HB 353-FN - AS INTRODUCED

2023 SESSION

23-0032
10/05

HOUSE BILL ***353-FN***

AN ACT establishing an interstate compact for universal healthcare.

SPONSORS: Rep. Schmidt, Straf. 14

COMMITTEE: Commerce and Consumer Affairs

ANALYSIS

This bill establishes an interstate compact for universal healthcare to provide payment for providing healthcare for the citizens of New Hampshire and other member states after the date of implementation.

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Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

23-0032
10/05

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Twenty Three

AN ACT establishing an interstate compact for universal healthcare.

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

1 Statement of Purpose. It is the purpose of this act to create a New Hampshire health insurance program as part of an interstate compact for all residents of New Hampshire as well as other participating states. The compact will provide the economies of scale necessary to achieve the savings and quality. If legislation of this kind is enacted on a federal level, it is the intent of this act for the interstate compact to become part of a nationwide system guaranteeing quality health insurance for all Americans.

2 New Chapter; Interstate Compact for Universal Healthcare. Amend RSA by inserting after chapter 404-J the following new chapter:

CHAPTER 404-K

INTERSTATE COMPACT FOR UNIVERSAL HEALTHCARE

404-K:1 This chapter may be cited as the New Hampshire interstate compact for universal healthcare.

404-K:2 Program Established. There is hereby adopted the New Hampshire interstate compact for universal healthcare. The program established by this compact shall provide universal access to health care for all individuals residing in New Hampshire. The program in this chapter shall be implemented by the board and made applicable to New Hampshire and other member states according to the provisions of RSA 404-K:17.

404-K:3 Definitions. In this chapter:

I. "Board" means the single governing board established by this chapter for the administration of the health insurance program in all states of the compact, including New Hampshire.

II. "Program" means the interstate compact for universal healthcare program established pursuant to the chapter. It shall be inclusive of all licensed healthcare practitioners and other clinicians in the current system of employment or service, and institutions providing care, who all are voluntary participants in the program in New Hampshire and in the other member states of the compact, or those outside New Hampshire and the member states of the compact that have had the privilege of inclusion extended to them by the relevant authorities of the compact.

III. "Trust" means the trust established by pooling the resources of New Hampshire with the other member states jointly responsible for funding the program. The trust shall manage all payments for services provided to beneficiaries and the program. This trust may also be referred to also as the Compact Trust Fund (CTF).

IV. "Beneficiary" means any individual qualified and accordingly registered to receive health insurance benefits provided by the program.

V. "Independent" physicians or other clinicians means those not working for a larger hospital, clinic, or other network which pays them a salary or other fee schedule. The board or its designated officers shall be at liberty to define this term more precisely for the purposes of their work.

404-K:4 Eligibility.

I. All individuals legally residing in New Hampshire or in one of the other member states shall be eligible to receive approved benefits and have payments made to the practitioner and to the facility providing the care on their behalf. These services must be provided at no cost to the beneficiary at the point of service to be eligible for reimbursement by the trust. All eligible individuals shall be enrolled via a process designed and implemented by the board or its designated officers. Each beneficiary shall be issued a Compact Health Insurance Card with a unique identifying number and any other relevant information the board or its designated officers deem necessary.

II. Unenrolled persons in an emergency situation shall be presumed enrolled by all relevant providers of healthcare and assistance, shall receive the care they need, and shall have the application process initiated at the time of service or as soon as possible thereafter. If an individual is found not to be eligible to be enrolled as a beneficiary after the provision of service in an emergency, they shall be billed personally at the same rate the program would pay for the provided services only after all other possible reimbursement options, such as a health insurance policy from outside the compact or from the federal government, have been exhausted. In the case of payment by more than one payer, the total amount billed to all payers involved shall not exceed the rate paid for the same services by the program.

404-K:5 Benefits and Portability.

I. The healthcare benefits coverage under this chapter shall be available through any participating licensed healthcare practitioner or facility in the state of New Hampshire or within the compact states and for emergency outpatient or inpatient care anywhere in the United States.

II. No deductible, copays, coinsurance, or other cost-sharing payments shall be imposed, as coverage for all medically necessary services and goods are provided under the chapter. Any service provided with a cost-sharing payment imposed as a condition of service inside or outside the compact member states shall be ineligible for further reimbursement from the program. The beneficiary forced to make such a payment shall be reimbursed for the amount of that payment, and if the board or its designated officers find the payment excessive compared to the rates the program pays for similar services within the compact, may seek a refund for some or all of said payment via appropriate means. The insurance card provided to beneficiaries shall clearly state the above ban on cost-sharing on it, as shall any other communications the board or its designated officers deem

necessary. Medically appropriate care shall not be denied coverage under the provisions of this compact. If any participating practitioner or entity providing care refuses to comply with appropriate refund requests or requires cost-sharing for services provided, the board or its designated officers may choose to impose appropriate consequences, such as withholding of future payments, exclusion from future contracts, or fines.

III. Covered services shall include, but shall not be necessarily limited to:

(a) Primary care and preventive services.

(b) Specialty care other than elective cosmetic care.

(c) Inpatient care.

(d) Outpatient clinic- or office-based care, and care at community health centers.

(e) Emergency care.

(f) Long-term car, including homecare, community-based care and traditional nursing - home care.

(g) Prescription drugs; generics whenever possible and appropriate; brand-name drugs shall be covered only if clinically warranted.

(h) Durable medical equipment and medical devices for appropriate clinical needs.

(i) Mental health services and substance use disorder management.

(j) Full-scope dental care other than elective cosmetic dentistry.

(k) Basic vision care and vision-corrective devices.

(l) Hearing care including basic devices.

(m) Chiropractic, podiatric, and optometric care if appropriate.

(n) A well-funded public health service at the local and state levels, which shall be coordinated with appropriate federal public health authorities when relevant.

(o) Rehabilitative services; institutional, outpatient and home-centered as judged appropriate.

(p) Free-standing dialysis centers, catheterization laboratories, imaging centers, same-day surgical centers, walk-in clinics, urgent care centers, and other related entities as determined by the board or its designated officers as providing care will be required to meet non-profit ownership criteria and guidelines set by the board including a time frame allowed for transitioning away from a 'for profit' status.

404-K:6 Qualification of Participating Practitioners or Facilities.

I. Facilities shall meet federal and state quality and licensing guidelines, including those for safe staffing ratios and care quality. Facilities shall also meet quality and licensing guidelines the board or its designated officers may from time to time deem necessary to create.

II. Participating practitioners must hold a valid state license and hold privileges commensurate with their training and credentials in the discipline or department of each hospital or facility in which they practice.

III. Patients shall have free choice of practitioners and of facility within the compact. Care not available within the state or within the compact may be approved for coverage by the board based on appropriate clinical criteria.

404-K:7 Reimbursement.

I. Physicians and other healthcare practitioners can choose to be paid by the program on a fee-for-service schedule or at a salary from the institutions or group practices in which they work. Under a fee-for-service payment system, the trust shall pay for all covered services in accordance with a fee schedule negotiated between appropriate representatives of physician groups such as state medical societies and specialty organizations such as the American Academy of Family Practice and the American College of Physicians, among others. This fee schedule shall be reviewed and updated on a biannual basis with and by the parties. The board shall have discretion to determine the appropriate negotiating partners for establishing, reviewing, and updating this fee schedule.

II. The program will reimburse independent physicians and other independent practitioners on an equal footing as those who do not fall under that category. Independent clinicians may choose a global budget, capitation model based on risk-stratified covered lives, or a fee-for-service model.

III. The program shall pay each hospital and other healthcare facilities including but not limited to nursing homes, rehab centers, community health centers, home health agencies, and other qualifying institutional care providers via a global operating budget. A global operating budget shall be paid by the trust monthly or as a lump sum annually. The institutions and designated officers of the board will negotiate the budget allocation amount based on past budgetary expenses (adjusted for inflation as appropriate), clinical performance (using scientifically sound metrics), and projected expenses for new services in increasing public demand that are demonstrated on sound medical grounds.

(a) The board shall generate a standard procedure for determining global operating budgets to streamline this process, which it shall regularly review and adjust as appropriate. Hospitals and other participating facilities may not use the operating budget funds for marketing, profit, excessive executive compensation (as defined by the board or its designated officers), or major capital expenditures.

(b) A separate capital budget allocation for expansion or renovation of physical infrastructure, construction of new facilities, launching of new clinical services and for purchase of major durable medical equipment shall be negotiated separately from the operating global budget.

(c) Prescription drugs, devices, and durable medical equipment and supplies shall be paid for according to a price schedule negotiated between the board by its designated officers and the manufacturers, vendors, and suppliers on an appropriate basis. The formulary shall use cost-effective medications where therapeutic equivalency exists except in specific instances of medical necessity.

404-K:8 Prohibition of Duplicate Coverage.

I. The sale of duplicate health insurance for services covered under the program, in New Hampshire and in the other compact member states, shall be unlawful unless such a policy is exempted from state regulation by the federal Employee Retirement Income Security Act (ERISA). Sale of additional or supplemental policies offering benefits not covered by the program is permitted under this chapter. Policies shall be assumed not exempt under ERISA unless the board has designated them so.

404-K:9 Interstate Compact Trust Fund.

I. There is hereby established an interstate compact trust fund, hereinafter referred to as the compact trust fund (CTF). It shall be accounted for distinctly and separately from all other funds and shall be non-interest bearing. The CTF shall be administered by the board established under this chapter and its designated officers and shall be purposed solely to pay and reimburse for approved services provided to eligible beneficiaries, with the funds sent directly to participating practitioners and facilities under the program. All monies in the CTF shall be non-lapsing and continually appropriated to the board for meeting the trust's obligations. The CTF shall be authorized to pay and reimburse for the following:

(a) The funds for the general global operating budgets of participating institutions.

(b) Reimbursement and payment for services by practitioners included in the benefits package of enrollees.

(c) The expenditures of capital budget funds of qualifying entities receiving global operating budgets, such as construction or renovation of healthcare facilities or major medical equipment purchases or for launching new clinical services. These expenditures shall be based on proven medical needs of the service area, as requested by the participating institutions and approved by the board or its designated officers.

(d) Public health services in both departmental and clinician practice settings.

(e) Re-education/retraining and job placement services for current employees in the healthcare system who lost their jobs as a result of the transition caused by this chapter, limited to the first 5 years after the start of the program.

II. The general court shall provide funds on a biennial basis to the CTF proportionate to the CTF's projected expenses relative to New Hampshire's population compared to the total of the compact states' population. This amount shall be set by the board, and the state may fulfill its biennial funding obligations how it sees fit. The general court shall not remove or borrow funds from the CTF nor attempt to negotiate during state budget cycles to underfund the program. Should the general court fail to fully fund its obligations as established by the board, the board shall be authorized to issue bonds on the state's behalf to make up for the shortfall. These bonds shall be labeled as a unique class and be distinct from all other state-issued bonds to reflect their special purpose. The funds obtained from the sale of these bonds shall go solely to the CTF and may not be

spent, transferred, or otherwise used by any entity other than the CTF for the purpose of meeting the CTF's above listed obligations to pay and reimburse.

III. Funding for CTF that the state shall furnish to meet its obligations as determined by the board shall include but not be limited to, all of the following:

(a) Funds appropriated for healthcare as outlined in the state's operating and capital budgets.

(b) All federal funds that are designated for, but not limited to, Medicaid, that the state may immediately transfer to the CTF. The CTF and board shall be authorized to negotiate with the federal government on New Hampshire's behalf for allowing funds from programs including but not limited to Medicare and the Children's Health Insurance Program, to be pooled into the CTF via a relevant waiver process (such as state innovation waivers under section 1332 of the Affordable Care Act) from Congress and/or the federal executive branch. Federal funds obtained by the program on behalf of a state's residents shall count towards that member state's required contribution to the CTF. The board shall make all efforts to utilize as much available federal funds as possible to minimize the amount of funds the participating states must contribute from other revenue sources.

(c) Public and private grants and contributions.

(d) Any other funds earmarked for healthcare or for healthcare education, such as from litigation settlements.

(e) The CTF shall be authorized to negotiate with the relevant authorities the merger of the healthcare funds for employees of corporations and their retirees domiciled in the compact states.

IV. The total overhead and administrative expenses of the program shall not exceed 10 percent for the first 2 years after initial implementation and 8 percent for the next 2 and 6 percent for the subsequent 2 years and under 4 percent thereafter annually, and not exceeding the contemporaneous Medicare overhead. If overhead and administrative expenses exceed these benchmarks, a committee of legislators from each participant state shall negotiate a legally binding plan to bring these expenses into compliance with these requirements. This committee shall be made up of one legislator per state or 3 total legislators, whichever is greater. These legislators shall be chosen by a majority vote of their state's legislature.

V. The program shall establish and maintain state districts for purposes of local governance and oversight of program needs specific to each participant state. The board shall have the authority to create more than one such districts in a given state if it sees fit.

404-K:10 Specific Areas of Priority.

I. Long-term care services. The program shall fund long-term care services including nursing homes, in-home care, and community-based care and adequately reimburse trained eldercare professionals. The program shall establish in each community a mechanism to determine eligibility and for coordination of home and facility-based care and for contracting with practitioners

of long-term care medicine, such as geriatricians, and with facilities offering the full range necessary care.

II. Mental health services. The program shall cover all medically necessary mental health services on the same basis as for other medical conditions, including supportive residencies, occupational therapy, and ongoing mental health and counseling services in both inpatient and outpatient settings. In all cases effective and high-quality care shall made be available to patients in need, including for alcohol and other substance use disorders.

III. Telemedicine. The board shall establish policies related to the reimbursement and regulation of care delivered via phone or Internet that encourage the most efficient usage of healthcare resources and funds allocated for healthcare with the goal of maximizing quality of care provided while minimizing the cost of that care to taxpayers.

404-K:11 Governing Board.

I. There is hereby established an interstate compact for universal healthcare governing board composed of members from each participant state, with the number determined according to the following formula:

(a) If there are 5 or fewer states in the compact: 2 members per state, with state members serving staggered 4-year terms that expire on dates that coincide with the terms of the members of the United States Congress.

(b) If there are more than 5 states in the compact: one member per state, serving a 4-year term that expires on dates that coincide with the terms of members of the United States Congress.

II. The board members shall either be elected by the voters of the state they represent or appointed by the legislature of each state, according to the preferences of each state in the compact.

III. The board members shall elect a chairperson from among their members, who shall serve at the pleasure of the rest of the board. Board members may be recalled by the voters of the state which they represent if such a procedure exists for other elected officeholders, and the recall shall occur according to such existing procedures. The board members shall each have one vote. In the case of a tie, the side whose members represent a larger proportion of the member states' population shall prevail. The board members shall be reimbursed by the CTF for reasonable expenses incurred in carrying out their established duties.

IV. The board shall administer the program by:

(a) Implementing beneficiary eligibility standards and enrollment.

(b) Adopting the benefits package, and regularly reviewing it, and implementing changes based on best evidence from clinical science.

(c) Establishing formulae for setting healthcare expenditure budgets.

(d) Approving and administering global budgets, separate capital expenditure budgets, and prompt reimbursement to practitioners and facilities participating in the program.

(e) Designating a team or teams of officers to negotiate fee structure for practitioners and for negotiating compact-wide prices with healthcare providers and suppliers of pharmaceuticals, durable medical equipment and devices, and medical supplies. The program shall negotiate on behalf of all the compact's beneficiaries, and the prices it negotiates shall not be exceeded in any sale that occurs inside the compact's territory. The negotiations for pharmaceuticals and medical devices and equipment shall revolve around a formulary based on evidence-based medical science and relevant cost criteria, and shall conform to the following:

(1) Negotiations and contracts shall be run on an open-bid state-wide or compact-wide competitive basis. Negotiated prices are to be reviewed annually and renegotiated when appropriate. An open forum of designated officers for hearing petitions and grievances from suppliers, manufacturers, providers, and the public shall be established under the board. The committee, reporting to the board shall meet quarterly or immediately when called by the chair of the board.

(2) Non-formulary drugs and devices and durable medical equipment not on the approved list may be made available to beneficiaries on a case-by-case basis, informed by science-based clinical evidence.

(f) Establishing a quality assurance committee of designated officers with appropriate medical and scientific qualifications for setting system-wide standards of comprehensive quality and for monitoring ongoing compliance thereto.

(g) Establishing a planning committee for capital expansion, infrastructure development, measurement of healthcare quality indicators, and for managing the future operation of long-term care.

404-K:12 Combating Fraud, Waste, and Abuse.

I. An inspection and monitoring office (IMO) to combat fraud, waste, and abuse is established independent of the board. The office shall serve to hold the program, board, CTF, and participant healthcare providers accountable to the interests of beneficiaries via investigations, enforcement, and lawsuits. The executive of the IMO shall be elected by the voters of all compact states with terms coinciding with those of the President of the United States.

II. The IMO shall be funded from money from the CTF. The board shall set the amount provided on a biennial basis. The board may appropriate additional funds more often than a biennial basis, but may not cut the office's budget without approval from at least half of the governors of the member states.

III. The IMO shall establish deputies in each member state to carry out the office's work and priorities on a more local level.

404-K:13 Medical Liability and Patients' Rights.

I. The program shall protect the privacy and rights of patients that it serves in accordance with all current state and federal statutes. Patients shall have the right to access their medical records on demand.

II. The board shall initiate steps to encourage member states to transition to a no-fault medical liability system and away from the current tort-based approach to medical-legal liability. As the cost of care are to be borne publicly under this compact and not by patients, monetary awards by jury for damages are expected to significantly decline. The board shall encourage other ways to ensure accountability in the case of malfeasance.

404-K:14 Implementation; Delayed Implementation.

I. The board shall be authorized to delay full implementation of the health insurance program, including setting and enforcing full funding requirements for the member states, until the number of projected beneficiaries is sufficient to achieve savings when compared to the pre-compact health system. The board shall accordingly delay full implementation until the number of expected beneficiaries is over 5,000,000 in the member states, but may choose to further delay until expected beneficiaries reach 10,000,000. The board shall take into consideration the acquisition of federal waivers that would allow the pooling of federal funds that would reduce member state funding obligations in the CTF when making decisions of whether to further delay implementation beyond the point of 5,000,000 expected beneficiaries.

II. The board shall speedily integrate into the compact any states that pass appropriate legislation to join as it sees appropriate, and this provision shall be construed as New Hampshire's consent to such additions to the compact.

3 New Subparagraph; New Hampshire Interstate Compact Trust Fund. Amend RSA 6:12, I(b) by inserting after subparagraph (386) the following new subparagraph:

(387) Moneys deposited in the New Hampshire interstate compact trust fund established under RSA 404-K:9.

4 Appropriation; Interstate Compact for Universal Healthcare Program. There is hereby appropriated to the interstate compact for universal healthcare governing board, established in RSA 404-K:11 as inserted by section 2 of this act, the sum of $1 for the biennium ending June 30, 2025. Such funds shall be in addition to any other funds appropriated to the board. The governor is authorized to draw a warrant for said sum out of any money in the treasury not otherwise appropriated.

5 Effective Date. This act shall take effect 60 days after its passage.

LBA
23-0032
12/30/22

HB 353-FN- FISCAL NOTE
AS INTRODUCED

AN ACT establishing an interstate compact for universal healthcare.

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

	Estimated Increase / (Decrease)			
STATE:	**FY 2023**	**FY 2024**	**FY 2025**	**FY 2026**
Appropriation	$0	$1	$0	$0
Revenue	$0	Indeterminable	Indeterminable	Indeterminable
Expenditures	$0	Indeterminable	Indeterminable	Indeterminable
Funding Source:	[X] General [ ] Education [X] Highway [X] Other - Various Government Funds and Federal Funds			

COUNTY:

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

LOCAL:

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

METHODOLOGY:

This bill establishes an interstate compact for universal healthcare to provide payment for providing healthcare for the citizens of New Hampshire and other member states after the date of implementation.

The Department of Administrative Services indicates the fiscal impact to the State Health Benefit Plan for Employees and Retirees (the Plan) is indeterminable. The Plan is regulated by multiple State statutes, including RSA 21-I:30, and collective bargaining agreements. It covers employees and retirees who reside in NH and other states surrounding NH and throughout the country. Nothing in the bill appears to repeal the Plan and there is nothing that prevents Plan participants from opting out of the Plan and choosing the Compact. Although the Department is not able to determine the number of participants that may opt out, it is presumed that the State's procurement and contracting leverage could be diminished. If the population covered by the Plan decreased, the result would be an increase in costs to the Plan and the State.

The Department of Health and Human Services states it is unclear whether the federal Centers for Medicare & Medicaid Services would continue to approve federal financial participation for

New Hampshire's Medicaid state plan and waiver services if the proposed interstate compact for a universal healthcare program is established. The Department cannot determine general fund expenditures unless there's an indication of how the federal government would adjudicate such a request. The Department is not aware of any other instance where this structure exists. In addition, the Department indicates different States have different levels of eligibility and coverage under Medicaid so another unknown factor would be how eligibility, services, and coverages would be standardized among the compact participants. All of these factors influence the cost. Therefore, the Department anticipates an indeterminable impact to state revenues and expenditures as a result of this bill beginning FY 2024.

The Insurance Department states, while the full extent of this bill's impact on private insurance is unclear, it is likely that there would be a substantial reduction in general fund premium tax revenue, given the bill's prohibition (proposed RSA 404-K:8) on the sale of duplicate health insurance for services covered under the program. At this time, the Department assumes there would be no changes to its operating budget attributable to the bill; however, it is likely that there would be increased costs associated with filing an innovation waiver application under proposed section 404-K:14.

This bill makes a general fund appropriation of $1 to the interstate compact for universal healthcare governing board for the biennium ending June 30, 2025.

It is assumed that any fiscal impact will occur after FY 2023.

AGENCIES CONTACTED:

Departments of Administrative Services, Health and Human Services and Insurance