multiple-employer welfare arrangement ***that is a bona fide pathway I association*** which offers or provides benefits which are fully insured by an authorized insurer or under the provisions of RSA 5-B.

5 Multible-Employer Welfare Arrangements. RSA 415-E:3 is repealed and reenacted to read as follows:

415-E:3 General Eligibility; Pathway I and Pathway II. To meet the requirements for approval and to maintain a multiple employer welfare arrangement, an association not exempted under RSA 415-E:2, II shall be approved either as a self-insured bona fide pathway I association or as a bona fide pathway II association as follows:

I. An association seeking approval as a self-insured bona fide pathway I association shall:

(a) Meet the definition in RSA 415-E:1, II of a bona fide pathway I association.

(b) Sponsor health coverage that is self-insured.

(c) Be nonprofit.

(d) Be established by a trade association, industry association, political subdivision of the state, religious organization, or professional association of employers or professionals which has a constitution or bylaws and which has been organized and maintained in good faith for a continuous period of one year for purposes other than that of obtaining or providing insurance.

(e) Be operated pursuant to a trust agreement by a board of trustees which shall have complete fiscal control over the arrangement and which shall be responsible for all operations of the arrangement. The trustees selected shall be owners, partners, officers, directors, or employees of one or more employers in the arrangement. A trustee may not be an owner, officer, or employee of the administrator or

service company of the arrangement. The trustees shall have the authority to approve applications of association members for participation in the arrangement and to contract with an authorized administrator or service company to administer the day-to-day affairs of the arrangement.

(f) Be neither offered nor advertised to the public generally.

(g) Be operated in accordance with sound actuarial principles.

II. An association seeking approval as a bona fide pathway II association shall:

(a) Meet the definition in RSA 415-E:1, III of a bona fide pathway II association.

(b) Have a formal organizational structure with a governing body, bylaws, and other similar indications of formality, and complies with RSA 415-E:3, I-a(e) and with all other organizational requirements under this chapter and, if the association offers fully insured coverage, under RSA 420-M.

(c) Have its functions and activities controlled by its employer members, and the association's employer members that participate in the group health plan shall control the plan, both in form and in substance.

(d) Have a commonality of interest with its employer members, such that one or both of the following standards are met, in a manner that is not a subterfuge for discrimination as prohibited under RSA 415-E:1-e:

(1) The employers are in the same trade, industry, line of business, or profession; or

(2) Each employer has a principal place of business in the same region.

(e) Have at least one substantial business purpose unrelated to offering and providing health coverage or other employee benefits to its employer members and their employees.

(f) Have each employer member of the association participating in the group health plan who is a person acting directly as an employer of at least one employee who is a participant covered under the plan.

(g) Not make health coverage through the association's group health plan available other than to:

(1) An employee of a current employer member of the association; and

(2) A beneficiary of an individual eligible under subparagraph (1).

(h) Not be a health insurance issuer, or owned or controlled by a health insurance issuer, or by a subsidiary or affiliate of a health insurance issuer, other than to the extent such entities participate in the association in their capacity as employer members of the association.

6 New Sections; Multiple-Employer Welfare Arrangements. Amend RSA 415-E by inserting after section 3 the following new sections:

415-E:3-a Bona Fide Pathway I and II Association Coverage; General Authorization. Bona fide pathway association coverage as set forth in the United States Department of Labor's June 21, 2018 amendment to 29 C.F.R. section 2510, 83 Fed. Reg. 28,961 (codified at 29 C.F.R. section 2510.3-5) shall be permissible in New Hampshire provided it conforms with this chapter and all of the provisions of Title XXXVII concerning this coverage.

415-E:3-b Bona Fide Pathway I and II Association Coverage: Option to Offer Fully-Insured Coverage.

I. A bona fide pathway I association may offer coverage on a fully insured basis if it is a qualified association trust as defined in RSA 420-G:2, XV.

II. A bona fide pathway II association may offer coverage on a fully insured basis if it is licensed as a qualified purchasing alliance under RSA 420-M and meets all of the pathway II requirements under this chapter.

III. No insurer shall issue a fully-insured health benefit plan to an association or MEWA with covered lives in New Hampshire unless the association or MEWA meets the requirements of either paragraphs I or II.

IV. A fully-insured association or MEWA that is a qualified association trust or that has been licensed by the department as a qualified purchasing alliance shall not be subject to the financial reporting and solvency requirements of this chapter that are applicable only to self-funded associations.

V. An insurer issuing a fully insured health benefit plan to an association or MEWA shall ensure that the terms of the plan conform with all applicable requirements of this chapter with respect to bona fide association coverage and that the coverage has received all required approvals from the department.

415-E:3-c Bona Fide Pathway II Association Coverage; Benefit Requirements.

I. Each health benefit plan offered to or by a bona fide pathway II association, whether on a fully insured or self-funded basis, shall, at a minimum, provide the following benefits:

(a) Coverage for each of the 10 essential health benefits as defined in 42 U.S.C. section 18022(b)(1), subject to approval of the commissioner based on the New Hampshire benchmark plan;

(b) Cost sharing requirements of 42 U.S.C. section 18022(c)(1)-(c)(3);

(c) Lifetime and annual limits as prescribed in 29 C.F.R. section 2590.715-2711;

(d) A level of coverage equal to or greater than that designed to provide benefits that are actuarially equivalent to 60 percent of the full actuarial value of the benefits provided under the plan; and

(e) All other benefits required to comply with applicable federal laws and regulations and with any provision of title XXXVII that applies to large group health insurance coverage.

II. Every health benefit plan offered by any bona fide pathway II association, whether offering coverage on a self-funded basis or fully insured basis, and any insurer contracting with an offering association, shall comply with the following:

(a) Except as otherwise specifically provided herein, all requirements of RSA 420-G, including claims data and other reporting requirements;

(b) Requirements contained in RSA 420-J, and any rules adopted thereunder by the commissioner including, but not limited to, network adequacy, balance billing protections, and appeal and grievance processes;

(c) Payment of premium tax as provided in RSA 400-A:31-35 and administrative assessment under RSA 400-A:39;

(d) Requirements pertaining to examinations under RSA 400-A:37;

(e) Requirements pertaining to unfair insurance trade practices under RSA 417;

(f) Vaccine association assessment under RSA 126-Q; and

(g) Individual market assessment under RSA 404-G.

III. No health benefit plan or related policy, contract, certificate, or agreement offered or issued in this state to a bona fide pathway II association, whether offering coverage on a self-funded basis or fully insured basis, shall reserve discretion to the insurer or sponsoring association to interpret the terms of the contract or to provide standards of interpretation or review that are inconsistent with the laws of this state. Any such policy, contract, certificate, or agreement shall be void and unenforceable to the extent it conflicts with this section.

IV. A bona fide pathway II association, whether offering coverage on a self-funded basis or fully insured basis, shall not offer, and an insurer shall not deliver or issue for delivery to such association, a health benefit plan covering lives located in this state that contains an exclusion or limitation for pre-existing conditions or a waiting period on the coverage of pre-existing conditions.

V. For any bona fide pathway II association, whether offering coverage on a self-funded basis or fully insured basis, if coverage is issued to a sole proprietor, the association sponsoring the coverage shall be responsible for monitoring and ensuring that the sole proprietor meets the requirements to qualify as an employer under 29 C.F.R. section 2510.3-5(b) and meets the per month hourly work requirement contained in RSA 126-AA:2, III. Failure to ensure compliance with this provision shall be a violation of this chapter.

415-E:3-d Rating Requirements for Bona Fide Pathway I Fully Insured Coverage and all Pathway II Coverage; Rating Requirements.

I. Any fully insured bona fide pathway I association and any pathway II association, whether self-funded or fully insured, or any insurer contracting with such bona fide pathway I or II association to provide a health benefit plan, shall comply with all requirements of RSA 420-G, except that, for any such association with 250 or more New Hampshire covered lives, the association as a whole may be rated as a single risk pool separately from the small employer market.

II. Coverage for a fully insured bona fide pathway I association with 250 or more New Hampshire covered lives and any bona fide pathway II association with 250 or more New Hampshire covered lives may be rated as a single large group based on the association's group experience and in accordance with all standards applicable to large employer groups under RSA 420-G. The following additional requirements shall apply to such coverage:

(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) For fully insured bona fide pathway I associations, the association may vary rates among member small employers only in accordance with the provisions in RSA 420-G:10 applying to qualified association trusts.

(c) For any pathway II association, whether self funded or fully insured, the association may vary rates among member small employers, including participating self-employed New Hampshire members, as follows:

(1) Variation associated with age shall not exceed 5:1.

(2) Variation associated with tobacco use shall not exceed 1.5 to 1.

(3) No other variation shall be permitted.

(d) The same rating methodology shall apply to newly covered member employer groups and employee members renewing at each annual renewal date or anniversary date. The 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.

(e) Nothing in this chapter shall be construed to allow a member small employer group within any association to be rated separately under large group rating standards.

415-E:3-e Bona Fide Pathway II Association Coverage; Nondiscrimination Requirements. In accordance with 29 C.F.R. section 2590.702, bona fide pathway II association coverage shall comply with the following:

I. The group or association shall not condition employer membership in the group or association on any health factor of any individual who is or may become eligible to participate in the group health plan sponsored by the group or association.

II. The group health plan sponsored by the group or association shall comply with 29 C.F.R. section 2590.702(b) with respect to nondiscrimination in rules for eligibility of benefits.

III. The group health plan sponsored by the group or association shall comply with 29 C.F.R. section 2590.702(c) with respect to nondiscrimination in premiums or contributions required by any participant or beneficiary for coverage under the plan.

IV. In applying the nondiscrimination provisions of paragraphs II and III, the group or association shall not treat the employees of different employer members of the group or association as distinct groups of similarly-situated individuals based on a health factor of one or more individuals.

415-E:3-f Free Movement Between Bona Fide Association Coverage and Small Group Coverage. A small employer that leaves the small group market for bona fide pathway I or II association coverage or that leaves pathway I or II association coverage for the small group market shall not be subjected to a waiting period before being permitted to return to the original market, nor shall an insurer or administrator be permitted to impose such a waiting period.

415-E:3-g Bona Fide Pathway II Association Coverage; Mitigation of Small Group Market Impacts of Pathway II Association Coverage.

I. In order to mitigate potential adverse effects of pathway II association coverage on the existing small group markets, the commissioner shall retain an independent actuarial firm to model and quantify the impacts of pathway II coverage on the existing small group markets and to perform the actuarial review necessary to support the small group risk adjustment program required under RSA 420-K. The plan of operation for the small group risk adjustment program required under RSA 420-K shall be approved and in place before any pathway II association coverage may be issued.

II. Upon the recommendation of the commission on the status of health coverage markets for individuals and small employers established under RSA 404-J, or upon the commissioner's own initiative, the commissioner may limit pathway II associations to the writing of existing business only and may adjust the risk score differential amount in RSA 420-K:4, I(d) as necessary to prevent the pathway II association market from having an adverse impact on the availability and choice of coverage in the small group market and as necessary to prevent average premiums for small groups from increasing at a rate that is significantly higher than the trend in claims costs.

7 Multiple-Employer Welfare Arrangements; Filing of Application. Amend the section heading and the introductory paragraph of RSA 415-E:4 to read as follows:

415-E:4 ***Self-Funded Arrangements;*** Filing of Application. ***For self-funded arrangements,*** the sponsoring association shall file with the commissioner an application for approval of the arrangement upon a form to be furnished by the commissioner, which shall include or have attached the following:

8 Multiple-Employer Welfare Arrangements; Termination Liability Fund. RSA 415-E:5 is repealed and reenacted to read as follows:

415-E:5 Self-Funded Arrangements: Termination Liability Fund.

I. Each self-funded multiple-employer welfare arrangement shall maintain a termination liability fund wherein the fund balance of the multiple-employer welfare arrangement shall at no time, for a consecutive 90-day period, be less than $750,000 or 33 percent of the aggregate premiums billed during the 12 prior months, whichever is greater. For purposes of this paragraph, that surety amount, if any, deposited with the commissioner pursuant to RSA 415-E:7, I, may be credited as a fund balance asset toward the termination liability fund amount.

II. Each self-funded multiple-employer welfare arrangement shall file with the commissioner, not later than 4 months following the end of each fiscal year, a report on the financial status of the termination liability fund, which report is filed under oath by a member of its board of trustees, or by an administrative executive duly appointed by the board, and further certified to by an independent certified public accountant.

9 Multiple-Employer Arrangements, Financial Condition, Loss Reserves. Amend RSA 415-E:6 to read as follows:

415-E:6 ***Self-Funded Arrangements;*** Financial Condition, Loss Reserves, Reinsurance, or Working Capital; Determination of Inadequacy.

I. Each self-funded arrangement shall maintain specific excess insurance with a retention level determined in accordance with sound actuarial principles and approved by the commissioner.

II. Each self-funded arrangement shall establish and maintain appropriate loss reserves determined in accordance with sound actuarial principles and approved by the commissioner.

[~~I.~~] ***III.*** The commissioner may, upon reasonable notice, conduct an examination of the loss reserves, financial condition, specific excess insurance, and working capital of a multiple-employer welfare arrangement ***the costs of which shall be borne by the arrangement***. If the commissioner preliminarily finds that the reserves, specific excess insurance, or financial condition may be inadequate, or that the arrangement does not have a combined working capital in an amount establishing the financial strength and liquidity of the arrangement to pay claims promptly and showing evidence of the financial ability of the arrangement to meet its obligations to covered employees, the commissioner shall notify the arrangement of such inadequacy. Upon being so notified, the arrangement shall within 30 days file with the commissioner all information which, in the belief of the arrangement, proves the reasonableness and adequacy of the condition noted as being inadequate.

[~~II.~~] ***IV.*** If the commissioner determines, after reviewing the information filed, that an inadequate condition exists, the arrangement shall implement, within 30 days, a plan to correct the inadequacy and shall file proof of reasonable improvement or adequate condition with the commissioner within 6 months of the implementation of the plan. If the commissioner is satisfied that the plan submitted to improve the inadequate condition of the arrangement is sufficient, he shall so notify the arrangement. The arrangement shall report quarterly to the commissioner until the causes of the inadequate condition have been corrected.

[~~III.~~] ***V.*** The commissioner may suspend or revoke the approval of an arrangement if he finds that the arrangement has failed to correct or reasonably improve an inadequate condition within the time authorized by paragraph [~~II~~] ***IV***.

10 Multiple-Employer Arrangements; Insolvency Protection. Amend RSA 415-E:7, I to read as follows:

I. To assure the faithful performance of its obligations to its member employers and covered employees ***who are Hampshire residents*** and their dependents, every arrangement shall, within 30 days after the close of the arrangement's fiscal year, deposit with the commissioner cash, securities, or any combination of these or other measures acceptable to the commissioner, in an amount equal to [~~25 percent of the preceding 12 months' health care claims expenditures or 5 percent of gross annual premiums for the succeeding year~~], ***$100,000 or 25 percent of the aggregate premiums billed during the 12 prior months attributable to New Hampshire residents,*** whichever is greater[~~; however, in no case shall the amount of the deposit exceed $100,000~~]. All income from deposits shall belong to the depositing arrangement and shall be paid to it as it becomes available. An arrangement that has made a securities deposit may withdraw that deposit, or any part of such deposit, after making a substitute deposit of cash, securities, or any combination of these or other measures of equal amount and value, upon approval by the commissioner. No judgment creditor or other claimant of a multiple-employer welfare association shall have the right to levy upon any of the assets or securities held in this state as a deposit under this section.

11 Multiple-Employer Arrangements. Amend RSA 415-E:8 through RSA 415-E:13 to read as follows:

415-E:8 Policy Forms.

I. ***Whether an arrangement is self-funded or fully insured,*** no policy or contract form, application form, certificate, rider, endorsement, summary plan description, or other evidence of coverage shall be ***sponsored or*** issued by an arrangement unless the form and all changes to it have been filed with the commissioner by or on behalf of the arrangement which proposed to use such form and have been approved by the commissioner.

II. The commissioner shall disapprove any form filed under this section, or withdraw any previous approval, only if the form:

(a) Is in any respect in violation of, or does not comply with, this chapter.

(b) Contains or incorporates by reference, where such incorporation is otherwise permissible, any inconsistent, ambiguous, or misleading clauses, or exceptions and conditions which deceptively affect the risk purported to be assumed in the general coverage of the contract.

(c) Has any title, heading, or other indication of its provisions which is misleading.

(d) Is printed or otherwise reproduced in such manner as to render any material provision of the form substantially illegible.

(e) Contains provisions which are unfair or inequitable, or contrary to the public policy of this state or which encourage misrepresentation.

III. Each self-funded arrangement shall issue to each covered employee a policy contract, certificate, summary plan description, or other evidence of the benefits and coverages provided. The evidence of the benefits and coverages provided shall contain in boldfaced print in a conspicuous location, the following statement: "The benefits and coverages described herein are provided through a trust fund established and funded by a group of employers."

IV. Each self-funded arrangement shall provide to each covered employee, on request, a written statement of the dollar amount of allowable benefit for any procedure which is requested by the appropriate procedure code.

415-E:9 ***Self-Funded Arrangements;*** Employer Participants' Liability. ***For self-funded arrangements:***

I. The liability of each employer participant for the obligations of the multiple-employer welfare arrangement shall be individual, several, and proportionate, but not joint.

II. Each employer participant shall have a contingent assessment liability pursuant to 415-E:10 for payment of actual losses and expenses incurred while the policy was in force.

III. Each policy issued by the arrangement shall contain a statement of the contingent liability. Both the application for insurance and policy shall contain, in contrasting color and not less than 10-point type, the following statement: "This is a fully assessable policy. In the event the arrangement is unable to pay its obligations, policyholders (employers) shall be required to contribute on a pro rata earned premium basis the money necessary to meet any unfulfilled obligations."

415-E:10 ***Self-Funded Arrangements;*** Termination of Arrangement. ***For self-funded arrangements,*** if an arrangement is terminated for any reason, it shall pay all outstanding claims, debts, and obligations. The arrangement may retain sufficient funds to provide coverage for such additional period as the trustees of the arrangement consider prudent. In addition, the trustees may purchase such additional insurance as they consider necessary for protection against potential future claims. Any funds remaining in the arrangement after satisfaction of all obligations upon termination shall be paid to participating employers and/or covered employees as of the termination date in some equitable manner meeting with the approval of the commissioner, including, without ruling out other alternatives, equally on a per capita basis to each participating employer and/or employee who is covered under the arrangement as of the effective date of termination.

415-E:11 ***Self-Funded Arrangements;*** Annual Reports and Triennial Actuarial Reports. ***For self-funded arrangements:***

I. Every ***such*** arrangement shall, annually within 4 months of the end of the fiscal year or within such extension of time as the commissioner for good cause may grant, file a report with the commissioner, verified by the oath of a member of the board of trustees or by an administrative executive appointed by the board, showing its condition on the last day of the preceding fiscal year. The report shall contain a financial statement of the arrangement, including its balance sheet and a statement of operations for the preceding year certified by an independent certified public accountant. The report shall also include an analysis of the adequacy of reserves and contributions or premiums charged, based on a review of past and projected claims and expenses.

II. In addition to information called for and furnished in connection with the annual report, if reasonable grounds exist, the commissioner may request information which summarizes paid and incurred expenses, and contributions or premiums received, and may request evidence satisfactory to the commissioner that the arrangement is actuarially sound. Such information and evidence shall be furnished to the commissioner by the arrangement as soon as reasonably possible after requested by the commissioner, but no later than 30 days after such request, unless the commissioner, for good cause, grants an extension.

III. At least once every 3 years, each ***such*** arrangement shall have a report prepared by an actuary who is a member of the Society of Actuaries of the American Academy of Actuaries as to the actuarial soundness of the arrangement. The report shall be made available to the commissioner upon request. The report shall consist of, but shall not be limited to, the following:

(a) Adequacy of contribution rate in meeting the level of benefits provided and changes, if any, needed in the contribution rates to achieve or preserve a level of funding deemed adequate to enable payment of the benefit amounts provided under the arrangement, which shall include a valuation of present assets, based on statement value, and prospective assets and liabilities of the plan and the extent of any unfunded accrued liabilities.

(b) A plan to amortize any unfunded liabilities and a description of actions taken to reduce unfunded liabilities.

(c) A description and explanation of actuarial assumptions.

(d) A schedule illustrating the amortization of any unfunded liabilities.

(e) A comparative review illustrating the level of funds available to the arrangement from rates, investment income, and other sources realized over the period covered by the report, indicating the assumptions used.

(f) A statement by the actuary that the report is complete and accurate and that in his opinion the techniques and assumptions used are reasonable and meet the requirements and intent of this chapter.

(g) Other factors or statements as may be reasonably required by the commissioner in order to determine the actuarial soundness of the plan.

415-E:12 [~~Place of Business;~~] Maintenance of Records. Each arrangement shall [~~have and maintain its principal place of business in this state and shall~~] make available to the commissioner complete records of its assets, transactions, and affairs in accordance with such methods and systems as are customary for, or suitable to, the kind or kinds of business transacted.

415-E:13 ***Qualification for Approval and*** Suspension[~~,~~] ***or*** Revocation of Approval.

I. Subject to other provisions in this chapter, the commissioner shall deny, suspend, or revoke an arrangement's approval if it finds that the arrangement:

(a) Has failed to meet the financial requirements of this chapter, RSA 420-G, or has violated any lawful order or rules.

(b) Has refused to be examined or to produce its accounts, records and files for examination, or if any of its officers has refused to give information with respect to its affairs or to perform any other legal obligation as to such examination, when required by the commissioner.

(c) Has failed to pay any final judgment rendered against it in this state within 60 days after the judgment became final.

(d) No longer meets the requirements for the authority originally granted.

II. The commissioner may, in his discretion, deny, suspend, or revoke the approval of any arrangement if it finds that the arrangement:

(a) Has violated any lawful order or rule of the commissioner, provision of this chapter, RSA 420-J, or relevant provision of RSA 161-H.

(b) Has refused to be examined or to produce its accounts, records, and files for examination, or if any of its officers have refused to give information with respect to its affairs or to perform any other legal obligation as to such examination, when required by the commissioner.

III. The commissioner shall not grant or continue approval until such time as the arrangement replaces any trustee found by the commissioner, upon the presentation of sufficient evidence:

(a) To be incompetent;

(b) To be guilty of, or to have pled guilty or no contest to a felony, or a crime involving moral turpitude;

(c) To have had any type of insurance license revoked in this or any other state;

(d) To have improperly manipulated assets, accounts, or specific excess insurance or to have otherwise acted in bad faith.

IV. To qualify for and retain approval to transact business, an arrangement shall make all contracts with administrators or service companies available for inspection by the department initially, and thereafter upon reasonable notice.

V. Failure to maintain compliance with applicable eligibility or filing requirements established by this section shall be grounds for suspension or revocation of approval of an arrangement, provided, however, that such arrangement shall have 60 days after notification by the commissioner to take such action necessary to correct the deficiency.

12 Multiple Employer Arrangements; Rehabilitation; Rulemaking. Amend RSA 415-E:15 and RSA 415-E:16 to read as follows:

415-E:15 Rehabilitation, Dissolution. Any rehabilitation, liquidation, conservation, ***supervision,*** or dissolution of a multiple-employer welfare arrangement shall be conducted under the supervision of the commissioner, who shall have all power with respect thereto granted to it under the laws governing the rehabilitation, liquidation, conservation, ***supervision,*** or dissolution of insurers.

415-E:16 Rulemaking. The commissioner may adopt such rules, pursuant to RSA 541-A, as [~~he deems~~] ***are*** reasonable and necessary in order to carry out properly the functions and responsibilities assigned the insurance department under [~~the laws of the state~~] ***this chapter***. [~~This rulemaking authority shall expire on January 1, 1993, at which time this section, unless replaced by a later legislative enactment, shall be deemed repealed. Any rules adopted under this section shall be drafted in as narrow a manner as possible, consistent with the authority granted the department under the laws of this state.~~]

13 Health Coverage; Definitions. Amend RSA 420-G:2, XVI(a) to read as follows:

XVI.(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. ***However, with respect to coverage written under RSA 415-E to a bona fide pathway II association, whether self funded or fully insured, if such association has at least 250 New Hampshire covered lives and meets all applicable standards under RSA 415-E and all large group standards under this chapter, coverage offered by such association may be offered to sole proprietors or self-employed persons***.

14 Purchasing Alliances; Definitions. Amend RSA 420-M:2, X to read as follows:

X. "Qualified purchasing alliance" means a purchasing alliance that has obtained certification from the commissioner under RSA 420-M:13 as a qualified purchasing alliance with authority to [~~operate in the same manner as a qualified association trust pursuant to RSA 420-G:10~~] ***sponsor fully-insured bona fide pathway II association coverage under RSA 415-E***.

15 Purchasing Alliances. RSA 420-M:13 is repealed and reenacted to read as follows:

420-M:13 Qualified Purchasing Alliance. A purchasing alliance that has a minimum of 500 enrollees may elect to obtain certification from the commissioner as a qualified purchasing alliance. To obtain certification, a purchasing alliance shall demonstrate:

I. That the purchasing alliance meets all requirements under RSA 415-E to operate as a bona fide pathway II association; and

II. That certification of the applicant as a qualified purchasing alliance will promote the purposes set out in RSA 420-M:1; and

III. That the purchasing alliance has the capacity to monitor and screen sole proprietor members purchasing pathway II association coverage to ensure that they meet all requirements to qualify as an “employee” under 29 C.F.R. section 2510.3-5(b) and meets the per month hourly work requirement contained in RSA 126-AA:2, III.

16 Definition of Qualified Association Trust. Amend the introductory paragraph of RSA 420-G:2, XV to read as follows:

XV. "Qualified association trust or other entity" means an association established trust or other entity in existence on January 1, 1995, and providing health coverage within the state of New Hampshire to at least [~~1,000~~] ***250*** employees and/or the dependents of association members, which association:

17 Health Coverage; Qualified Association Trust. Amend RSA 420-G:10 to read as follows:

420-G:10 Qualified Association Trust [~~and Qualified Purchasing Alliance~~].

I. A qualified association trust or other entity, as defined in RSA 420-G:2, XV[~~, and a qualified purchasing alliance, as defined in RSA 420-M:2, X,~~] shall:

(a) Comply with the rating restrictions outlined in RSA 420-G:4 for all small employer members with 50 or fewer employees based upon the association's or alliance's group experience, except that [~~for a qualified association trust,~~] no rating factor shall be utilized without the express written consent of the association.

(b) Offer all eligible members, as defined under the applicable trust or other documents, coverage and rates on a guaranteed issue and renewable basis.

(c) Comply with the regulations concerning medical underwriting in RSA 420-G:5.

(d) Comply with the preexisting conditions provision of RSA 420-G:7.

[~~(e) Prohibit any employer that voluntarily discontinues participation in either a qualified association trust or a qualified purchasing alliance from rejoining for a period of at least 24 months.~~]

II. Nothing in this chapter shall be interpreted to limit the size of employers who may participate in coverage with a qualified association trust [~~or a qualified purchasing alliance~~].

18 Small Employer Health Reinsurance Pool. Amend the chapter heading of RSA 420-K to read as follows:

SMALL EMPLOYER HEALTH [~~REINSURANCE POOL~~]

RISK ADJUSTMENT PROGRAM

19 Small Employer Health Reinsurance Pool; Definitions. RSA 420-K:1 is repealed and reenacted to read as follows:

420-K:1 Definitions. In this chapter:

I. "Assessment" means the liability of the member insurer to the reinsurance pool.

II. "Board" means the board of directors of the small employer health reinsurance pool.

III. “Bona fide pathway II association coverage” means coverage, whether self-funded or fully insured, that constitutes an employee welfare benefit plan sponsored by a bona fide pathway II association as defined in RSA 415-E:1.

IV. "Commissioner" means the insurance commissioner.

V. "Covered lives" shall include all persons who have health insurance via a health carrier and who are employees or dependents of employees of a small employer, including sole proprietors covered under bona fide pathway II association coverage.

VI. "Health insurance" means "health insurance" as defined in RSA 404-G:2, VII.

VII. "Plan of operation" means the plan of operation of the small employer health risk adjustment program, including articles, bylaws and operating rules, procedures and policies approved by the commissioner and adopted by the pool.

VIII. "Small employer" means "small employer" as defined in RSA 420-G:2, XVI.

IX. "Small employer health carrier" means any entity licensed pursuant to RSA 402, RSA 420-A, or RSA 420-B that delivers, issues for delivery or maintains in force policies of health insurance in New Hampshire to any small employer. For purposes of this chapter, health carrier shall include any association, organization or arrangement offering or sponsoring bona fide pathway II association coverage.

20 Establishment of the Risk Adjustment Program. Amend RSA 420-K:2 to read as follows:

420-K:2 Establishment of the [~~Pool~~] ***Risk Adjustment Program***.

I. There is established a nonprofit entity to be known as the "New Hampshire small employer health [~~reinsurance pool~~] ***risk adjustment program***." All ***small employer*** health carriers[~~, writers of health insurance, and other insurers~~] issuing or maintaining health insurance in this state shall be members of the [~~pool~~] ***program***.

II. [~~On or before July 1, 2005,~~] The commissioner shall give notice to all members of the [~~pool~~] ***program*** of the time and place for the initial organizational meeting[~~, which shall take place by July 15, 2005~~]. The members shall select the initial board at the organizational meeting and such initial board shall be subject to approval by the commissioner. The members shall elect each subsequent board at the annual meeting of members and each such subsequent board shall be subject to approval by the commissioner. The initial board and each subsequent board shall consist of at least 5 and not more than 9 representatives of members. There shall be no more than one board member on the initial board and each subsequent board representing any one member company. In determining voting rights at the organizational meeting and all subsequent meetings of members, each member shall be entitled to vote

in person or by proxy. All such votes shall be proportional to the member's covered lives. To the extent possible, at least 2/3 of members of each board shall be small employer health carriers. [~~At least one member of each board shall be a small employer health carrier with less than $100,000,000 in net small employer health insurance premium in this state.~~] The commissioner, or designee, shall be an ex-officio voting member of the board. In approving selection of each board, the commissioner shall assure that all members are fairly represented.

III. If the initial board is not elected at the organizational meeting, the commissioner shall appoint the initial board within 15 days of the organizational meeting.

IV. Within 60 days after the appointment of such initial board, the board shall submit to the commissioner a plan of operation and thereafter any amendments to the plan necessary or suitable to assure the fair, reasonable, and equitable administration of the [~~pool~~] ***program***. The commissioner shall, after notice and hearing, approve the plan of operation provided he or she determines it to be suitable to assure the fair, reasonable, and equitable administration of the [~~pool, and provides for the sharing of pool gains or losses on an equitable proportionate basis in accordance with the provisions of paragraph VI of this section~~] ***program***. The plan of operation shall become effective upon approval in writing by the commissioner consistent with the date on which the coverage under this section shall be made available. If the board fails to submit a suitable plan of operation within 60 days after its appointment, or at any time thereafter fails to submit suitable amendments to the plan of operation, the commissioner shall, after notice and hearing, adopt and promulgate a plan of operation or amendments [~~no later than October 1, 2005~~]. The commissioner shall amend any plan adopted by him or her, as necessary at the time a plan of operation is submitted by the board and approved by the commissioner.

V. The board shall select [~~reinsurance pool~~] ***risk adjustment program*** administrators through a competitive bidding process to administer the [~~pool~~] ***program***. The board shall evaluate bids submitted based on criteria established by the board. [~~Each month, total payments to administrators shall not exceed the larger of $2,500 or an amount equal to $10 per life for which the reinsurance pool has any potential claims liability.~~]

VI. The plan of operation shall establish procedures for:

(a) Handling and accounting of assets and moneys of the pool, and for annual fiscal reporting to the commissioner.

(b) Filling vacancies on the board, subject to the approval of the commissioner.

(c) Selecting an administrator and setting forth the powers and duties of the administrator.

(d) [~~Reinsuring risks in accordance with the provisions of this chapter~~] ***Establishing risk adjustment parameters***.

(e) Collecting assessments from all members to provide for [~~claims reinsured~~] ***risk adjustment payments*** by the [~~pool~~] ***program*** and for administrative expenses incurred or estimated to be incurred during the period for which the assessment is made.

(f) Any additional matters at the discretion of the board.

21 Powers of the Program. RSA 420-K:3 and RSA 420-K:4 are repealed and reenacted to read as follows:

420-K:3 Powers of the Program. The program may:

I. Enter into contracts as are necessary or proper to carry out the provisions and purposes of this chapter, including the authority, with the approval of the commissioner, to enter into contracts with programs of other states for the joint performance of common functions, or with persons or other organizations for the performance of administrative functions.

II. Sue or be sued, including taking any legal actions necessary or proper for recovery of any assessments for, on behalf of, or against members.

III. Take such legal action as necessary to avoid the payment of improper claims against the program.

IV. Define the array of health coverage products for which risk adjustment will be applied in accordance with the requirements of this chapter.

V. Establish rules, conditions, and procedures pertaining to the risk adjustment mechanism, including implementation and measurement time frames and the permitted risk corridor where no transfer of risk adjustment funds shall take place.

VI. Establish appropriate rates, rate schedules, rate adjustments, rate classifications, and any other actuarial functions appropriate to the operation of the program.

VII. Assess members in accordance with the provisions of this chapter, and to make advance interim assessments as may be reasonable and necessary for organizational and interim operating expenses and to pay claims by the program. Any such interim assessments shall be credited as offsets against any regular assessments due following the close of the fiscal year.

VIII. Appoint from among the members appropriate legal, actuarial, and other committees as necessary to provide technical assistance in the operation of the program, policy, and other contract design, and any other function within the authority of the program.

IX. Borrow money to effectuate the purposes of the program. Any notes or other evidence of indebtedness of the program not in default shall be legal investments for insurers and may be carried as admitted assets.

420-K:4 Risk Adjustment Program.

I. The board shall:

(a) Develop and monitor a measure of risk to be used in comparing populations covered by small employer health insurance coverage and bona fide pathway II association coverage. The population covered by qualified association trust coverage or by bona fide pathway I association coverage, whether self-funded or fully insured, shall not be a part of the risk adjustment program and, for the purposes of this chapter, shall not be considered to be small group coverage.

(b) Access from the New Hampshire comprehensive health care information system (CHIS), as described under RSA 420-G:11-a, member level information, including length of coverage, gender, age, and diagnosis, sufficient to measure and monitor risk for carriers issuing or administering small employer health insurance.

(c) Perform risk adjustment analysis which may include the use of data from the CHIS, including calculating New Hampshire specific relative weights as necessary, to analyze the difference in the medical care resources expected to be necessary to treat the 2 different populations, one covered in the small group insurance risk pool and the other covered by bona fide pathway II association coverage.

(d) Subject to the limitation in paragraph II, establish risk adjustment payments between carriers that are triggered whenever the average risk over any calendar year between bona fide pathway II association coverage and all other small group coverage differs by more than the maximum allowed amount, and that serve to create a net effect of reducing future expected risk score differences after payments to approximately the target amount. The commissioner shall establish the maximum allowed amount and the target amount by retaining actuarial experts. The standard that the actuarial experts shall use in recommending values for the maximum allowed amount and the target amount is that such amounts should be so determined as to prevent the pathway II association market from having an adverse impact on the availability and choice of coverage in the small group market and to prevent adverse selection against the small group market that is sufficient to cause the average premiums for small groups to increase at a rate that is significantly higher than the trend in claims costs.

(e) Provide a report to the insurance commissioner in a form and format acceptable to the commissioner.

II. The board shall not implement any adjustments until the number of lives covered by bona fide pathway II association coverage exceeds 2,000 member months for 3 consecutive months.

22 Immunity and Indemnification. Amend RSA 420-K:7 to read as follows:

420-K:7 Immunity and Indemnification.

I. Neither the participation in the [~~pool~~] ***program*** as members, the establishment of rates, forms, or procedures, nor any other joint or collective action required by this chapter shall be the basis of any legal action against the [~~pool~~] ***program*** or any of its members.

II. Any person or member made a party to any action, suit, or proceeding because the person or member served on the board or on a committee or was an officer or employee of the [~~pool~~] ***program*** shall be held harmless and be indemnified by the [~~pool~~] ***program*** against all liability and costs, including the amounts of judgments, settlements, fines or penalties, and expenses and reasonable attorney's fees incurred in connection with the action, suit, or proceeding. The indemnification shall not be provided on any matter in which the person or member is finally adjudged in the action, suit, or proceeding to have committed a breach of duty involving gross negligence, dishonesty, willful misfeasance, or reckless disregard of the responsibilities of office. Costs and expenses of the indemnification shall be prorated and paid for by all members. The right of indemnification shall not be exclusive of other rights or defenses to which such person or the legal representative or successors of such person, may be entitled to as a matter of law. The commissioner may retain actuarial consultants necessary to carry out his or her responsibilities pursuant to this chapter and such expenses shall be paid by the [~~pool~~] ***program*** established in this chapter.

23 New Chapter; Commission on the Status of Health Coverage Markets for Individuals and Small Employers. Amend RSA by inserting after chapter 404-I the following new chapter:

CHAPTER 404-J

COMMISSION ON THE STATUS OF HEALTH COVERAGE MARKETS

FOR INDIVIDUALS AND SMALL EMPLOYERS

I. There is hereby established a commission on the status of health coverage markets for individuals and small employers.

(a) The members of the commission shall be as follows:

(1) Three members of the senate, one of whom shall be a member of the minority party, appointed by the president of the senate.

(2) Three members of the house of representatives, one of whom shall be a member of the minority party, appointed by the speaker of the house of representatives.

(3) The insurance commissioner, or designee.

(4) Three persons representing health carriers, appointed by the insurance commissioner, as follows:

(A) One person representing a health carrier with a significant presence in the individual market;

(B) One person representing a health carrier with a significant presence in the small employer market; and

(C) One person representing a health carrier with an interest in providing or administering health coverage in the pathway II association market.

(5) Two producers, appointed by the insurance commissioner, one of whom shall be a producer with a significant clientele in the individual market and the other a producer with a significant clientele in the small employer market.

(6) A public member from an academic institution or charitable foundation who has health care and health insurance expertise, appointed by the senate president.

(7) A public member who shall represent the interests of persons who obtain their coverage through that market, appointed by the speaker of the house of representatives.

(8) A public member who shall represent the interests of persons who obtain their coverage through the individual market, appointed by the president of the senate.

(9) Two public members from organizations that represent the interests of the medically underserved, persons with pre-existing conditions, or persons with chronic health conditions, including mental health or substance use disorders, appointed by the governor.

(10) A public member who shall represent the interests of small employers sponsoring health coverage for their employees, appointed by the governor.

(11) A public member from the Business and Industry Association of New Hampshire or a New Hampshire chamber of commerce, appointed by the governor.

(12) A public member from a national organization with a New Hampshire chapter that is interested in qualifying as a bone fide pathway II association, as defined in RSA 415-E:1, III, appointed by the governor.

(b) Of the commission members listed under subparagraph (a), only the 6 legislative members shall be voting members. All other members shall serve in an advisory capacity only.

(c) Legislative members of the commission shall receive mileage at the legislative rate when attending to the duties of the commission.

(d) The commission shall be a public body subject to RSA 91-A, and its meetings shall be considered public proceedings.

II.(a) The commission shall evaluate the status of health coverage markets for individuals and small employers. This shall include the individual market, the small employer market, and alternative sources of coverage that may be available to individuals and small employers, including pathway II association coverage, transitional coverage, and short-term limited duration coverage. These markets shall be evaluated in terms of their performance in making available to individuals and small employers affordable coverage that provides access to medically necessary care on affordable terms. Consideration shall be given to market competitiveness, price, choice of plans, market size, market segmentation, the risk profile of the covered population in each market, adverse selection against specific markets, migration between markets, the rate of growth or diminution in the overall number of covered lives, and other similar factors that may affect the coverage available to individuals and small employers. Specifically, the commission shall evaluate markets and make recommendations on the following:

(1) The performance and effectiveness of the small group market in itself and in conjunction with other markets that may be available to small employers and their employees, including, if applicable, pathway II association coverage. This shall include consideration of coverage for pre-existing conditions and essential health benefits, premium rates and product offerings, impact on premiums, the availability and choice of plans, the number of covered lives, and the overall impact on the availability and affordability of coverage for higher risk individuals and small employer groups. Based on this evaluation, the commission shall make recommendations in its annual report for future program or legislative modifications, including, if applicable, modifications to the risk adjustment program authorized under RSA 420-K, as well as a final recommendation as to whether the general court should allow the continuation or should phase out the market for pathway II association coverage.

(2) The performance and effectiveness of the individual market in itself and in conjunction with other markets that may be available to individuals and sole proprietors, including, if applicable, pathway II association coverage. This shall include consideration of the migration of sole proprietors to the pathway II market and the effectiveness of screening procedures in validating sole proprietorship status, the price and availability of coverage for individuals who do not qualify for an advanced premium tax credit or cost sharing reduction assistance through the marketplace exchange, and the design and effectiveness of the risk sharing mechanism and 1332 waiver for the individual market authorized under RSA 420-N:6-a. Based on this evaluation, the commission shall make recommendations concerning the individual market risk sharing mechanism under the 1332 waiver, any changes that are needed to screening and monitoring procedures for compliance with the hourly work standard to qualify as a sole proprietor under pathway II association coverage, and any other legislative or regulatory measures that would promote market stability and growth in the individual market.

(b) The commission shall not make any recommendation that includes the use of new general funds.

(c) The commission shall solicit information from any person or entity the commission deems relevant to its study.

III. The insurance commissioner shall provide information and reports to the commission on a biannual basis concerning the status of the individual, small employer and, if applicable, pathway II association markets as necessary to allow the commission to carry out its duties. The commission shall have the authority, at any time, upon a finding that pathway II association coverage is having an adverse impact on the availability and choice of coverage in the individual or small employer markets or is causing average premiums for individuals or small groups to increase at a rate that is significantly higher than the trend in claims costs, to recommend that the commissioner limit pathway II associations to the writing of existing business only or adjust the risk score differential amount in RSA 420-K:4, I(d), and the commissioner shall have authority to implement this recommendation by order pursuant to RSA 400-A:14 and this paragraph.

IV. The members of the commission shall elect a chairperson from among the members. The first meeting of the commission shall be called by the first-named senate member. The first meeting of the commission shall be held within 45 days of the effective date of this section. Four of the 6 voting members of the commission shall constitute a quorum.

V. The commission shall submit an annual report on or before November 1 of each year with its findings and any recommendations for proposed legislation, and a final report on December 1, 2024 to the president of the senate, the speaker of the house of representatives, the senate clerk, the house clerk, the governor, and the state library. If applicable, the commission's reports shall contain the commission’s recommendation regarding whether the market for pathway II association coverage should continue or be phased out.

24 Individual Health Insurance; Market; Contingency. RSA 404-G:12, I and II are repealed and reenacted to read as follows:

I. Notwithstanding RSA 404-G:11, and if supported by the recommendations of actuarial experts retained by the department, the commissioner may request that the board of directors of the association develop a plan of operation to support the affordability and accessibility of health insurance in the state's individual health insurance market. The proposal may include resumption of a risk sharing program similar to that referenced in RSA 404-G:5, creation and operation of a reinsurance program, or such other program as the board finds will best support the availability and affordability of health insurance in the state and may also include the development of a waiver application under the Act. The commissioner shall approve the revised plan of operations if the commissioner finds that the plan will further the purpose of this chapter as stated in RSA 404-G:1, I, and is otherwise consistent with New Hampshire and federal law.

II. The board’s proposal may include a recommendation that the state apply for a waiver under the Act, or any successor to the Act. If the approved plan includes an application for a waiver, the commissioner and the board shall proceed in accordance with RSA 420-N:6-a. If the waiver is approved by the federal government, the board shall prepare a revised plan of operations consistent with the terms of the waiver, and shall implement it upon approval by the commissioner.

25 Federal Health Care Reform 2010; Waiver. RSA 420-N:6-a is repealed and reenacted to read as follows:

420-N:6-a Waiver. If such action is supported by the recommendations of actuarial experts retained by the department as being consistent with the purposes of RSA 404-G:1, I, the commissioner shall, at the earliest practicable date, submit an application on behalf of the state to the United States Secretary of the Treasury, and if required, to the United States Secretary of Health and Human Services, to waive certain provisions of the Act, as provided in section 1332 of the Act, or any other applicable waiver provision in order to create a risk sharing or reinsurance mechanism for the individual market under RSA 404-G which is eligible to draw down federal pass-through funding to support such mechanism. The commissioner shall publish and accept public comment on the 1332 waiver application and the plan of operation for the individual market mechanism prior to approving such plans. Upon approval of the joint health care reform oversight committee, the commissioner shall implement any federally approved waiver, including but not limited to overseeing the implementation of a revised plan of operations under RSA 404-G:12.

26 Repeal. The following are repealed:

I. RSA 404-J, relative to the commission on the status of health insurance markets for individuals and small employers.

II. 2017, 221:8, relative to the 2020 repeal of RSA 404-G:12.

III. 2017, 221:11, relative to the 2020 repeal of RSA 420-N:6-a.

27 Applicability. Sections 3-23 of this act shall take effect 60 days after the insurance commissioner, with the advice of the department of justice, certifies to the secretary of state and the director of legislative services that the federal rule codified at 29 C.F.R. section 2510.3-5(b) is legally valid and the issues raised by the opinion issued on March 28, 2019 in *State of New York v. United States Department of Labor*, United States District Court of the District of Columbia, Civil Action No. 18-1747 have been resolved. However, in no event shall sections 3-23 of this act take effect at a date later than December 1, 2021.

28 Effective Date.

I. Sections 3-23 of this act shall take effect as provided in section 27 of this act.

II. Paragraph I of section 26 of this act shall take effect December 1, 2024.

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

LBAO
19-1100
Amended 4/3/19

SB 228-FN- FISCAL NOTE

AS AMENDED BY THE SENATE (AMENDMENT #2019-0841s and #2019-1055s)

AN ACT relative to multiple-employer welfare arrangements.

FISCAL IMPACT: [X] State [X] County [X] Local [ ] None

	Estimated Increase / (Decrease)			
STATE:	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**
Appropriation	$0	$0	$0	$0
Revenue	$0	$0	$0	$0
Expenditures	Indeterminable	Indeterminable	Indeterminable	Indeterminable
Funding Source:	[X] General [ ] Education [X] Highway [X] Other - Various Government Funds			

COUNTY:

Revenue	$0	$0	$0	$0
Expenditures	Indeterminable	Indeterminable	Indeterminable	Indeterminable

LOCAL:

Revenue	$0	$0	$0	$0
Expenditures	Indeterminable	Indeterminable	Indeterminable	Indeterminable

METHODOLOGY:

This bill makes changes to multi-employer welfare arrangements.

The Insurance Department states this bill establishes parameters for association health plans pursuant to recent federal regulations. The Department assumes the intent is to provide more insurance purchasing alternatives for employers and self-employed individuals. To the extent rules for the associations differ from the rest of the marketplace, there could be anti selection, where lower risk customers leave current insurance plans for lower cost insurance. This may impact how other markets price their product. The Department assumes the new plans would be subject to the insurance premium tax. The Department indicates the bill would not impact its operating budget. The Department indicates the bill requires the Department to pursue a section 1332 waiver of the Patient Protection and Affordable Care Act. The Department estimates this work will require the work of a consultant at approximately $350,000. In addition, the Department has begun the process of issuing a request for proposals to retain a consultant to model the impact of this type of legislation on markets and premiums.

AGENCIES CONTACTED:

Insurance Department