May 7, 2001
No. 22

STATE OF NEW HAMPSHIRE

Legislative

SENATE CALENDAR

REPORTS, HEARINGS, MEETINGS & NOTICES

THE SENATE WILL MEET IN SESSION ON WEDNESDAY, MAY 9, 2001 AT 1:00 P.M.

LAID ON THE TABLE

SB 29, relative to amending warrant articles by political subdivisions that have adopted the official ballot referendum form of meeting.

SB 30, establishing a committee to study the DNA database of sexual offenders.

SB 31, eliminating straight ticket voting.

SB 32, exempting dumbwaiters from the elevator law.

SB 52, relative to liquor liability insurance coverage.

SB 60, relative to the authority of the board of tax and land appeals to assess attorney's fees.

SB 90, relative to misdemeanor jury trials.

SB 95, relative to campaign contribution limits and independent expenditures.

SB 96-FN, repealing the requirements for resident and nonresident licenses to carry concealed weapons.

SB 97-FN, requiring the annual registration of manufactured housing parks.

SB 112, relative to voter registration forms.

SB 116-FN, relative to motor vehicle offenses which result in the death or serious bodily injury of another.

SB 122-FN, relative to the license to carry a weapon.

SB 126, relative to the use of certain credit data in underwriting certain insurance policies.

SB 180-FN-A, establishing the Hooksett district court as a full-time court and making an appropriation therefor.

SB 185, relative to push-polling.

CACR 16, relating to procedure for nomination and review of judges. Providing that judges shall be nominated and selected by an independent commission and reviewed every 8 years thereafter.

HB 101, (New Title) requiring registered lobbyists to sign a statement concerning false statements or misrepresentation of material facts.

HB 126-FN, relative to the board of pharmacy and the regulation of pharmacists.

HB 130, relative to the maintenance of boundaries and fences.

HB 141, relative to regulation of junk yards.

HB 211, establishing a restricted probationary permit to drive and correcting the ignition interlock program laws.

REPORTS

EDUCATION

SB 160-FN-A-L, establishing a comprehensive, statewide educational accountability system, including the provision of education improvement assistance to local school districts, and making an appropriation therefor. Vote 4-0

Inexpedient to Legislate, Senator McCarley for the committee.

SB 164-FN-A-L, establishing a comprehensive statewide accountability system concerning an adequate education. Vote 4-0

Ought to pass with amendment, Senator O'Hearn for the committee.

ENVIRONMENT

SB 189-FN-A, establishing a gasoline remediation and elimination of ethers fund. Vote 4-0

Ought to pass with amendment, Senator Cohen for the committee.

HB 166, establishing a committee to study gas and hazardous substance pipeline safety. Vote 4-0

Ought to pass with amendment, Senator Johnson for the committee.

HB 274-FN, banning the residential open burning of trash and relative to a dioxin emissions reduction and control program. Vote 3-0

Ought to pass with amendment, Senator Eaton for the committee.

EXECUTIVE DEPARTMENTS & ADMINISTRATION

SB 48, relative to the rental of shared living facilities. Vote 3-0

Ought to pass with amendment, Senator Prescott for the committee.

SB 77, relative to the regulation of plumbers and plumbing. Vote 3-0

Ought to Pass, Senator D'Allesandro for the committee.

SB 79, relative to plumber's licenses. Vote 4-0

Re-referred, Senator Francoeur for the committee.

SB 171-FN, relative to the negotiation of cost items within the public employee collective bargaining process and relative to computation of leave for state police employees injured in the line of duty. Vote 3-1

Inexpedient to Legislate, Senator Flanders for the committee.

SB 179-FN, relative to procedures for bid listing for state construction contracts. Vote 3-1

Inexpedient to Legislate, Senator Prescott for the committee.

SB 181, relative to the manufacture, sale, or installation of certain smoke detectors.

MINORITY REPORT: Inexpedient to Legislate, Senator Prescott for the committee. Vote 1-2

MAJORITY REPORT: Ought to Pass, Senator Flanders for the committee. Vote 2-1

SB 182-FN-A, establishing a brain and spinal cord injury trust fund and continually appropriating a special fund. Vote 4-0

Ought to pass with amendment, Senator Prescott for the committee.

SB 186-FN, relative to the powers of and classification for criminal justice and consumer protection investigators of the department of justice. Vote 3-1

Ought to Pass, Senator D'Allesandro for the committee.

SB 187-FN, requiring the state to pay for an independent appraiser in eminent domain proceedings.

SPLIT REPORT: Ought to Pass, Senator D'Allesandro for the committee. Vote 2-2

SPLIT REPORT: Inexpedient to Legislate, Senator Francoeur for the committee. Vote 2-2

SB 192-FN, relative to the issuance of high/medium voltage licenses by the electricians' board. Vote 3-0

Ought to Pass, Senator D'Allesandro for the committee.

FINANCE

SB 67-FN, relative to costs of locating and apprehending persons improperly at large for driving-related offenses. Vote 5-0

Ought to Pass, Senator Eaton for the committee.

SB 69-FN-A-L, relative to a New Hampshire legal assistance office in Nashua and making an appropriation therefor. Vote 4-2

Ought to Pass, Senator Below for the committee.

SB 76-FN, (New Title) requiring attendance in an education and training program by those who obtain a liquor license and relative to applications for one-day liquor licenses. Vote 6-0

Ought to Pass, Senator Boyce for the committee.

SB 110-FN-A, extending the kindergarten construction program. Vote 5-0

Ought to pass with amendment, Senator Barnes for the committee.

SB 114, (New Title) establishing a committee to study issues relating to judicial reform, and making an appropriation therefor. Vote 5-0

Ought to pass with amendment, Senator Barnes for the committee.

SB 142-FN, relative to the collection of debts owed to the state. Vote 5-0

Ought to Pass, Senator Gatsas for the committee.

SB 149-FN, (New Title) permitting persons involved in motor vehicle accidents and certain medical researchers access to motor vehicle records. Vote 6-0

Ought to Pass, Senator Boyce for the committee.

SB 163-FN, relative to salaries for New Hampshire state police. Vote 5-1

Re-referred, Senator Eaton for the committee.

SB 170-FN-L, making certain changes to the excavation tax and excavation activity tax. Vote 5-0

Ought to Pass, Senator Hollingworth for the committee.

SB 176-FN-A, establishing an equipment depository and disabled person's employment fund in the department of administrative services. Vote 5-0

Ought to Pass, Senator Below for the committee.

SB 188-FN-L, relative to abatements and appeals of betterment assessments. Vote 5-0

Ought to Pass, Senator Below for the committee.

HB 189-FN, increasing the facility funding limits under the oil discharge and disposal cleanup fund. Vote 5-0

Ought to Pass, Senator Gatsas for the committee.

INTERNAL AFFAIRS

SB 139, relative to uniform electronic transactions. Vote 3-0

Ought to pass with amendment, Senator Flanders for the committee.

SB 174-FN-A, including Martin Luther King, Jr. Civil Rights Day as a holiday for which certain state employees are entitled to holiday pay. Vote 3-0

Ought to pass with amendment, Senator O'Neil for the committee.

SB 178, relative to uniform computer information transactions. Vote 3-0

Ought to pass with amendment, Senator Flanders for the committee.

INSURANCE

SB 39, establishing the positions of director of consumer affairs and market conduct chief administrator in the insurance department. Vote 5-0

Ought to pass with amendment, Senator Burns for the committee.

SB 109, implementing certain federal regulations relative to setting minimum requirements for employee benefit plan procedures pertaining to the filing of benefit claims, notification of benefit determinations, and appeal of adverse benefit determinations. Vote 5-0

Ought to pass with amendment, Senator Wheeler for the committee.

SB 118, relative to individual health insurance coverage.

MINORITY REPORT: Ought to pass with amendment, Senator Wheeler for the minority. Vote 2-3

MAJORITY REPORT: Ought to Pass, Senator Francoeur for the majority. Vote 3-2

SB 119, relative to small group health insurance coverage.

MINORITY REPORT: Ought to pass with amendment, Senator Wheeler for the minority. Vote 2-3

MAJORITY REPORT: Ought to Pass, Senator Francoeur for the majority. Vote 3-2

SB 127, relative to stress-related injuries under workers' compensation. Vote 5-0

Re-referred, Senator Francoeur for the committee.

SB 158-FN, relative to payment of medical benefits for certain retirement system members retiring with combined creditable service or for certain members who have dependent children. Vote 5-0

Ought to Pass, Senator Wheeler for the committee.

SB 159-FN, relative to benefit options for surviving spouses and designated beneficiaries of deceased members of the retirement system. Vote 5-0

Ought to Pass, Senator Wheeler for the committee.

SB 175-FN, relative to the position of assistant commissioner of the department of corrections. Vote 5-0

Ought to Pass, Senator Hollingworth for the committee.

SB 194-FN, relative to retirement allowances for certain surviving spouses of group II retirement system members. Vote 3-2

Ought to Pass, Senator Hollingworth for the committee.

JUDICIARY

HB 203, allowing a psychiatric/mental health nurse practitioner employed under contract with the department of corrections to be indemnified and defended by the state under the same conditions as psychiatrists. Vote 5-0

Ought to pass with amendment, Senator Roberge for the committee.

PUBLIC INSTITUTIONS, HEALTH & HUMAN SERVICES

SB 167-FN-A, relative to the medicaid payment for long-term care services. Vote 3-2

Ought to pass with amendment, Senator Boyce for the committee.

WAYS & MEANS

SB 172-FN, exempting rentals of motor vehicles by governmental entities and certain nonprofit organizations from the meals and rooms tax. Vote 4-1

Inexpedient to Legislate, Senator Barnes for the committee.

SB 173-FN-A, creating a business profits tax credit for certain donations made for science and technology equipment and facilities to the university system of New Hampshire or any of its component institutions. Vote 5-0

Re-referred, Senator Barnes for the committee.

HB 303-FN-A-L, relative to funding of training and certification of fire fighters and emergency medical service providers programs in the department of safety, extending certain motor vehicle license expiration dates, and increasing certain motor vehicle license fees. Vote 5-0

Ought to Pass, Senator D'Allesandro for the committee.

AMENDMENTS

Senate Education
May 3, 2001
2001-1113s
04/10

Amendment to SB 164-FN-A-LOCAL

Amend the bill by replacing all after the enacting clause with the following:

1 Statement of Purpose. The general court finds that in order to ensure a balance between education improvement and assessment and an adequate public education, it is necessary to establish a comprehensive, statewide educational accountability system that shall include:

I. Statewide performance goals for all pupils.

II. Statewide systematic measurement of school performance at the state and local levels using multiple valid measures.

III. Reporting on pupil performance at the school, school district, and state levels.

IV. The development, implementation, and evaluation, with broad input from community teams, of local education improvement and assessment plans designed to meet state goals and other criteria for making progress, and any performance goals developed locally to meet identified educational needs.

V. The opportunity for schools that are not making satisfactory progress toward statutory performance goals to receive assistance from the state.

2 New Chapter; School Performance and Accountability. Amend RSA by inserting after chapter 193-F the following new chapter:

CHAPTER 193-G

SCHOOL PERFORMANCE AND ACCOUNTABILITY

193-G:1 Definitions. In this chapter:

I. "Commissioner" means the commissioner of the department of education.

II. "Department" means the department of education.

III. "NHEIAP" means the New Hampshire education improvement and assessment program as established under RSA 193-C.

193-G:2 Statewide Performance Goals. A school shall make satisfactory progress as defined in this section, or shall meet or exceed each of the following performance goals:

I. Pupils shall, at a minimum, perform at grade level on the reading component of the statewide assessment administered in grade 3 pursuant to RSA 193-C:3, IV(i) at the following rates:

(a) 75 percent for school year 2002-2003.

(b) 77.5 percent for school year 2003-2004.

(c) 80 percent for school year 2004-2005.

(d) 85 percent for school year 2005-2006.

(e) 90 percent for school year 2006-2007.

(f) 92.5 percent for school year 2007-2008.

(g) 95 percent for school year 2008-2009, and each school year thereafter.

(h) The most recent 3-year rolling average shall be used to determine if a school is meeting this performance goal, except that a 2-year average shall be used for school year 2002-2003. If, starting in school year 2003-2004, a 3-year rolling average is not available for a particular school, either a 2-year average or, if a 2-year average is not available, a single year's data shall be used for this purpose.

(i) For pupils with disabilities who qualify for the alternate version of the statewide assessment, performance at the adequate level shall be based on the communication component of the alternate assessment.

(j) For pupils whose native language is other than English and whose English language reading ability prevents them from participating in the statewide assessment, school districts, in conjunction with the department, shall provide an alternate assessment of each pupil's reading ability the pupil's native language. The school district shall report pupil performance to the department of education for inclusion in school, district, and state third grade reading reports. If it is not feasible to administer the assessment in the pupil's native language, then the pupil may be excused from the assessment.

II. Pupils shall perform at the basic and above levels in the designated academic areas assessed on the statewide tests administered at the following grades in accordance with RSA 193-C at the following rates:

(a) 70 percent in English language arts in grade 3.

(b) 70 percent in mathematics in grade 3.
(c) 70 percent in English language arts in grade 6.
(d) 70 percent in mathematics in grade 6.
(e) 55 percent in science in grade 6.
(f) 65 percent in social studies in grade 6.
(g) 70 percent in English language in grade 10.
(h) 60 percent in mathematics in grade 10.
(i) 55 percent in science in grade 10.
(j) 50 percent in social studies in grade 10.

(k) The most recent 3-year rolling averages shall be used to determine if a school is meeting the academic-area statewide assessment performance goals that apply to it, except that if 3-year rolling averages are not available for a particular school, either 2-year averages or, if 2-year averages are not available, a single year's data shall be used for this purpose.

III. Pupils shall attend school at the following rates:
(a) 95 percent for elementary schools.
(b) 94 percent for middle schools and junior high schools.
(c) 92 percent for high schools.
(d) The appropriate grade-range attendance rate collected by the department at the district level shall be used as the school attendance rate in districts that have multiple schools at a particular grade range.

IV. The percentage of pupils who drop out of school annually shall not exceed the following rates:
(a) 0.5 percent for middle schools and junior high schools.
(b) 5 percent for high schools.
(c) The department shall calculate and report the annual dropout rate as a percentage based on the reported number of pupils who dropped out of school and did not return during a one year period as compared to the total school population.

V. The percentage of graduating pupils who go on to post-secondary education or military service shall be at least 66 percent.

VI. Each school shall comply with the applicable standards for school approval adopted by the state board pursuant to RSA 21-N:9, I.

VII. "Satisfactory progress" means that for each school, the most recent 3-year rolling average shall be an improvement over the prior year's 3-year rolling average, except that if a 3-year rolling average is unavailable for a particular school, either a 2-year average or, if a 2-year average is unavailable, 2 adjacent year's data shall be used for this purpose. The use of a 3-year rolling average shall not be required for the first 2 years in which satisfactory progress is being measured.

VIII. Not later than May 1, 2004, and annually thereafter, the commissioner shall determine if a school has demonstrated that it is making satisfactory progress toward, or has met or exceeded the performance goals established in this section. The criteria to be used to determine if a school is making satisfactory progress shall be established as follows:

(a) Not later than May 1, 2002, and every 3 years thereafter, based on generally accepted statistical procedures, the commissioner in conjunction with the state board of education shall determine and publish the criteria for making satisfactory progress in each of the areas established in paragraphs I-V. In making these determinations, consideration shall be given to the effect of school and grade-level enrollments and other relevant demographic data on the validity and comparability of the data collected and, to the extent feasible, the performance of discrete subgroups of pupils, including pupils with disabilities, limited English proficient pupils, vocational education pupils, and low income pupils.

(1) Satisfactory progress in meeting the reading performance goal established in paragraph I shall be based on the average of the mean-scaled scores obtained on the reading component of the grade 3 statewide assessment administered in accordance with RSA 193-C:3, IV(i). If a primary school does not include grade 3, then reading performance shall be based on

the performance of the pupils from that school who attend grade 3 in the elementary school attended by the majority of the pupils from said primary school.

(2) Satisfactory progress in meeting the NHEIAP performance goals established in paragraph II shall be based on the mean-scaled scores obtained in the academic areas assessed at each grade level. If a school does not include a grade assessed in NHEIAP, then NHEIAP performance shall be based on the performance of the pupils from that school who attend the next highest NHEIAP grade level assessed in the school attended by the majority of the pupils from the school that does not include a grade assessed in NHEIAP.

(3) Satisfactory progress in meeting the performance goals established in paragraphs III-V shall be based on the rolling 3-year averages of performance in these areas.

(b) A school shall be considered to be making satisfactory progress in meeting the school approval standards specified in paragraph VI, if it either has been conditionally approved or granted a delay in full compliance by the state board.

IX. Not later than May 1, 2004, and annually thereafter, the commissioner shall compile and disseminate to the governor and council, the general court, the state board, local school board chairpersons, superintendents of schools, school principals, and the public, a list of schools that are not making satisfactory progress in meeting the statewide performance goals set forth in RSA 193-G:1.

X. No later then January 1, 2005, and every 3 years thereafter, the state board shall submit to the education committees of the house and senate a report outlining the results of the state board's review of the performance goals established in paragraphs I-VI together with any recommendations to the general court for changes in these goals that have been adopted by a majority of the state board. In conducting its review, the state board shall consider the statistical validity and comparability of using additional performance data collected at the school and district levels.

193-G:3 Aid to Schools.

I. A school district that is unable to meet the goals of excellence in education in RSA 193-G:2 may request assistance from the department of education, including financial assistance from the local education improvement assistance program established in RSA 193-G:4, for any school within the district. If a school district that is unable to meet the goals of excellence in education in RSA 193-G:2 does not request assistance, the department of education may initiate such review as it deems appropriate and, on the basis of such review, offer its assistance to the school district, but the school district shall not be required to accept such assistance.

II. A school district may request up to 3 years of assistance. A detailed plan and budget shall be submitted to the department of education. The department may offer aid in developing the plan and budget.

III. The department of education shall evaluate and approve proposals based on their efficacy, as determined by a cost-benefit analysis, and the extent to which school district revenues are insufficient to implement the proposed activity without adverse educational consequences.

IV. Priority shall be given to lower-performing schools.

193-G:4 State Assistance to Local School Districts; Education Improvement Fund Established.

I. There is hereby established an education improvement fund in the department of education for the purpose of providing assistance to local school districts. This fund shall be non-lapsing and shall be administered by the department. Beginning July 1, 2001, and annually thereafter, 1/3 of one percent of the statewide cost of providing an adequate education as calculated in accordance with RSA 198:40, III shall be transferred from the education trust fund to the education improvement fund. In order to satisfy this obligation, the governor is authorized to draw a warrant from the education trust fund to satisfy the provisions of this paragraph.

II. The department is authorized to use the amounts transferred to the education improvement fund to provide instructional improvement assistance to local school districts,

administer the fund, and provide technical assistance to schools. These funds shall be used for no other purposes. For the biennium beginning July 1, 2001, appropriations from the fund shall be authorized at the class level by the legislative fiscal committee and the governor and council. For the biennium beginning July 1, 2003, and each biennium thereafter, appropriations from the fund at the class level shall be included in and authorized as part of the department's biennial operating budget.

3 New Subparagraphs; Statewide Education Improvement and Assessment Program; Program Goals Amended. Amend RSA 193-C:3, IV by inserting after subparagraph (h) the following new subparagraphs:

(i) At the end of grade 3, to determine if pupils are reading at grade level on a standardized reading test to be chosen by the department with the approval of the state board of education.

(j) At the school, district, and state levels, to provide performance reports on specific subgroups of pupils as required by federal law and regulations, including performance reports on pupils with disabilities, educationally disadvantaged pupils, and vocational education pupils.

4 Pupil Achievement Assessment Pilot Program Established.

I. The department of education, in consultation with the state board of education and the school administrative unit superintendents, shall establish a 4-year pupil achievement assessment pilot program in 10 selected school districts in the state for the school years 2001-2002 through 2004-2005. Participation in the pilot program shall be voluntary. The pilot program shall examine the use of standardized achievement tests for pupils in grades 4 through 9 in each of the selected pilot schools as well as other techniques to measure pupil achievement over time. The purpose of the pilot program is to identify multiple measures of pupil achievement and to analyze such data from those measures to assess the extent to which such data yields valid and comparable information on the average annual rate of gain or value-added. In addition, the program would provide for a so-called gains-based statistical analysis of data collected in years 2-4 of the program for each pupil, school, and district. Upon the collection of multiple years of data, an analysis of such data may be performed to measure the average gain or value-added to an individual pupil over the course of the measurement period.

II. After 3 years, the state board of education in conjunction with the legislative oversight committee established under RSA 193-C:7 shall evaluate the potential value of the information collected under the pilot program and consider the merits of the approaches used in the pilot program to determine whether such approaches may be used as additional or alternative methods of measuring educational achievement and success.

5 Reporting on Pupil Performance. RSA 193-E:3 is repealed and reenacted to read as follows:

193-E:3 Reporting on the Delivery of Education.

I. By August 1, 2001, and annually thereafter, each school district shall report to the department of education data at the school and district levels for the previous school year on the following indicators, provided however, that the department shall develop a reasonable schedule to phase-in the reporting of data that is not being collected systematically during school year 2000-2001:

(a) Numbers and percentages of pupils with disabilities, limited English proficient pupils, vocational education pupils, pupils in advanced placement programs, and pupils eligible for free or reduced-price meals.

(b) Pupil mobility rates calculated as the percentages of pupils who transfer into or out of a school each year. These percentages shall not include pupils who enter the school on opening day at the lowest grade in the school or pupils who leave the school upon completion of the highest grade in the school.

(c) Attendance and dropout rates.

(d) Performance on statewide tests administered pursuant to RSA 193-C:3, IV(i) including the percentage of pupils reading at grade level on the reading component of the grade 3

statewide educational assessment and performance on any other standardized tests administered at local option.

(e) Percentage of graduating pupils going on to post-secondary education and military service.

(f) Average class size for instructional purposes at the primary, intermediate, and secondary levels as of October 1.

(g) Number and percentage of educators teaching one or more courses outside of the educator's certification area and the percentage of all courses being taught by educators outside their certification area.

(h) Teacher and administrator turnover rates at the school and district levels.

II. By August 1, 2001, and annually thereafter, each school district shall report to the department of education data at the school and district levels for the previous school year any other data required by federal law on the same or similar subject matter specified in subparagraphs I (b) (g) or for any of the subgroups set forth in subparagraph I (a).

III. The department of education, with the approval of the legislative oversight committee established in RSA 193-C:7, may implement and report data on any additional indicators deemed relevant to the purposes of this section.

IV. In order to reduce school districts' administrative time and costs, the department of education shall develop and utilize user-friendly, computer forms and programs to collect the data set forth in paragraph I as well as all enrollment and cost data related to determining the cost of an adequate education The department shall request funds as part of its biennial operating budget to develop, update, and maintain the required forms and programs.

V. Not later than December 1, 2001, and annually thereafter, the department of education shall issue a public report on the condition of education statewide and on a district-by-district and school-by-school basis. This report shall be entitled "New Hampshire School District Profiles." It shall include demographic and pupil performance data including, but not limited to, district and school performance on state tests administered pursuant to RSA 193-C, all other data provided under paragraph I, as well as other relevant statistics as determined by the department of education. Comparisons with state averages shall be provided for data reported under subparagraphs I(a)-(h). Comparisons of each district and school to itself based on its own performance for either the prior school year or its most recent 3-year rolling averages shall be provided for data reported under subparagraphs I(c)-(e). Statewide rankings of each district and school shall be provided for data reported under subparagraphs I(c)-(e). The report shall be organized and presented in a manner that is easily understood by the public and that assists each school district with the identification of trends, strengths, and weaknesses and the development of its local school education improvement and assessment plan.

VI. Each school district shall provide an opportunity for public discussion of the report at a meeting of its governing body. The school district shall make the report available to the public at least 10 days prior to the meeting.

VII. No later then January 1, 2003, the department of education shall prepare and submit to the education committees of the house and senate a plan for collecting and evaluating data to determine the correlation between level of academic performance and such factors as pupils' gender, socioeconomic status, cost per pupil, class size, teacher qualifications, and use of various instructional strategies as well as an in-depth study of community members' perceptions of their involvement in education and of important educational issues. The plan shall include an estimate of the costs to the department and local school districts of collecting, analyzing, and reporting the results of these studies.

6 Statewide Education Improvement and Assessment Program; Local Education Improvement and Assessment Plans. RSA 193-C:9, I is repealed and reenacted to read as follows:

I. Each school district shall be responsible for coordinating the development and implementation of a local education improvement and assessment plan. The plan shall be evaluated and reviewed annually and shall be included in the school district's annual report.

The development and implementation of the plan and the annual evaluation and review shall be carried out with input from administrators, teachers, parents, employers, and other community members. The plan shall be approved by the local school board no later then October 31, 2003. At a minimum, each plan shall identify and set forth objectives for the school or each school in the district to achieve, including:

(a) Objectives and annual benchmarks for improved pupil performance in each of the statewide performance goals.

(b) Local assessment measures which focus on individual student performance.

(c) Participation in the program.

(d) The use of local and statewide assessment results to improve instruction and enhance student learning.

(e) Methods for reporting the results of all assessment measures.

7 Statewide Education Improvement and Assessment Program; Local Education Improvement and Assessment Plans. RSA 193-C:9, IV is repealed and reenacted to read as follows:

IV. The department of education shall develop a model local education improvement and assessment plan which can be used by school districts. The model plan shall:

(a) Identify and set forth objectives for the school or each school in the district to achieve, including objectives and annual benchmarks for improved pupil performance in each of the applicable areas in which statewide performance goals have been established.

(b) Identify areas where improvements are needed immediately.

(c) Specify how the school or each school in the district will work to make improvements in the combined performance of all pupils enrolled in a school as well as the performance of discrete subgroups of pupils, including pupils with disabilities, limited English proficient pupils, vocational education pupils, and low income pupils.

(d) Specify the methods and assessments to be used in addition to NHEIAP assessments for the annual evaluation and review of the plan, including data to be collected, analyzed, and reported. This shall include the data specified in RSA 193-E:3, I as well as additional data determined locally.

8 Legislative Oversight Committee; Duties Amended. Amend RSA 193-C:8 to read as follows:

193-C:8 Duties of the Legislative Oversight Committee; Report. ***The oversight committee shall:***

I. [~~The oversight committee shall review~~] ***Review*** the development and implementation of the program to ensure that they are in accordance with legislative policy. Implementation of the program shall be in conjunction with the committee's review.

II. Review all of the provisions of RSA 193-G and submit a report of such review every 2 years after the effective date of this section to the speaker of the house of representatives, the president of the senate, the governor, and the chairpersons of the house and senate education committees.

III. Prepare any legislation that is needed as a result of the review of the progress and results of the policies implemented under this chapter.

9 School Money; Education Trust Fund Amended. Amend the introductory paragraph of RSA 198:39, I to read as follows:

198:39 Education Trust Fund Created and Invested.

I. The state treasurer shall establish an education trust fund in the treasury. Moneys in such fund shall not be used for any purpose other than to distribute adequate education grants to municipalities' school districts pursuant to RSA 198:42, and to provide education property tax hardship relief under RSA 198:55***, and to fund the education improvement fund established in RSA 193-G:4***. The state treasurer shall deposit into [~~this~~] ***the education trust*** fund immediately upon receipt:

10 Commission Established; Purpose. In order to improve our educational system, standards of achievement must be raised for all students and the department of education must

be prepared to provide instructional improvement assistance to those schools which are not meeting the standards. To this end, it is appropriate and consistent with the mission and purpose of the New Hampshire department of education for the department to provide technical assistance to local school communities to support their efforts to improve student results. In order to fulfill this role and related tasks, there is a need to build the capacity of the department of education. Accordingly, a bipartisan commission is hereby established to address the issue of how to build the capacity of the New Hampshire department of education to support improved school performance.

11 Membership and Compensation.

I. The members of the commission shall be as follows:

(a) Three members of the senate, appointed by the president of the senate.

(b) Three members of the house of representatives, appointed by the speaker of the house.

(c) One member of the business community, appointed by the governor.

(d) One member of the higher education community, appointed by the governor.

(e) One member representing the New Hampshire School Administrators Association, appointed by the chief executive officer, or appropriate appointing authority.

(f) One member representing the New Hampshire School Boards Association, appointed by the chief executive officer, or appropriate appointing authority.

(g) One member of the state board of education, appointed by the chairperson or designee.

(h) One locally elected school district official, appointed by the governor.

(i) The commissioner of the department of education who shall serve as an ex officio member.

(j) One member representing the department of education, appointed by the commissioner of the department of education.

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

12 Duties. The commission shall study the following areas:

I. Operational principles which should guide the work of the department of education in supporting improved school performance.

II. Necessary services and resources that the department of education should provide to local school communities in order to support improved school performance.

III. Current department of education programs and initiatives that are working toward supporting improved school performance and the enhancement of such programs and initiatives, if deemed necessary.

IV. Staffing requirements for providing support to local school communities

V. Organizational implications in order to support improved school performance.

13 Chairperson; Quorum. The members of the study commission shall elect a chairperson from among the members. The first meeting of the commission shall be called by the first-named house member. The first meeting of the commission shall be held within 45 days of the effective date of this section. Four members of the commission shall constitute a quorum.

14 Report. The commission shall issue a final report of its findings, including recommendations for changes in staffing, organizing, and funding necessary for the department of education to provide support to local school communities, and any recommendations for proposed legislation to the senate president, the speaker of the house of representatives, the chairpersons of the house and senate education committees, the chairperson of the state board of education, the senate clerk, the house clerk, the governor, and the state library on or before July 1, 2002.

15 Effective Date. This act shall take effect July 1, 2001.

2001-1113s

AMENDED ANALYSIS

This bill establishes criteria for measuring school performance standards, requires the development of a local education improvement and assessment plan in each school district, defines satisfactory progress in school performance areas, and establishes an education improvement fund in the department of education which shall be funded by a transfer from the education trust fund in the amount of 1/3 of one percent of the statewide cost of an adequate education for all pupils.

Environment
May 2, 2001
2001-1093s
08/10

Amendment to SB 189-FN-A

Amend the bill by replacing all after the enacting clause with the following:

1 Oil Discharge and Disposal Cleanup Fund; Purpose. Amend RSA 146-D:1 to read as follows:

146-D:1 Purpose.

I. The general court finds that gasoline and diesel fuel, due to their extreme fluidity and suspected carcinogenic qualities, comprise a sufficiently distinct class of property which represents a potential serious health and safety problem to the citizens of New Hampshire. In particular, gasoline and diesel fuel present a potential threat to the quality of New Hampshire's groundwater and environment because of the speed with which these products are able to flow into, and contaminate, valuable groundwater supplies. The purpose of this chapter is to establish financial responsibility for the cleanup of oil discharge and disposal, and to establish a fund to be used in addressing the costs incurred by the owners of underground storage facilities and bulk storage facilities for the cleanup of oil discharge and disposal, to protect groundwater, and for reimbursement for third party damages. The fund established under this chapter shall be in addition to the oil pollution control fund established pursuant to RSA 146-A:11-a.

II. The general court recognizes the adverse effect of discharges of gasoline ethers due to the speed with which ethers are able to flow into, contaminate, and accumulate in invaluable groundwater and surface water supplies. The purpose of this chapter is to provide financial assistance, in accordance with RSA 146-G, to victims of such discharges and to address the costs incurred by owners of public and private water supplies for the treatment and removal of gasoline from those supplies and remediation of groundwater and surface water contaminated by gasoline containing ethers.

2 New Paragraphs; Definitions. Amend RSA 146-D:2 by inserting after paragraph VII the following new paragraphs:

VIII. "Gasoline" means all products commonly or commercially known or sold as gasoline, including casinghead and absorption of natural gasoline, regardless of their classification or uses, and any liquid prepared, advertised, offered for sale, or sold for use as or commonly and commercially used as a fuel in internal combustion engines, which when subjected to distillation in accordance with the standard method of test for distillation of gasoline, naphtha, kerosene, and similar petroleum products (ASTM Designation D-86) show not

less than 10 percent distilled (recovered) below 347 degrees Fahrenheit (175 degrees Centigrade) and not less than 95 percent distilled (recovered) below 464 degrees Fahrenheit (240 degrees Centigrade); provided that the term gasoline shall not include commercial solvents or naphthas which distill by ASTM method D-86 not more than 9 percent at 176 degrees Fahrenheit and which have a distillation range of 150 degrees Fahrenheit or less, or liquefied gases which would not exist as liquid at a temperature of 60 degrees Fahrenheit and a pressure of 14.7 pounds per square inch absolute.

IX. "Diesel fuel" means a liquid hydrocarbon fuel used in internal combustion high speed engines that operate with a diesel thermodynamic cycle.

X. "Person" means any operator, distributor, dealer, or broker who, or any wholesale terminal facility which, imports or causes to be imported gasoline containing ethers into the state. "Person" does not mean an oil spill cleanup organization or other person acting to contain, remove, cleanup, restore, or take other remedial or corrective action or measures with regard to the spillage or discharge of gasoline or threatened spillage or discharge of gasoline.

XI. "Import" means, for the purpose of determining the license fees under this section, any import of gasoline ethers or gasoline containing ethers into this state by any person whether by vessel, pipeline, truck, railroad, or any other contrivance to the extent that the import of such gasoline ethers has not been previously subject to the license fee under this section.

XII. "Gasoline ethers" means any ether added to gasoline to improve or increase octane or to increase gasoline oxygen content, and their by-products, including, but not limited to, methyl tertiary butyl ether, tertiary amyl methyl ether, di-isopropyl ether, and ethyl tertiary butyl ether.

3 Fund Established. RSA 146-D:3, VI is repealed and reenacted to read as follows:

VI. The fee collected on motor fuels shall be in the amounts and divided between the accounts as follows:

(a) For each gallon of diesel fuel for which a fee is assessed, $.014 shall be placed in an account for reimbursement of owners of eligible underground storage facilities and $.001 shall be placed in an account to be used for reimbursement of owners of eligible bulk storage facilities.

(b) For each gallon of gasoline for which a fee is assessed, the following amounts shall be placed in the corresponding accounts: $0.0115 in the underground storage facilities account, $0.001 in the bulk storage facilities account and $0.0025 in the gasoline remediation and elimination of ethers fund established under RSA 146-G for the cleanup of contamination from gasoline ethers.

(c) For all fees collected on gasoline during the period from January 1, 2001 to July 1, 2001 and deposited in the account for reimbursement of owners of eligible underground storage facilities, 18 percent of those fees shall be transferred to gasoline remediation and elimination of ethers fund for the cleanup of contamination from gasoline ethers.

4 New Chapter; Gasoline Remediation and Elimination of Ethers Fund. Amend RSA by inserting after chapter 146-F the following new chapter:

CHAPTER 146-G

GASOLINE REMEDIATION AND ELIMINATION OF ETHERS FUND

146-G:1 Purpose.

I. In recognition of its fiduciary responsibility to minimize the contamination of our citizens' drinking water and the water sources of the state, the general court finds that ethers contained in gasoline, due to their extreme fluidity, recalcitrance to natural degradation, low taste and odor thresholds, and probable carcinogenic qualities, comprise a sufficiently distinct class of property which represent a particular, present, and rapidly escalating threat to the quality of all the water of the state and, thereby, to our citizens. The general court also finds that potentially serious health, safety, and environmental problems are evidenced due to the speed with which ethers are able to flow into, contaminate, and accumulate in invaluable groundwater supplies.

II. The intent of this chapter is to provide procedures that will expedite the cleanup of gasoline ether spillage, mitigate the adverse affects of gasoline ether discharges, encourage

preventive measures, provide financial assistance to victims of such discharges, and to establish a fund to be used in addressing the costs incurred by owners of public and private water supplies for the treatment and removal of gasoline ethers from those supplies and the remediation of groundwater and surface water contaminated by gasoline ethers. The fund established under this chapter shall be in addition to the oil pollution control fund established pursuant to RSA 146-A:11-a and is separate from the oil discharge and disposal cleanup fund established pursuant to RSA 146-D:3.

146-G:2 Definitions. In this chapter:

I. "Discharge" or "spillage" means the release or addition of any gasoline containing ethers to land, groundwater, or surface water.

II. "Distributor" means any person, wherever resident or located, who imports or causes to be imported gasoline, as defined in this section, into the state; provided, however, that bringing gasoline into the state in the fuel supply tank attached to the engine of a vehicle or aircraft shall not be considered importing. "Distributor" does not mean a gasoline spill cleanup organization or other person acting to contain, remove, clean up, restore, or take other remedial or corrective action or measures with regard to the spillage or discharge of gasoline, or threatened spillage or discharge of gasoline.

III. "Ethers" means organic compounds formed by the treatment of an alcohol with a dehydrating agent resulting in 2 organic radicals joined by an oxygen atom. Gasoline ethers include but are not limited to methyl tertiary butyl ether (MtBE), tertiary amyl methyl ether (TAME), di-isopropyl ether (DIPE), and ethyl tertiary butyl ether (EtBE) and other ethers which may be contained in or added to gasoline prior to sale to the public.

IV. "Facility" means a location, including structures or land, at which gasoline is subjected to treatment, storage, processing, refining, pumping, transfer, or collection.

V. "Gasoline" means all products commonly or commercially known or sold as gasoline, including casinghead and absorption of natural gasoline, regardless of their classification or uses, and any liquid prepared, advertised, offered for sale, or sold for use as or commonly and commercially used as a fuel in internal combustion engines, which when subjected to distillation in accordance with the standard method of test for distillation of gasoline, naphtha, kerosene, and similar petroleum products (ASTM Designation D-86) show not less than 10 percent distilled (recovered) below 347 degrees Fahrenheit (175 degrees Centigrade) and not less than 95 percent distilled (recovered) below 464 degrees Fahrenheit (240 degrees Centigrade); provided that the term gasoline shall not include commercial solvents or naphthas which distill by ASTM method D-86 not more than 9 percent at 176 degrees Fahrenheit and which have a distillation range of 150 degrees Fahrenheit or less, or liquefied gases which would not exist as liquid at a temperature of 60 degrees Fahrenheit and a pressure of 14.7 pounds per square inch absolute.

VI. "Gasoline remediation and elimination of ethers fund" means the fund established pursuant to RSA 146-G:4.

VII. "Gasoline terminal facility" means any facility of any kind and its related appurtenances located within the boundaries of this state that is used or capable of being used for pumping, handling, transferring, processing, refining, or storing gasoline.

VIII. "Groundwater" means subsurface water that occurs beneath the water table in soils and geologic formations.

IX. "Neat gasoline ethers" mean ethers intended for blending with gasoline prior to sale to the public which are imported into the state with little or no admixtures or dilution. Neat gasoline ethers shall contain a minimum of 92.1 percent by volume ether, including its impurities.

X. "Oxygenate" means an organic compound containing oxygen added to gasoline to increase its oxygen content.

XI. "Operator" means any person owning or operating any gasoline terminal facility or vessel, whether by lease, contract, or any other form of agreement.

XII. "Removal costs" means the costs of containment, removal, cleanup, restoration, and remedial or corrective action or measures that are incurred after a spillage or discharge of

gasoline has occurred or, in any case in which there is a threat of a spillage or discharge of gasoline, the cost to prevent, minimize, or mitigate gasoline pollution from such an incident.

XIII. "Surface water" means streams, lakes, ponds, and tidal waters within the jurisdiction of the state, including all streams, lakes, or ponds bordering on the state, marshes, watercourses, and other bodies of water, natural or artificial.

XIV. "Vessel" includes every description of watercraft or other contrivance used, or capable of being used as a means of transportation on water or land whether self-propelled or otherwise and shall include barges, tanker trucks, and railroad cars.

XV. "Wholesale terminal facility" means any facility of any kind and its related appurtenances that is primarily a wholesale distributor of gasoline products and that is used or capable of being used for pumping, handling, transferring, processing, refining, or storing gasoline.

146-G:3 Recovery by State. The attorney general shall institute such legal or equitable action as he or she deems necessary to recover or obtain judgment for the costs of containment, cleanup, removal, corrective measures, or civil penalties. This action may be brought in conjunction with an action for injunctive relief or in a separate action in superior court. In connection with an action brought under this section, the attorney general may obtain a prejudgment attachment.

146-G:4 Fund Established; Collection.

I. There is hereby established the gasoline remediation and elimination of ethers fund. This nonlapsing, revolving fund shall be used to pay the costs to implement the provisions of this chapter which include, but are not limited to, the salaries and expenses of additional personnel, as approved by the legislature, to the extent that such salaries and expenses are incurred in implementing the provisions of this chapter, testing and monitoring activities, and other costs of treatment or removal or corrective measures deemed necessary by the department of environmental services as a result of an actual or potential discharge of gasoline ethers into or onto the surface water or groundwater of the state. Moneys from the fund shall be used to mitigate the adverse affects of gasoline ether discharges including, but not limited to, provision of emergency water supplies to persons affected by such pollution, and, where necessary as determined by the department of environmental services, the establishment of an acceptable source of potable water to injured parties. Not more than $150,000 shall be allocated annually for research programs dedicated to the development and improvement of preventive and cleanup measures concerning such gasoline ether discharges. The waste management council shall approve any agreements entered into by the department for purposes of conducting research. Income derived from the fund shall only be used for those administrative costs needed to implement this chapter.

II. Moneys in the fund not currently needed to meet the obligations of the department of environmental services under this chapter shall be deposited with the state treasurer to the credit of the fund and shall be invested as provided by law. Interest received on such investment shall also be credited to the fund. If the fund's balance becomes greater than $2,500,000, the transfer of monies into the fund as established in RSA 146-D:3 shall be discontinued and only re-established when the fund's balance is below $1,000,000. Those fees normally transferred to the gasoline remediation and elimination of ethers fund shall accumulate instead in the account for reimbursement of owners of eligible underground storage facilities under RSA 146-D:3,VI.

III. All moneys paid to the state to reimburse costs paid out of the gasoline remediation and elimination of ethers fund by any person strictly liable to the state under this chapter shall be placed in the gasoline remediation and elimination of ethers fund.

IV. Any person who imports or causes to be imported neat gasoline ethers into the state shall be licensed by the department of safety under this chapter. The annual fee for the license shall be $0.10 per gallon of neat gasoline ethers imported into this state for the purpose of being mixed or blended with gasoline prior to sale to the public. The fee shall be paid monthly by such person to the department of safety and deposited by the department of safety into the gasoline

remediation and elimination of ethers fund. Imposition of the fee shall be based on the records of the person and certified as accurate to the department of safety.

146-G:5 Competitive Bidding Required. The commissioner of environmental services shall enter into the competitive bidding process for any project undertaken by the department of environmental services under the authority of this chapter with an estimated cost of $10,000 or more. The commissioner may enter the competitive bidding process for any such project with an estimated cost of less than $10,000.

146-G:6 Corrective Measures Authorized. Corrective measures authorized by this chapter shall include but not be limited to:

I. Provision of interim water supplies to residents whose water supplies have been contaminated due to the presence of gasoline ethers above standards set by the department of environmental services or a condition determined to be hazardous by the office of community and public health and the state forensic toxicologist. This may include the supply of bottled water and the installation and operation of water supply treatment systems, approved or provided by the department.

II. The establishment of an acceptable source of potable water to injured parties, where necessary, as determined by the department of environmental services. This may include but not be limited to a proportioned share of the costs of construction of the extension of public water mains and appurtenances, the installation of replacement water supply wells and appurtenances, or the installation of water treatment processes for new or existing water supplies. Operation and maintenance costs or annual user fees for new or upgraded public water supply main extensions or treatment processes shall not be eligible expenses under this paragraph.

146-G:7 License Required; Fee.

I. Every person who imports or causes to be imported neat gasoline ethers into the state shall file a monthly report for the preceding month and shall include all fees due for that reporting period with the department of safety on or before the twentieth day of the following calendar month. Failure to file by the required date or to enclose fees due shall result in the assessment of a 10 percent penalty to be added to the amount of fees due for that month. If no fees are due, a penalty of $10 per day shall be assessed. Such penalty shall immediately accrue and thereafter the overdue fees and the penalty shall bear interest at the rate established by the Internal Revenue Service effective on the first business day of the calendar year. To this rate shall be added 2 percent. In determining the monthly rate, that figure shall be rounded off to the nearest quarter percent. The department of environmental services may waive all or any portion of penalties or interest for good cause. Such cause and incident shall be recorded in the records of the gasoline remediation and elimination of ethers fund.

II. No distributor licensed under this section shall import gasoline ethers into this state without paying the fee required by this section.

III. Unless otherwise provided, any person who violates any provision of this section shall be guilty of a misdemeanor if a natural person or guilty of a felony if any other person.

146-G:8 Administrative Costs.

I. Notwithstanding any other provision of law, if the expenditure of additional funds is necessary for the costs of administration of the collection process established in RSA 146-G:6, II and III, upon request of the commissioner of safety, the governor and council, upon recommendation of the department of environmental services and with prior approval of the fiscal committee of the general court, may authorize the transfer of funds from the gasoline remediation and elimination of ethers fund to the department of safety for such specific purposes only.

II. The commissioner of safety shall file reports with the department of environmental services on a quarterly basis, relative to the administrative costs of the collection activities of the department of safety under RSA 146-G:4, IV. Such report shall include detailed accounting of such costs, including procedures taken to separate such costs from any other administrative costs

incurred by the department of safety relative to any other statutory responsibilities of that department.

146-G:9 Reporting by Department of Environmental Services. The department of environmental services shall file annual reports of the status of the gasoline remediation and elimination of ethers fund no later than October 1, to the speaker of the house and president of the senate. The first such report shall be submitted no later than October 1, 2002. The department of environmental services shall also file an interim report on the activities of the gasoline remediation and elimination of ethers fund, including expenditures and reimbursements, and enforcement and remediation activities under RSA 146-G, by January 1, 2005 to the senate president, the speaker of the house of representatives, the senate clerk, the house clerk, the house and senate committees having jurisdiction over water quality policy, the governor, and the state library. The department shall file a final report on the activities of the fund and enforcement and remediation activities by November 1, 2006 to the senate president, the speaker of the house of representatives, the senate clerk, the house clerk, the house and senate committees having jurisdiction over water quality policy, the governor, and the state library.

146-G:10 Review and Report. Upon issuance of the interim report by the department of environmental services required by RSA 146-G:7, the members of house and senate committees having jurisdiction over water quality policy shall constitute a joint committee for purposes of reviewing the effectiveness of the program implemented by this chapter. The joint committee shall review the effectiveness of the program implemented by this act, and shall report the joint committee's findings and recommendations to the full senate.

146-G:11 Rulemaking. The commissioner shall adopt rules, pursuant to RSA 541-A, relative to the allocation of funds from the gasoline remediation and elimination of ethers fund authorized under this section. Construction costs due to contamination from gasoline ethers incurred by operators of public water supplies between May 4, 2000 and the effective date of department rules may be considered for compensation on a case-by-case basis subject to approval of the waste management council.

5 Repeal. RSA 146-G, relative to the gasoline remediation and elimination of ethers fund, is repealed.

6 Effective Date.

I. Section 5 of this act shall take effect July 1, 2006.

II. The remainder of this act shall take effect July 1, 2001.

Environment
May 2, 2001
2001-1090s
06/01

Amendment to HB 166

Amend the title of the bill by replacing it with the following:

AN ACT requiring the gas utility restructuring oversight committee to study gas and hazardous substance pipeline safety.

Amend the bill by replacing all after the enacting clause with the following:

1 New Subparagraph; Gas Utility Restructuring Oversight Committee; Duties; Pipeline Safety. Amend RSA 374:60, IV by inserting after subparagraph (b) the following new subparagraph:

(c) Study gas and hazardous substance pipeline safety.

2 Effective Date. This act shall take effect upon its passage.

2001-1090s

AMENDED ANALYSIS

This bill requires the gas utility restructuring oversight committee to study gas and hazardous substance pipeline safety.

Environment
May 2, 2001
2001-1091s
08/01

Amendment to HB 274

Amend RSA 125-N:3, II as inserted by section 1 of the bill by replacing it with the following:

II. The department shall not implement or impose dioxin emission limits for emissions resulting from stationary source combustion of virgin petroleum fuels, coal and untreated wood and wood products without further legislative authorization unless such limits are required to be implemented or imposed under federal authority enacted or promulgated after the date of this act.

Amend the bill by replacing section 2 with the following:

2 Effective Date.

I. RSA 125-N:5, II as inserted by section 1 of this act shall take effect January 1, 2003.

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

Senate Executive Departments and Administration
May 4, 2001
2001-1118s
05/03

Amendment to SB 48

Amend the bill by replacing all after section 2 with the following:

3 New Chapter; Rental of Non-Owner Occupied Shared Facilities. Amend RSA by inserting after chapter 540-A the following new chapter:

CHAPTER 540-B

RENTAL OF NON-OWNER OCCUPIED SHARED FACILITIES

540-B:1 Definition; Non-Owner Occupied Shared Facility.

I. A "non-owner occupied shared facility" means real property rented for residential purposes which has separate sleeping areas for each occupant and in which each occupant has access to and shares with other occupants one or more significant portions of the facility in common, such as kitchen, dining area, bathroom, or bathing area, for which the occupant has no rented right of sole personal use.

II. A non-owner occupied shared facility shall not include:

(a) Facilities rented to transient guests intended for use of less than 90 days.

(b) Rooms in hotels, motels, inns, tourist homes, and other dwellings rented for recreational or vacationing use.

(c) Rooms provided ancillary to other primary purposes such as jails, student dormitories, nursing homes, hospitals, group homes, and emergency shelters.

540-B:2 Nature of Tenancy. Every tenancy shall be deemed to be at will, and the rent payable as agreed, unless a written contract defines the terms of the tenancy differently. Except as otherwise provided, a verbal rental agreement shall be permitted.

540-B:3 Termination of Tenancy; Notice of Termination.

I. The owner or agent of the owner of a non-owner occupied shared facility may terminate any tenancy without stating any reason. A written 30-day notice of termination shall be required.

II. The owner or agent of the owner of a non-owner occupied shared facility may terminate any tenancy for non-payment of rent. A written 7-day notice of termination shall be required.

III. The owner or agent of the owner of a non-owner occupied shared facility may terminate any tenancy for damage to the premise, or behavior of the occupant or guest of any family member of the occupant which adversely affects the health or safety of the other occupants, or material breech of any rental agreement. A written 72-hour notice of termination shall be required.

540-B:4 Termination by Occupant. An occupant may terminate any at will tenancy by a written 30-day notice or in accordance with any notice requirement of a written rental agreement.

540-B:5 Services of Notice.

I. The owner or agent of the owner of a non-owner occupied shared facility shall give the notice of termination personally to the occupant or attach the notice to the primary entrance to the occupant's separated area.

II. The occupant shall give the notice of termination by the same method used to pay rent or in accordance with any written rental agreement.

540-B:6 Possessory Rights. The occupant shall have no possessory rights to any portion of a non-owner occupied shared facility. The owner or agent of the owner may request law enforcement intervention for any behavior if such action is deemed necessary. The law enforcement officer shall not be precluded from any normal response based on the fact of the rental agreement.

540-B:7 Remedies. Violations of this chapter shall be subject to the remedies set forth in RSA 540-A:4.

540-B:8 Possession. The owner or agent of the owner of a non-owner occupied shared facility may take possession of the separated areas used by the occupant at the end of the notice period. The owner or agent of the owner may request law enforcement intervention as necessary.

540-B:9 Personal Property. The owner or agent of the owner of a non-owner occupied shared facility shall retain and exercise reasonable care in the storage of the personal property of the occupant who has vacated the premises for a period of 3 days after the date on which such

occupant has vacated. After the 3-day period, the owner or agent of the owner of a non-owner occupied shared facility may dispose of such property without notice to the occupant.

540-B:10 Security Deposit. The owner or agent of the owner of a non-owner occupied shared facility may require a security deposit in an amount to be determined by the owner or agent of the owner. If the deposit amount is more than the equivalent of 30 days rent, there shall be a written instrument acknowledging receipt and explaining where the deposit shall be maintained and when it shall be returned. If there is no written agreement, the deposit shall be returned within 20 days after the occupant has vacated.

4 New Subparagraph; Actions Against Tenants; Owner Occupied Shared Facilities Within Definition of "Nonrestricted Property". Amend RSA 540:1-a, I by inserting after subparagraph (d) the following new subparagraph:

(e) Owner occupied shared facilities. For purposes of this subparagraph, an owner occupied shared facility means real property rented for residential purposes which has separate sleeping areas for each occupant and the owner and in which each occupant has access to and shares with other occupants or the owner of the facility one or more significant portions of the facility in common, such as kitchen, dining area, bathroom, or bathing area, for which the occupant has no rented right of sole personal use. An owner occupied shared facility does not include rooms in hotels, motels, inns, tourist homes, and other dwellings rented for recreational or vacationing use or rooms provided ancillary to other primary purposes such as jails, student dormitories, nursing homes, hospitals, group homes, and emergency shelters. Nor does this chapter apply to owner occupied facilities if they are rented to occupants for less than 90 days.

5 New Section; Hotels, Tourist Cabins, Etc.; Applicability to Owner Occupied Shared Living Facilities. Amend RSA 353 by inserting after section 10 the following new section:

353:11 Applicability to Owner Occupied Shared Facilities.

I. For purposes of this section, an owner occupied facility means real property rented for residential purposes which has separate sleeping areas for each occupant and the owner and in which each occupant has access to and shares with other occupants or the owner of the facility one or more significant portions of the facility in common, such as kitchen, dining area, bathroom, or bathing area, for which the occupant has not rented right of sole personal use. An owner occupied shared facility does not include rooms in hotels, motels, inns, tourist homes, and other dwellings rented for recreational or vacationing use or rooms provided ancillary to other primary purposes such as jails, student dormitories, nursing homes, hospitals, group homes, and emergency shelters.

II. The following sections of this chapter shall apply to owner occupied shared facilities that are rented to occupants for less than 90 days:

(a) RSA 353:1, except that the owner of the shared facility shall not be required to provide a suitable safe for the occupants' valuables.

(b) RSA 353:2, relative to fire losses.

(c) RSA 353:3-c, relative to ejection of guests.

(d) RSA 353:7 through 353:10, relative to defrauding an innkeeper.

6 Effective Date. This act shall take effect January 1, 2002.

2001-1118s

AMENDED ANALYSIS

This bill distinguishes between non-owner occupied shared facilities, owner occupied shared facilities rented to occupants for less than 90 days, and owner occupied shared facilities rented to occupants for 90 or more days.

A new statutory chapter governs the rights and remedies available to the owner and occupants in the context of non-owner occupied shared facilities.

Owner occupied shared facilities rented to occupants for 90 or more days are treated as nonrestricted property for purposes of the rights and remedies available to the owner and occupants under RSA 540.

Owner occupied shared facilities rented to occupants for less than 90 days are governed by certain provisions of RSA 353, relative to hotels and tourist cabins.

Senate Executive Departments and Administration
May 2, 2001
2001-1102s
08/01

Amendment to SB 182-FN-A

Amend the title of the bill by replacing it with the following:

AN ACT establishing a brain and spinal cord injury trust fund and appropriating certain moneys to such fund.

Amend the bill by replacing all after the enacting clause with the following:

1 Advisory Council; Duties. RSA 137-K:2, IV(c) is repealed and reenacted to read as follows:

(c) Receive and review information from the brain and spinal cord injury registry, established in RSA 137-K:5; review the status of the brain and spinal cord injury trust fund, established in RSA 137-K:9; and recommend to the commissioner priorities and criteria for disbursement of any moneys in the brain and spinal cord injury trust fund consistent with the purposes of the fund, and of any moneys received under paragraph V.

2 New Section; New Hampshire Brain and Spinal Cord Injury Trust Fund Established. Amend RSA 137-K by inserting after section 8 the following new section:

137-K:9 New Hampshire Brain and Spinal Cord Injury Trust Fund Established. There is hereby established in the office of the state treasurer a fund to be known as the brain and spinal cord injury trust fund. Receipts from RSA 6:12, I(aa) in excess of $750,000 and receipts from payments for forfeited recognizances for non-driving offenses as provided in RSA 597:38-b, II shall be deposited into the fund. The fund shall be expended by the commissioner, after consultation with and pursuant to the criteria and priorities established by the advisory council, to provide direct services on behalf of individuals and their families affected by brain or spinal cord injuries, including, but not limited to, community resource coordination, support of a statewide toll-free number for information and assistance, family support, advocacy and vocational support, to administer the brain and spinal cord injury registry, and to fund injury prevention efforts. The moneys in the fund shall be non-lapsing and shall be continually appropriated to the department for the purpose of the fund.

3 Moneys Credited to the Brain and Spinal Cord Injury Trust Fund. Amend RSA 6:12, I(aa) to read as follows:

(aa) The assessments collected under RSA 188-F:31 and 651:63, V and the surcharges on state commissary purchases under RSA 622:7-b designated for the victims' assistance fund which shall be credited to the victims' assistance fund until that fund exceeds $750,000, at which time moneys in excess of $750,000 shall be credited to the [~~general fund~~] ***New Hampshire brain and spinal cord injury trust fund established in RSA 137-K:9***.

4 New Paragraph; Non-driving Offenses. Amend RSA 597:38-b by inserting after paragraph II the following new paragraph:

III. Whenever a party recognized to appear for any offense not involving driving makes default and the recognizance is declared forfeited, payment of the forfeited recognizance shall be paid to the state treasurer to deposit in the New Hampshire brain and spinal cord injury trust fund, established pursuant to RSA 137-K:9.

5 New Subparagraph; Special Fund. Amend RSA 6:12, I by inserting after subparagraph (dddd) the following new subparagraph:

(eeee) Moneys received under RSA 597:38-b, III, which shall be credited to the New Hampshire brain and spinal cord injury trust fund, established in RSA 137-K:9.

6 Repeal. RSA 137-K:2, IV(e), relative to the feasibility of establishing a special fund, is repealed.

7 Effective Date. This act shall take effect January 1, 2002.

2001-1102s

AMENDED ANALYSIS

This bill establishes a brain and spinal cord injury trust fund. The fund is to be capitalized by moneys from the victims' assistance fund in excess of $750,000 and from payments for forfeited recognizances for non-driving offenses.

Senate Finance
May 1, 2001
2001-1084s
04/10

Amendment to SB 110-FN-A

Amend 1997, 348:6 as inserted by section 2 of the bill by replacing it with the following:

348:6 Appropriation; Kindergarten Construction. A sum not to exceed [~~$22,500,000~~] ***$37,500,000*** is hereby appropriated to the department of education for the purposes of constructing kindergarten classrooms. This appropriation shall be nonlapsing and in addition to any other appropriation to the department of education; provided, however, that the department of education shall not approve grant requests for such purposes for more than:

I. $6,000,000 in the biennium ending June 30, 1999.
II. $5,000,000 in the fiscal year ending June 30, 2000.
III. $5,000,000 in the fiscal year ending June 30, 2001.
IV. $6,500,000 in the fiscal year ending June 30, 2002.
V. $7,500,000 in the fiscal year ending June 30, 2003.
VI. $7,500,000 in the fiscal year ending June 30, 2004.

Amend the bill by replacing section 3 with the following:

3 Kindergarten Construction Program; Bonding Amount Amended. Amend 1997, 348:7, I as amended by 1997, 351:56 to read as follows:

I. To provide funds for the appropriation made in section 6 of this act, the state treasurer is hereby authorized to borrow upon the credit of the state not exceeding the sum of

[~~$22,500,000~~] ***$37,500,000*** and for said purpose may issue bonds and notes in the name of and on behalf of the state of New Hampshire in accordance with RSA 6-A; provided that bonds or notes shall not be issued in excess of:

(a) $6,000,000 in the biennium ending June 30, 1999.
(b) $5,000,000 in the fiscal year ending June 30, 2000.
(c) $5,000,000 in the fiscal year ending June 30, 2001.
(d) $6,500,000 in the fiscal year ending June 30, 2002.
(e) $7,500,000 in the fiscal year ending June 30, 2003.
(f) $7,500,000 in the fiscal year ending June 30, 2004.

2001-1084s

AMENDED ANALYSIS

This bill extends the kindergarten construction program through the fiscal year ending June 30, 2004 and increases by $15,000,000 the amount of the bonded appropriation for the kindergarten construction program.

Senate Finance
May 1, 2001
2001-1077s
04/03

Amendment to SB 114

Amend the bill by replacing section 6 with the following:

6 Appropriation. The sum of $5,000 for the fiscal year ending June 30, 2001 is hereby appropriated to the committee established by this act for the purpose of assuring that the committee's staffing and research needs are satisfied, and to provide payment for expert testimony from individuals in other states as may be requested by the committee. The governor shall draw a warrant for said sum out of money in the treasury not otherwise appropriated.

2001-1077s

AMENDED ANALYSIS

This bill establishes a committee to study judicial reform issues and makes an appropriation of $5,000 for the fiscal year ending June 30, 2001 for staffing, research, and expert testimony as required by the committee.

Internal Affairs
May 4, 2001
2001-1121s
05/10

Amendment to SB 139

Amend RSA 294-E:3 as inserted by section 1 of the bill by replacing it with the following:

294-E:3 Scope.

I. Except as otherwise provided in paragraph II, this chapter applies to electronic records and electronic signatures relating to a transaction.

II. This chapter does not apply to a transaction to the extent it is governed by:

(a) A law governing the creation and execution of wills, codicils, or testamentary trusts.

(b) The Uniform Commercial Code other than Sections 1-107 and 1-206, Article 2, and Article 2A.

III. This chapter applies to an electronic record or electronic signature otherwise excluded from the application of this chapter under paragraph II to the extent it is governed by a law other than those specified in paragraph II.

IV. This chapter is not intended to modify, limit, or supersede the requirements of Section 101(c), (d), or (e), or to authorize the electronic delivery of any notice of the type described in Section 103(b) of the Electronic Signatures in Global and National Commerce Act, Public Law 106-229.

V. A transaction subject to this chapter is also subject to other applicable substantive law.

Amend RSA 294-E:12, I(b) as inserted by section 1 of the bill by replacing it with the following:

(b) Remains accessible and is capable of being accurately reproduced for later reference.

Amend RSA 294-E:17 through RSA 294-E:19 as inserted by section 1 of the bill by replacing them with the following:

294-E:17 Creation and Retention of Electronic Records and Conversion of Written Records by Governmental Agencies. The department of administrative services, in cooperation with the secretary of state, shall determine whether, and the extent to which, a governmental agency will create and retain electronic records and convert written records to electronic records.

294-E:18 Acceptance and Distribution of Electronic Records by Governmental Agencies.

I. Except as otherwise provided in RSA 294-E:12, VI, department of administrative services, in cooperation with the secretary of state, shall determine whether, and the extent to which, a governmental agency will send and accept electronic records and electronic signatures to and from other persons and otherwise create, generate, communicate, store, process, use, and rely upon electronic records and electronic signatures.

II. To the extent that a governmental agency uses electronic records and electronic signatures under paragraph I, the department of administrative services, in cooperation with the secretary of state, giving due consideration to security, may specify:

(a) The manner and format in which the electronic records must be created, generated, sent, communicated, received, and stored and the systems established for those purposes;

(b) If electronic records must be signed by electronic means, the type of electronic signature required, the manner and format in which the electronic signature must be affixed to the electronic record, and the identity of, or criteria that must be met by, any third party used by a person filing a document to facilitate the process;

(c) Control processes and procedures as appropriate to ensure adequate preservation, disposition, integrity, security, confidentiality, and auditability of electronic records; and

(d) Any other required attributes for electronic records which are specified for corresponding nonelectronic records or reasonably necessary under the circumstances.

III. Except as otherwise provided in RSA 294-E:12, VI, this chapter does not require a governmental agency of this state to use or permit the use of electronic records or electronic signatures.

294-E:19 Interoperability. The department of administrative services, in cooperation with the secretary of state, after adopting standards pursuant to RSA 294-E:18, may encourage and promote consistency and interoperability with similar requirements adopted by other governmental agencies of this and other states and the federal government and nongovernmental persons interacting with governmental agencies of this state. If appropriate, those standards may specify differing levels of standards from which governmental agencies of this state may choose in implementing the most appropriate standard for a particular application.

Internal Affairs
May 4, 2001
2001-1122s
08/10

Amendment to SB 174-FN-A

Amend the title of the bill by replacing it with the following:

AN ACT including Martin Luther King, Jr. Civil Rights Day as a holiday for which certain state employees are entitled to holiday pay and relative to employees of the department of youth development services.

Amend the bill by replacing section 1 with the following:

1 Temporary, Seasonal and Part-Time State Employees; Holiday Pay; Martin Luther King Day and the Department of Youth Development Services; Added. Amend RSA 98-A:6-b to read as follows:

98-A:6-b Holiday Pay. Notwithstanding any agreement, law, or rule to the contrary, state employees involved in the care of persons in the state mental health system, the department of health and human services, ***the department of youth development services***, the state prison, the secure psychiatric unit or the veterans' home on a part-time basis who work on New Year's Day, ***Martin Luther King, Jr. Civil Rights Day,*** Memorial Day, July 4, Labor Day, Veterans Day, Washington's Birthday, Thanksgiving Day, the day after Thanksgiving, or Christmas Day, shall be entitled to holiday pay for the hours worked, provided that such employees shall be required to work the scheduled day before and the scheduled day after such holidays.

2001-1122s

AMENDED ANALYSIS

This bill includes Martin Luther King, Jr. Civil Rights Day as a holiday for which certain state employees are entitled to holiday pay and adds the department of youth development services to those employees.

Internal Affairs
May 4, 2001
2001-1120s
05/03

Amendment to SB 178

Amend the title of the bill by replacing it with the following:

AN ACT establishing a committee to study the uniform computer information transactions act.

Amend the bill by replacing all after the enacting clause with the following:

1 Committee Established. There is established a committee to study the uniform computer information transactions act.
2 Membership and Compensation.
I. The members of the committee shall be as follows:
(a) Three members of the senate, appointed by the president of the senate.
(b) Three members of the house of representatives, appointed by the speaker of the house.
II. Members of the committee shall receive mileage at the legislative rate when attending to the duties of the committee.
3 Duties. The committee shall:
I. Study the uniform computer information transactions act approved and recommended by the National Conference of Commissioners on Uniform State Laws.
II. Assess New Hampshire's need for a state contract law that specifically regulates computer information transactions on the Internet and elsewhere.
III. If the committee recommends adoption of the act, consider any appropriate, state-specific changes to the uniform law.
4 Chairperson; Quorum. The members of the study committee shall elect a chairperson from among the members. The first meeting of the committee shall be called by the first-named senate member. The first meeting of the committee shall be held within 45 days of the effective date of this section. Four members of the committee shall constitute a quorum.
5 Report. The committee shall report its findings and recommendations for proposed legislation to the senate president, the speaker of the house of representatives, the senate clerk, the house clerk, the governor, and the state library on or before November 1, 2001.
6 Effective Date. This act shall take effect upon its passage.

2001-1120s

AMENDED ANALYSIS

This bill establishes a committee to study adoption of the uniform computer information transactions act, a contract law statute that regulates computer information transactions on the Internet and elsewhere.

Insurance
May 2, 2001
2001-1094s
09/01

Amendment to SB 39

Amend the title of the bill by replacing it with the following:

AN ACT establishing the position of market conduct chief administrator in the insurance department.

Amend the bill by replacing section 1 with the following:

1 New Paragraph; Position Established. Amend RSA 400-A:6 by inserting after paragraph VII the following new paragraph:

VIII. There shall be a market conduct chief administrator, who shall be appointed by the commissioner, and who shall perform such duties and exercise such powers as the commissioner may authorize.

2001-1094s

AMENDED ANALYSIS

This bill establishes the position of market conduct chief administrator in the insurance department.

This bill is a request of the insurance department.

Insurance
May 2, 2001
2001-1098s
01/09

Amendment to SB 109

Amend the bill by replacing all after the enacting clause with the following:

1 New Paragraphs; Definitions Added. Amend RSA 415-A:1 by inserting after paragraph I the following new paragraphs:

I-a. "Claim denial" means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

I-b. "Claim involving urgent care" means any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

(a) Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or

(b) In the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

I-c. "Claimant's representative" shall mean an individual authorized by a claimant in writing to pursue a claim or appeal on the claimant's behalf.

I-d. "Employee benefit plan" means employee benefit plans described in section 4(a) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1133 and 1135 and not exempted under section 4(b) of this Act.

2 New Paragraphs; Definitions Added. Amend RSA 415-A:1 by inserting after paragraph III the following new paragraphs:

IV. "Post-service claim" means any claim for a health or disability benefit to which the terms of the plan do not condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining the medical care or disability benefit. "Post-service claim" shall not include a request for reimbursement made by a provider pursuant to the terms of an agreement between the provider and the health carrier.

V. "Pre-service claim" means any claim for a benefit under a health plan with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care. "Pre-service claim" shall not include a request for reimbursement made by a provider pursuant to the terms of an agreement between the provider and the health carrier.

3 New Sections; Minimum Standards for Claim Review; Accident and Health Insurance. Amend RSA 415-A:4 by inserting after section 4 the following new sections:

415-A:4-a Minimum Standards for Claim Review; Accident and Health Insurance. Any carrier that offers group health plans, employee benefit plans, and disability plans shall establish and maintain written procedures by which a claimant may obtain a determination of claims and by which a claimant may appeal a claim denial.

I. The procedures for determination of a claim shall meet the following minimum standards:

(a) The plan shall maintain a toll-free telephone number to ensure that a representative of the plan shall be accessible by telephone to insureds, patients, and claimant's representatives as required to meet the response times specified herein.

(b) Clinical review criteria considered or utilized in making claim benefit determinations shall be:

(1) Developed with input from appropriate actively practicing practitioners in the licensed entity's service area;

(2) Updated at least biennially and as new treatments, applications, and technologies emerge;

(3) Developed in accordance with the standards of national accreditation entities;

(4) Based on current, nationally accepted standards of medical practice; and

(5) If practicable, evidence-based.

(c) The notification of a claim denial shall be communicated in writing or by electronic means and shall include:

(1) The specific reason or reasons for the determination and shall refer to the specific provision of the policy or plan on which the determination is based;

(2) A statement of the claimant's or the representative of the claimant's right to access the internal grievance process and the process for obtaining external review. The notification shall also include a written explanation of any claim denial, with the name and credentials of the carrier or other licensed entity medical director, including board status and the state or states where the person is currently licensed, and the relevant clinical rationale used to make the claim denial. If the person making the claim denial is not the medical director but a designee, then the credentials, board status, and state or states of current license shall also be provided for that person. Nothing in this section shall be construed to require a carrier or other licensed entity to provide proprietary information protected by third party contracts;

(3) If an internal rule, guideline, protocol, or other similar provision was relied upon in making the benefit determination, a reference to the specific rule, guideline, protocol, or other similar provision; and a statement that such a rule, guideline, protocol, or other similar provision was relied upon in making the claim denial and that a copy of such rule, guideline, protocol, or other provision will be provided free of charge to the claimant or claimant's representative upon request;

(4) If the claim denial is based on a medical necessity or experimental treatment or other similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan or the policy to the claimant's medical circumstances;

(5) Any clinical review criteria that are used by the carrier or other licensed entity as the basis of a determination shall be disclosed to the treating provider and the claimant. Such disclosure shall be accompanied by the following notice: "The materials provided to you are criteria used by this plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract;" and

(6) A description of the plan's grievance procedures and the time limits applicable to such procedures. In the case of a denial of a benefit concerning a claim involving urgent care or in the case of a denial of a claim related to continuation of an ongoing course of treatment for a person who has received emergency services, but who has not been discharged from a facility, a description of the expedited review applicable to such a claim shall be included in the determination. For all other claim benefit determinations, a description of the grievance process shall be specifically described in the determination.

II. Notification of a claim denial shall be made within the following time periods:

(a) The determination of a claim involving urgent care shall be made as soon as possible, taking into account the medical exigencies, but in no event later than 72 hours after receipt of the claim, unless the claimant or claimant's representative fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable. In the case of such failure, the licensee shall notify the claimant or claimant's representative within 24 hours of receipt of the claim and shall advise the claimant or claimant's representative of the specific information necessary to determine the claim. The 72-hour period shall be tolled until such time as the claimant submits the required information.

(b) The determination of a claim involving urgent care and relating to the extension of an ongoing course of treatment and involving a question of medical necessity shall be made within 24 hours of receipt of the claim, provided that the claim is made at least 24 hours prior to the expiration of the prescribed period of time or course of treatment. In the event the claimant or claimant's representative fails to provide sufficient notice or sufficient information, the licensee shall notify the claimant or claimant's representative within 24 hours of the receipt of the claim and shall advise the claimant or claimant's representative of the specific information necessary to determine the claim. If the determination relates to a reduction or termination of

coverage for a course of treatment beyond the end of the period of time or number of treatments previously approved, coverage for the services shall not be terminated during the pendency of the determination proceeding.

(c) The determination of all other claims for preservice benefits shall be made within a reasonable time period, but in no event more than 15 days after receipt of the claim, unless the claimant or claimant's representative fails to provide sufficient information to determine whether, or to what extent, benefits are covered as payable. In the case of such failure, the licensee shall notify the claimant or claimant's representative within 5 days of receipt of the claim. The 15-day period shall be tolled until such time as the claimant or claimant's representative submits the required information.

(d) The determination of a post service claim shall be made within 30 days of the date of filing. In the event the claimant fails to provide sufficient information to determine the claim, the carrier shall notify the claimant within 15 days as to what additional information is required to process the claim and the claimant shall be given at least 45 days to provide the required information. The 30-day period for claim determination shall be tolled until such time as the claimant submits the required information.

III. Any carrier or other licensed entity that offers group health plans, employee benefit plans, and disability plans shall file with the department a copy of its claim determination procedure, including all forms used, and a copy of the materials designed to inform its members or insureds of the requirements of the claim determination and grievance procedure and the responsibilities and rights of the members or insureds under the plan each year. The carrier shall also file an acknowledgment that all applicable state and federal laws to protect the confidentiality of individual medical records are followed.

IV. In any request for a benefit determination, the claimant may authorize a representative to pursue the claim or benefit determination by submitting a written statement to the license that acknowledges the representation.

V. No fees or costs shall be assessed against a claimant related to a request for claim benefit determination.

415-A:4-b Appeal Procedure. Every carrier or other licensed entity which offers group health insurance, employee benefit plans, or disability benefits shall file with the insurance department, by April 1 of each year, and shall maintain a written procedure by which a claimant, or a representative of the claimant, shall have a reasonable opportunity to appeal a claim denial to the carrier or other licensed entity, and under which there shall be a full and fair review of the claim denial. The written procedure filed with the insurance department shall include all forms used to process an appeal.

I. Full and fair review shall require that:

(a) The person or persons reviewing the grievance shall not be the same person or persons making the initial determination, shall not be subordinate to or the supervisor of the person making the initial determination, and shall act as a fiduciary;

(b) The person reviewing the grievance on a first or second level appeal shall have appropriate medical and professional expertise and credentials to competently render a determination on appeal;

(c) The claimant or claimant's representative shall have at least 180 days following receipt of a notification of an adverse benefit determination to appeal;

(d) The claimant or claimant's representative shall have an opportunity to submit written comments, documents, records, and other information relating to the claim without regard to whether those documents or materials were considered in making the initial determination;

(e) The claimant or claimant's representative shall be provided upon request, and without charge, reasonable access to, and copies of all documents, records, and other information relevant to or considered in making the initial adverse claim determination; and

(f) The review shall be a *de novo* proceeding and shall consider all information, documents, or other material submitted in connection with the appeal without regard to whether the information was considered in making the claim denial.

II. In the appeal of a claim denial that is based in whole or in part on a medical judgment:

(a) The review shall be conducted by or in consultation with a health care professional who has appropriate training and experience in the field of medicine;

(b) The titles and qualifying credentials of the person conducting the review shall be included in the decision; and

(c) The identity and qualifications of any medical or vocational expert whose advice was considered, without regard to whether it was relied upon in making the initial claim denial, shall be made available to the claimant upon request.

III. In the appeal of a claim for urgent care, a claim involving a matter that would seriously jeopardize the life or health of a covered person or would jeopardize the covered person's ability to regain maximum function, or a claim concerning an admission, availability of care, or the continued stay or health care service for a person who has received emergency services, but who has not been discharged from a facility, an expedited appeal process shall be made available which shall provide for:

(a) The submission of information by the claimant to the carrier by telephone, facsimile, or other expeditious method; and

(b) The determination of the appeal shall be made not more than 72 hours after the submission of the completed request for appeal.

IV. Timing and Notification for Determination on Appeal.

(a) In the case of nonexpedited appeal of a pre-service claim or a post-service claim, the determination on appeal shall be made within a reasonable time appropriate to the medical circumstances, but in no event more than 30 days after receipt by the carrier or other licensed entity of the claimant's appeal.

(b) In the case of an expedited appeal related to an urgent care claim, a carrier or other licensed entity shall make a decision and notify the covered person as expeditiously as the covered person's medical condition requires, but in no event more than 72 hours after the appeal is filed. If the expedited review involves ongoing urgent care services, the service shall be continued without liability to the covered person until the covered person has been notified of the determination. A carrier or other licensed entity shall provide written confirmation of its decision concerning an expedited review within 2 business days of providing notification of that decision, if the initial notification was not in writing.

(c) The period of time within which a decision shall be rendered on appeal shall begin to run at the time the appeal is filed in accordance with the appeal procedures of the carrier or other licensed entity, without regard to whether all the information necessary to make a determination on appeal is contained in the filing. In the event the claimant fails to submit information necessary to decide the appeal, the period for making the determination on appeal shall be tolled from the date the claimant is notified in writing of what additional information is required until the date the claimant responds to the request. The carrier or other licensed entity shall provide notification of incompleteness as soon as possible; but in no event more than 24 hours after the filing of the appeal in appeals involving urgent care. In the event that the claimant fails, within a 45-day period from the date of notification, to provide sufficient information, the carrier may deny the appeal on the basis of incompleteness. The appeal may be reopened upon receipt of the required information.

V. Manner and Content of Notification of Determination on Appeal.

(a) The carrier or other licensed entity shall provide a claimant with a written determination of the appeal that shall include:

(1) The specific reason or reasons for the determination, including reference to the specific provision, rule, protocol, or guideline on which the determination is based;

(2) A statement that the rule, protocol, or guideline governing the appeal will be provided without charge to the claimant upon request;

(3) A statement describing all other dispute resolution options available to the claimant, including, but not limited to other options for internal review options for external review, and options for bringing a legal action;

(4) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;

(5) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the claim denial, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the claim denial and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;

(6) If the claim denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the denial, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

(7) The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency;" and

(8) A statement describing the claimant's right to contact the insurance commissioner's office for assistance which shall include a toll-free telephone number and address of the commissioner.

(b) A carrier or other licensed entity that offers group health plans, employee benefit plans, or disability plans shall file with the commissioner a certificate of compliance by, April 1 of each year, stating that the carrier or other licensed entity has established and maintained, for each of its health benefit plans, grievance procedures that fully comply with the provisions of this chapter. Material modifications to the procedure shall be filed with the commissioner prior to becoming effective.

(c) A carrier or other licensed entity that offers group health plans, employee benefit plans, or disability plans shall maintain written records documenting all grievances and appeals received during a calendar year, a general description of the reason for the appeal or grievance, the name of the claimant, the dates of the appeal or grievance and the date of resolution.

(d) A carrier or other licensed entity which offers group health plans, employee benefit plans, or disability plans shall provide to consumers:

(1) A description of the internal grievance procedure for claim determinations and other matters. The description shall be set forth in or attached to the policy, certificate, membership booklet, or other evidence of coverage provided to covered persons;

(2) A statement of a covered person's right to contact the commissioner's office for assistance at any time. The statement shall include the toll-free telephone number and address of the commissioner; and

(3) A statement that the carrier or other licensed entity will provide assistance in preparing an appeal of an adverse benefit determination, and a toll-free telephone number to contact the carrier or other licensed entity.

(e) In any case where a carrier or other licensed entity that offers group health plans, employee benefit plans, or disability plans provides 2 levels of appeal for the pre-service claim determinations, the first level shall be completed within 15 days and the second level completed within the 30-day time period beginning from the initial date of filing the appeal or grievance. With respect to a second level appeal involving a claim for continuation of services or urgent care, the carrier or other licensed entity shall make a decision and notify the claimant within 72 hours after the second level appeal is filed. For second level appeals involving a post-

service claim, the carrier shall make a decision and notify the claimant within 60 days of the date the appeal was filed.

(f) Annual reports shall be made to the insurance commissioner regarding plan complaints, claim denials, and prior authorization statistics in such form and containing such information as the commissioner may prescribe by rule or otherwise.

VI. In an appeal of a claim denial or other matter, the claimant may authorize a representative to pursue a claim or an appeal by submitting a written statement to the carrier or other licensed entity that acknowledges the representation.

VII. No fees or costs shall be assessed against a claimant related to a request for a grievance or appeal.

4 New Paragraph; Definition Added. Amend RSA 420-E:1 by inserting after paragraph I the following new paragraph:

I-a. "Claim involving urgent care" means any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

(a) Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or

(b) In the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

5 New Paragraph; Definition Added. Amend RSA 420-E:1 by inserting after paragraph III the following new paragraph:

III-a. "Pre-service claim" means any claim for a benefit under a health plan with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

6 Licensure of Medical Utilization Review Entities; Minimum Standards. RSA 420-E:4 is repealed and reenacted to read as follows:

420-E:4 Minimum Standards; Licensure of Medical Utilization Review Entities. All licensees shall establish and maintain a utilization review procedure by which a claimant or claimant's representative may seek a claim benefit determination. The procedure shall meet the following minimum standards:

I. The licensee shall maintain a toll-free telephone number to ensure that a representative of the licensee shall be accessible by telephone to insureds, patients, and providers 7 days a week during normal working hours.

II. Claim benefit determinations shall be made by a licensed or certified health care provider.

III. Clinical review criteria considered or utilized in making claim benefit determinations shall be:

(a) Developed with input from appropriate actively practicing practitioners in the carrier or other licensed entity's service area;

(b) Updated at least biennially and as new treatments, applications, and technologies emerge;

(c) Developed in accordance with the standards of national accreditation entities:

(d) Based on current, nationally accepted standards of medical practice; and

(e) If practicable, evidence-based.

IV. Notification of claim benefit determinations shall be made within the following time periods:

(a) The determination of a claim involving urgent care shall be made as soon as possible, taking into account the medical exigencies, but in no event later than 72 hours after receipt of the claim, unless the claimant or claimant's representative fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable. In the case of such failure, the licensee shall notify the claimant or claimant's representative within 24 hours of receipt of the claim and shall advise the claimant or claimant's representative of the

specific information necessary to determine the claim. The 72-hour period shall be tolled until such time as the claimant submits the required information.

(b) The determination of a claim relating to the extension of an ongoing course of treatment and involving a question of medical necessity shall be made within 24 hours of receipt of the claim, provided that the claim is made at least 24 hours prior to the expiration of the prescribed period of time or course of treatment. In the event the claimant or claimant's representative fails to provide sufficient notice or sufficient information, the licensee shall notify the claimant or claimant's representative within 24 hours of the receipt of the claim and shall advise the claimant or claimant's representative of the specific information necessary to determine the claim. Services shall not be terminated during the pendency of the determination proceeding.

(c) The determination of all other claims for benefits shall be made within a reasonable time period, but in no event more than 15 days after receipt of the claim, unless the claimant or claimant's representative fails to provide sufficient information to determine whether, or to what extent, benefits are covered as payable. In the case of such failure, the licensee shall notify the claimant or claimant's representative within 5 days of receipt of the claim. The 15-day period shall be tolled until such time as the claimant or claimant's representative submits the required information.

V. The manner and content of notification of claim benefit determinations shall be as follows:

(a) The licensee shall notify the claimant or claimant's representative in writing or electronically of the claim determination.

(b) The notification shall state the specific reason or reasons for the determination and shall refer to the specific provision of the policy or plan on which the determination is based.

(c) The notification shall include a statement of the claimant's right or the right of the claimant's representative to access the internal grievance process and the process for obtaining external review. The notification shall also include a written explanation of any claim denial, with the name and credentials of the carrier or other licensed entity medical director; including board status and the state or states where the person is currently licensed, and the relevant clinical rationale used to make the claim denial. If the person making the claim denial is not the medical director but a designee, then the credentials, board status, and state or states of current license shall also be provided for that person. Nothing in this section shall be construed to require a carrier or other licensed entity to provide proprietary information protected by third party contracts.

(d) If an internal rule, guideline, protocol, or other similar provision was relied upon in making the benefit determination, the determination shall reference the specific rule, guideline, protocol, or other similar provision; and shall include a statement that such a rule, guideline, protocol, or other similar provision was relied upon in making the claim denial and that a copy of such rule, guideline, protocol, or other provision will be provided free of charge to the claimant or claimant's representative upon request.

(e) If the claim denial is based on a medical necessity or experimental treatment or other similar exclusion or limit, the determination shall include an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan or the policy to the claimant's medical circumstances.

(f) Any clinical review criteria that are used by the carrier or other licensed entity or its designee utilization review entity as the basis of an claim denial shall be disclosed to the treating provider and the claimant. Such disclosure shall be accompanied by the following notice: "The materials provided to you are criteria used by this plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract."

(g) In the case of a denial of a benefit concerning a claim involving urgent care or in the case of a denial of a claim related to continuation of an ongoing course of treatment for a person who has received emergency services, but who has not been discharged from a facility, a

description of the expedited review applicable to such a claim shall be included in the determination. For all other claim benefit determinations, a description of the grievance process shall be specifically described in the determination.

VI. A licensee shall file with the department a copy of the materials designed to inform patients of the requirements of the utilization plan and the responsibilities and rights of patients under the plan and an acknowledgment that all applicable state and federal laws to protect the confidentiality of individual medical records are followed.

VII. In any request for a benefit determination, the claimant may authorize a representative to pursue the claim or benefit determination by submitting a written statement to the licensee that acknowledges the representation.

VIII. No fees or costs shall be assessed against a claimant related to a request for claim benefit determination.

7 Reference Change. Amend RSA 420-E:6 to read as follows:

420-E:6 Periodic Reviews. The commissioner or [~~his~~] designee may conduct periodic reviews of the operations of the entities licensed under this chapter to ensure that they continue to meet the minimum standards set in RSA 420-E:4 and any applicable rules adopted by the commissioner. The commissioner may perform periodic telephone audits of licensees to determine if representatives of the licensee are reasonably accessible, as required in RSA 420-E:4, [~~III~~] ***I***.

8 Reference Changes. Amend RSA 420-E:7, III and IV to read as follows:

III. The time period for notification of determination as required under RSA 420-E:4, [~~I~~] ***IV***.

IV. Standards for telephone accessibility as required under RSA 420-E:4, [~~III~~] ***I***.

9 Reference Change. Amend RSA 420-E:7, X to read as follows:

X. Qualification of the reviewer, as required under RSA 420-E:4, [~~V~~] ***II***.

10 New Paragraphs; Definitions. Amend RSA 420-J:3 by inserting after paragraph V the following new paragraphs:

V-a. "Claim involving urgent care" means any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

(a) Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or

(b) In the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

V-b. "Claimant's representative" shall mean an individual authorized by a claimant in writing to pursue a claim or appeal on the claimant's behalf.

11 New Paragraphs; Definitions. Amend RSA 420-J:3 by inserting after paragraph XXVIII the following new paragraphs:

XXVIII-a. "Post service claim" means any claim for a health or disability benefit to which the terms of the plan do not condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining the medical care or disability benefit. "Post-service claim" shall not include a request for reimbursement made by a provider pursuant to the terms of an agreement between the provider and the health carrier.

XXVIII-b. "Pre-service claim" means any claim for a benefit under a health plan with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care. "Pre-service claim" shall not include a request for reimbursement made by a provider pursuant to the terms of an agreement between the provider and the health carrier.

12 Grievance Procedures. RSA 420-J:5 is repealed and reenacted to read as follows:

420-J:5 Grievance Procedures. Every carrier or other licensed entity shall establish and shall maintain a written procedure by which a claimant or a representative of the claimant, shall have a reasonable opportunity to appeal a claim denial to the carrier or other licensed entity, and

under which there shall be a full and fair review of the claim denial. The written procedure filed with the insurance department shall include all forms used to process an appeal.

I. Full and fair review shall require that:

(a) The persons reviewing the grievance shall not be the same person or persons making the initial determination, and shall not be subordinate to or the supervisor of the person making the initial determination;

(b) The person reviewing the grievance on a first or second level appeal have appropriate medical and professional expertise and credentialing to competently render a determination on appeal;

(c) The claimant shall have at least 180 days following receipt of a notification of a claim denial to appeal;

(d) The claimant shall have an opportunity to submit written comments, documents, records, and other information relating to the claim without regard to whether those documents or materials were considered in making the initial determination;

(e) The claimant shall be provided upon request, and without charge, reasonable access to, and copies of all documents, records, and other information relevant to or considered in making the initial adverse claim determination; and

(f) The review shall be a *de novo* proceeding and shall consider all information, documents, or other material submitted in connection with the appeal without regard to whether the information was considered in making the denial.

II. In the appeal of a claim denial that is based in whole or in part on a medical judgment:

(a) The review shall be conducted by or in consultation with a health care professional who has appropriate training and experience in the field of medicine;

(b) The titles and qualifying credentials of the person conducting the review shall be included in the decision; and

(c) The identity and qualifications of any medical or vocational expert whose advice was considered, without regard to whether it was relied upon in making the initial claim denial, shall be made available to the claimant upon request.

III. In the appeal of a claim for urgent care, a claim involving a matter that would seriously jeopardize the life or health of a covered person or would jeopardize the covered person's ability to regain maximum function, or a claim concerning an admission, availability of care, continued stay or health care service for a person who has received emergency services, but who has not been discharged from a facility, an expedited appeal process shall be made available which shall provide for:

(a) The submission of information by the claimant to the carrier by telephone, facsimile, or other expeditious method; and

(b) The determination of the appeal not more than 72 hours after the submission of the request for appeal.

IV. Timing and Notification for Determination on Appeal

(a) In the case of nonexpedited appeal of a pre-service claim or post-service claim, the determination on appeal shall be made within a reasonable time appropriate to the medical circumstances, but in no event more than 30 days after receipt by the carrier or other licensed entity of the claimant's appeal.

(b) In the case of an expedited appeal related to an urgent care claim, a carrier or other entity shall make a decision and notify the covered person as expeditiously as the covered person's medical condition requires, but in no event more than 72 hours after the appeal is filed. If the expedited review involves ongoing urgent care services, the service shall be continued without liability to the covered person until the covered person has been notified of the determination. A carrier or other licensed entity shall provide written confirmation of its decision concerning an expedited review within 2 business days of providing notification of that decision, if the initial notification was not in writing.

(c) The period of time within which a decision shall be rendered on appeal shall begin to run at the time the appeal is filed in accordance with the appeal procedures of the carrier or other licensed entity, without regard to whether all the information necessary to make a determination on appeal is contained in the filing. In the event the claimant fails to submit information necessary to decide the appeal, the period for making the determination on appeal shall be tolled from the date the claimant is notified in writing of precisely what is required until the date the claimant responds to the request. The carrier or other licensed entity shall provide notification of incompleteness as soon as possible; but in no event more than 24 hours after the filing of the appeal in appeals involving urgent care. In the event that the claimant fails, within a 45-day period from the date of notification, to provide sufficient information, the carrier may deny the appeal on the basis of incompleteness. The appeal may be reopened upon receipt of the required information.

V. Manner and Content of Notification of Determination on Appeal

(a) The carrier or other licensed entity shall provide a claimant with a written determination of the appeal that shall include:

(1) The specific reason or reasons for the determination, including reference to the specific provision, rule, protocol, or guideline on which the determination is based;

(2) A statement that the rule, protocol, or guideline governing the appeal will be provided without charge to the claimant upon request;

(3) A statement describing all other dispute resolution options available to the claimant, including, but not limited to other options for internal review and options for external review and options for bringing a legal action;

(4) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;

(5) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the claim denial, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the claim denial and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;

(6) If the claim denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the denial, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

(7) The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency;" and

(8) A statement describing the claimant's right to contact the insurance commissioner's office for assistance which shall include the toll-free telephone number and address of the commissioner.

(b) A carrier or other licensed entity that offers group health plans, employee benefit plans, or disability plans shall file annually with the commissioner, as part of its annual report required by RSA 420-J:5, V(g), a certificate of compliance stating that the carrier or other licensed entity has established and maintained, for each of its health benefit plans, grievance procedures that fully comply with the provisions of this chapter. Material modifications to the procedure shall be filed with the commissioner prior to becoming effective.

(c) A carrier or other licensed entity that offers group health plans, employee benefit plans, or disability plans shall maintain written records documenting all grievances and appeals received during a calendar year, a general description of the reason for the appeal or grievance, the name of the claimant, the dates of the appeal or grievance and the date of resolution.

(d) A carrier or other licensed entity that offers group health plans, employee benefit plans, or disability plans shall provide to consumers:

(1) A description of the internal grievance procedure required under RSA 420-J:5 for claim denials and other matters and a description of the process for obtaining external review under RSA 420-J:5-a - RSA 420-J:5-e. These descriptions shall be set forth in or attached to the policy, certificate, membership booklet, or other evidence of coverage provided to covered persons.

(2) A statement of a covered person's right to contact the commissioner's office for assistance at any time. The statement shall include the toll-free telephone number and address of the commissioner.

(3) A statement that the carrier or other licensed entity will provide assistance in preparing an appeal of an adverse benefit determination, and a toll-free telephone number to contact the carrier or other licensed entity.

(e) In any case where a carrier or other licensed entity provides 2 levels of appeal, the first level shall be completed within 15 days and the second level completed within the 30-day time period beginning from the initial date of filing the appeal or grievance. With respect to a second level appeal involving a claim for continuation of services or urgent care, the carrier or other licensed entity shall make a decision and notify the claimant within 72 hours after the second level appeal is filed. For appeals involving post service claims, the carrier shall make a decision and notify the claimant within 60 days of the date the completed appeal was filed.

(f) Annual reports shall be made to the insurance commissioner regarding plan complaints, adverse determinations, claim denials, and prior authorization statistics in such form and containing such information as the commissioner may prescribe by rule or otherwise.

(g) If the claimant has filed an appeal and the carrier or other licensed entity has not issued a decision within the required time frames, the carrier or other licensed entity shall promptly provide the claimant with a statement of the claimant's right to file an external appeal as provided in RSA 420-J:5-a - RSA 420-J:5-e. The statement of appeal rights shall include a description of the process for obtaining external review of a determination, a copy of the written procedures governing external review, including the required time frames for requesting external review, and notice of the conditions under which expedited external review is available.

VI. In an appeal of a claim denial or other matter, the claimant may authorize a representative to pursue a claim or an appeal by submitting a written statement to the carrier or other licensed entity that acknowledges the representation.

VII. No fees or costs shall be assessed against a claimant related to a request for a grievance or appeal.

13 Utilization Review. RSA 420-J:6, III is repealed and reenacted as follows:

III. Notification of a claim denial shall be made within the following time periods:

(a) The determination of a claim involving urgent care shall be made as soon as possible, taking into account the medical exigencies, but in no event later than 72 hours after receipt of the claim, unless the claimant or claimant's representative fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable. In the case of such failure, the licensee shall notify the claimant or claimant's representative within 24 hours of receipt of the claim and shall advise the claimant or claimant's representative of the specific information necessary to determine the claim. The 72-hour period shall be tolled until such time as the claimant submits the required information.

(b) The determination of a claim involving urgent care and relating to the extension of an ongoing course of treatment and involving a question of medical necessity shall be made within 24 hours of receipt of the claim, provided that the claim is made at least 24 hours prior to the expiration of the prescribed period of time or course of treatment. In the event the claimant or claimant's representative fails to provide sufficient notice or sufficient information, the licensee shall notify the claimant or claimant's representative within 24 hours of the receipt of the claim and shall advise the claimant or claimant's representative of the specific information necessary to determine the claim. If the determination relates to a reduction or termination of coverage for a course of treatment beyond the end of the period of time or number of treatments

previously approved, coverage for the services shall not be terminated during the pendency of the determination proceeding.

(c) The determination of all other claims for pre-service benefits shall be made within a reasonable time period, but in no event more than 15 days after receipt of the claim, unless the claimant or claimant's representative fails to provide sufficient information to determine whether, or to what extent, benefits are covered as payable. In the case of such failure, the licensee shall notify the claimant or claimant's representative within 5 days of receipt of the claim. The 15-day period shall be tolled until such time as the claimant or claimant's representative submits the required information.

14 New Paragraph; Definition Added. Amend RSA 420-J:3 by inserting after paragraph V the following new paragraph:

V-a. "Claim denial" means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

15 Reference Changes. Amend RSA 420-J:5-a, I(b) and (c) to read as follows:

(b) The covered person has completed the internal review procedures provided by the carrier or other ***licensed*** entity pursuant to RSA 420-J:5, [~~III through VI,~~] or the carrier or other entity has agreed to submit the determination to independent external review prior to completion of internal review, or the covered person has requested first or second level, standard or expedited review and has not received a decision from the carrier or other ***licensed*** entity within the required time frames;

(c) The covered person or the covered person's authorized representative has submitted the request for external review in writing to the commissioner within 180 days of the date of the carrier or other ***licensed*** entity's second level denial decision provided pursuant to RSA 420-J:5, [~~V or VI,~~] or if the carrier or other ***licensed*** entity has failed to make a first or second level, standard or expedited review decision that is past due, within 180 days of the date the decision was due;

16 Reference Change. Amend RSA 420-H:4, VI to read as follows:

VI. For companies or insurers providing health insurance through a managed care system of health care delivery or reimbursement, a description of the grievance procedures as required pursuant to RSA 420-J:5[~~, II(a)~~].

17 Effective Date. This act shall take effect January 1, 2002.

Insurance
May 2, 2001
2001-1096s
01/09

Amendment to SB 118

Amend the bill by replacing all after the enacting clause with the following:

1 Purpose. RSA 420-G:1, III is repealed and reenacted to read as follows:

III. To regulate underwriting and rating practices in the small employer and individual markets so as to promote access to affordable coverage for higher risk groups or individuals.

2 Ratio Changed. Amend RSA 420-G:4, I(a)(2) to read as follows:

(2) Health carriers may modify such average premium as established pursuant to subparagraph I(a)(1) for age and health status only in accordance with the following limitations:

(A) The maximum premium differential for age as determined by ratio shall be [~~3~~] ***4*** to 1 ***for individual health insurance and 3 to 1 for small employer health insurance. The limitation shall not apply for determining rates for an attained age of less than 19.***

[~~(B) Health carriers modifying such average premium for age may do so only by using the following age brackets:~~
~~0 - 18~~
~~19 - 24~~
~~25 - 29~~
~~30 - 34~~
~~35 - 39~~
~~40 - 44~~
~~45 - 49~~
~~50 - 54~~
~~55 - 59~~
~~60 - 64~~
~~65 +~~]

[~~(C)~~] ***(B)*** In the individual market only, the maximum differential due to health status shall be [~~1.2~~] ***1.5*** to 1.

[~~(D)~~] ***(C)*** Permissible rating characteristics shall not include changes in health status after issue.

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

III. Health carriers shall actively market, issue, and renew all of the health coverages they sell in the [~~individual or~~] small employer market[~~,~~] to all [~~individuals or~~] small [~~employees~~] ***employers***.

4 Definition; Covered Lives. Amend RSA 404-G:2, V to read as follows:

V. "Covered lives" shall include all persons living or working in New Hampshire for which a carrier provides health insurance evidenced by a policy or a group certificate issued in New Hampshire. For group excess loss insurance, or other types of group health insurance for which no certificates are issued, covered lives shall mean those New Hampshire employees and their dependents who are protected, in part, by a policy ***or a certificate***, issued in New Hampshire, and purchased by a group health insurance plan subject to the Employee Retirement Income Security Act of 1974, Public Law No. 93-406 (ERISA).

5 New Paragraphs; Definitions Added. Amend RSA 404-G:2 by inserting after paragraph X the following new paragraphs:

X-a. "Plan of operation" means the plan of operation of the risk sharing mechanism and the high risk pool, including articles, bylaws and operating rules, procedures and policies adopted by the association.

X-b. "Pool" means the New Hampshire health insurance high risk pool.

6 Association's Powers and Duties. RSA 404-G:3 is repealed and reenacted to read as follows:

404-G:3 Association's Powers and Duties.

I. The association shall be a not-for-profit, voluntary corporation under RSA 292 and shall possess all general powers as derive from that status and such additional powers and duties as are approved by the commissioner or as specified below.

II. The board of directors of the association shall have the following powers:

(a) Enter into contracts as necessary or proper to administer the plan of operation.

(b) Sue or be sued, including taking any legal action necessary or proper for the recovery of any assessments for, on behalf of, or against members of the association or other participating person.

(c) Take legal action as necessary to avoid the payment of improper claims against the plan or to defend the coverage provided by or through the pool.

(d) Oversee the issuance of policies of insurance and certificates or evidences of coverage.

(e) Retain appropriate legal, actuarial, and other persons as necessary to provide technical assistance in the operation of the plan, policy development, and other contract design and in any other function within the authority of the plan.

(f) Borrow money to carry out the plan of operation.

(g) Provide for reinsurance of risks incurred.

(h) Perform any other functions within the authority of the association as may be necessary or proper to carry out the plan of operation.

III. The board of directors of the association shall have the following duties:

(a) Fulfill the plan of operation as approved by the commissioner.

(b) Issue policies of insurance to persons eligible for the high risk pool.

(c) Prepare certificate of eligibility forms and enrollment instruction forms.

(d) Determine and collect assessments for the risk sharing mechanism and for the high risk pool.

(e) Disburse assessment payments, as provided in the plan of operation for the high risk pool.

(f) Establish appropriate rates, rate schedules, rate adjustments, expense allowances, agent referral fees, claim reserve formulas and any other actuarial functions appropriate to the plan of operation for the high risk pool.

(g) Provide for and employ cost-containment measures and requirements, which shall include but not be limited to, preadmission screening, second surgical opinion, concurrent utilization review, and individual case management for the purpose of making the benefit plan more cost effective.

(h) Develop a list of medical or health conditions the existence or history of which makes an individual eligible for participation in the high risk pool without first requiring application to a carrier for health coverage.

(i) In connection with the managed care coverage options required pursuant to RSA 404-G:5-a, III, design, utilize, contract or otherwise arrange for the delivery of cost-effective health care services, including establishing or contracting for administration and operation of the pool with a carrier, a preferred provider organizations, a health maintenance organizations, or any other network provider arrangement.

IV. Neither the association nor its employees shall be liable for any obligations of the plan. No member or employee of the association shall be liable, and no cause of action of any nature may arise against them, for any act or omission related to the performance of their powers and duties under this chapter unless such act or omission constitutes willful or wanton misconduct. The association may provide in its bylaws or rules for indemnification of, and legal representation for, its members and employees.

7 Association Membership and Governance. Amend RSA 404-G:4, II-VII to read as follows:

II. The initial board of directors of the association shall be the same as that set forth in the order. Except as provided in paragraph IV, each successor board shall consist of [~~5~~] ***6*** individuals who are representative of categories of members of the association***, health care providers, consumers who have purchased or are likely to purchase coverage from the pool,*** and the commissioner who shall be an ex-officio member. In the initial and in each successor board, 2 directors shall be representative of and elected by qualified writers of group health insurance [~~and 3~~]***, 2*** directors shall be eligible to receive a subsidy under this chapter and shall be representative of and elected by qualified writers of individual health insurance***, one***

director shall be representative of the health care provider community and shall be appointed by the commissioner, and one director shall be representative of consumers and shall be appointed by the commissioner.

III. There shall be no more than one director representing any one qualified writer or its affiliate. For purposes of this section, the insurance activities of any elected director's affiliate shall be deemed to be insurance activities of the elected director.

IV. Qualified writers of individual or group health insurance shall be those that provide coverage for at least 500 covered lives or 5 percent of the total covered lives in the relevant market. A member's votes for individual or group market representatives shall be proportional to the member's assessment in that market.

V. If, at any board election subsequent to the establishment of the initial board, one or more elected group representatives are also [~~writing~~] ***qualified*** individual health insurance ***writers***, then the membership of the board shall be altered by applying the provisions in subparagraphs (a) through (d) to such elected group representatives.

(a) If the elected group representative writing in the individual market is also an elected individual representative, then that member shall take a seat on the board as an individual representative and relinquish the group seat. The group writer with the next highest number of group votes shall take the relinquished group seat.

(b) If the elected group representative writing in the individual market is not also an elected individual representative, then [~~up to 2 directors~~] ***one director*** will be added to the board as follows:

(1) If the total size of the board-elect is [~~5 or~~] 6, the elected group representative shall remain on the board, but neither as a group or an individual representative, and the group writer with the next highest number of group votes shall join the board as a group representative; but

(2) If the total size of the board-elect is 7, the elected group representative shall not remain on the board and the group writer with the next highest number of group votes shall take the relinquished group seat.

(c) The provisions in subparagraphs (a) and (b) shall be applied to elected group representatives in the order of the number of votes received.

(d) The seats added to the board pursuant to subparagraph (b) shall not survive the term of the seat-holder.

VI. Members of the board of directors shall be elected to terms of one year.

VII. The board of directors shall take action by affirmative vote of [~~one~~] ***2*** less than the total number of directors.

8 Plan of Operation. RSA 404-G:5 is repealed and reenacted to read as follows:

404-G:5 Plan of Operation. The board of directors of the association shall adopt a plan of operation, which shall describe the operations of the risk sharing mechanism and the New Hampshire high risk pool. The plan of operation shall be submitted to the commissioner for approval prior to adoption by the board.

I. Description of the risk sharing mechanism. Sharing shall be implemented through a risk adjustment and subsidization mechanism whereby writers of health insurance will subsidize losses of writers in the individual market. The mechanism shall include parameters which will limit its costs and ensure proper claims management by the nongroup writers.

(a) The plan of operation for the risk sharing mechanism shall:

(1) Describe the risks to be shared;

(2) Describe the risk adjustment and subsidization mechanism;

(3) Establish the criteria and procedures to limit costs and ensure proper claims management by nongroup writers;

(4) Establish procedures to determine the amount of the subsidy for the risk sharing mechanism;

(5) Establish procedures for the handling and accounting of the money raised by assessment to fund the risk sharing mechanism, including the financial and other records to be kept; and

(6) Establish regular times and places for board meetings.

(b) Subsidy determination for the risk sharing mechanism. For a given calendar year, the subsidy calculations for the risk sharing mechanism shall be based on the experience of the prior year. Only individual health insurance writers who are actively marketing individual health insurance, in accordance with the provisions of RSA 420-G, during the calendar year in which the subsidy is distributed shall be eligible for a subsidy. For companies which utilize health status factors, only individuals whose coverage is written at the maximum allowable health status factors under RSA 420-G and whose coverage was issued prior to July 1, 2002 shall be eligible for a subsidy. For companies which do not utilize varied health status factors, all individuals whose coverage is written under RSA 420-G and whose coverage was issued prior to July 1, 2002 shall be eligible for a subsidy. The subsidy determination process shall recognize and compensate writers based on the risk characteristics of coverages eligible for consideration in the subsidy relative to standards established by the association board. Nothing in this chapter shall preclude the commissioner from approving a subsidy mechanism that fully compensates individual health insurers for all costs incurred on subsidy-eligible coverages on excess of the premiums collected from subsidy-eligible coverages.

(c) Assessment determination for the risk sharing mechanism.

(1) Assessment liabilities shall commence on the effective date of this chapter. The association shall calculate the assessment necessary to fund the risk sharing mechanism based on the number of covered lives. The number of covered lives shall be determined each month during the calendar year. The assessment shall be calculated as the number of covered lives times a specified amount. The specified amount shall be fixed throughout the calendar year and shall be determined by the board no later than the first day of November preceding the calendar year for which the amount is to be used. The amount shall be subject to approval by the commissioner. The board shall provide a basis for recommending the specified amount, including a projection of the calculated subsidy and consideration of any prior year shortfalls or overages.

(2) The commissioner shall approve such amount if he or she finds, after consideration of the:

(A) Board's subsidy determination process;

(B) Number of subsidy-eligible lives;

(C) Size of the entire non-group market;

(D) Morbidity experience of the subsidy-eligible lives; and

(E) Morbidity experience of the entire non-group market; that the amount petitioned by the board is no greater than is necessary to fulfill the purposes of this chapter. For the purpose of making this determination, the commissioner may, at the expense of the association, seek independent actuarial certification of the need for the increase.

(3) Each covered life should be included in the assessment only once. The board shall adopt procedures by which affiliated carriers calculate their assessment on an aggregate basis and procedures to ensure that no covered life is counted more than once.

II. The high risk pool shall be funded in part through an assessment mechanism whereby writers of health insurance contribute an amount sufficient to cover the expenses and losses of the pool not covered by premiums.

(a) The plan of operation for the high risk pool shall establish:

(1) Procedures for handling and accounting for the assets and moneys of the plan;

(2) Procedures for selecting and retaining a pool administrator;

(3) Procedures to establish and maintain public awareness of the plan, including its eligibility requirements and enrollment procedures;

(4) Procedures to create a fund, under management of the board, for administrative expenses;

(5) Procedures for the handling, accounting and auditing of assets, moneys and claims of the pool;

(6) Requirements for the financial and other records required to be kept;

(7) Regular times and places for meetings of the board; and

(8) Procedures by which applicants and participants can submit utilization review determinations and grievances to the pool administrator. The procedures shall ensure that utilization review determinations and grievances will be processed properly and in accordance with all statutory and regulatory requirements.

(b) The assessment shall be based on the number of covered lives times a specified assessment rate. The association shall specify the basis for calculating the amount of the assessment.

(c) The association shall establish a regular assessment rate which shall be:

(1) Calculated on a calendar year basis;

(2) Established no later than November first in the year preceding the calendar year for which the carrier's experience shall be used to calculate the assessment; and

(3) Anticipated to suffice the high risk pool's funding needs.

(d) In addition to the regular assessment rate, the association may establish a special assessment rate.

(1) The association shall only establish a special assessment if the association determines that its funds are or will become insufficient to pay the high risk pool's expenses in a timely manner.

(2) The association shall only assess, through the special assessment, at a rate necessary to fund the deficiency ascertained in subparagraph (1) above.

(e) The regular assessment rate, and any special assessment rates, shall be subject to the approval of the commissioner. The commissioner shall approve the rates if she or he finds that the amount is reasonable required to fulfill the purposes of the high risk pool. For the purpose of making this determination, the commissioner may, at the expense of the association, seek independent actuarial certification of the need for the proposed rates.

(f) The association shall impose and collect assessments from its members.

(g) If the assessment exceeds the amount actually needed, the excess shall be held and invested and, with the earnings and interest thereon, be used to offset future net losses.

(h) Each covered life should be included in the assessment only once. The association shall adopt procedures by which affiliated carriers calculate their assessment on an aggregate basis and procedures to ensure that no covered life is counted more than once.

(i) The initial assessment rate to fund the high risk pool shall be 60 cents per covered life per month, and shall take effect on policies or certificates issued or renewed on or after July 1, 2001.

9 New Sections; High Risk Pool; Administrator; Premiums; Eligibility. Amend RSA 404-G by inserting after section 5 the following new sections:

404-G:5-a High Risk Pool.

I. There is hereby created the New Hampshire high risk pool. This pool shall operate subject to the supervision and control of the association and shall offer policies of insurance on or after July 1, 2002. The pool shall offer health care coverage consisting of 4 benefit plans, 2 of which shall be managed care plans.

II. The coverage to be issued by the plan, a schedule of benefits, exclusions and other limitations shall be established by the association subject to the approval of the commissioner. In establishing the plan coverage, the association shall take into consideration the levels of health insurance coverage provided in the state and medical economic factors as may be deemed appropriate and shall promulgate benefit levels, deductibles, coinsurance factors, exclusions and limitations determined to be generally reflective of and commensurate with comprehensive, major medical health insurance coverage provided in the state. The association shall, utilizing standard morbidity assumptions, annually place a value on all plans presently being written or issued in the individual market. The association shall average these values, weighed according

to each plan's written premium volume, or some other suitable proxy, and utilizing the same standard morbidity assumptions, shall develop 2 coverage options: Option A and Option B.

III. The value of Option A developed by the association shall be 10 percent higher than the average value computed under paragraph II and the value of Option B shall be 10 percent lower than the average value computed under paragraph II. The association shall also provide a managed care version of Option A and a managed care version of Option B for a total of 4 plan choices.

IV. The insurance plans developed by the association shall comply with all applicable insurance laws and rules, except as provided herein.

V.(a) The pool shall be payer of last resort of benefits whenever any other benefit or source of third-party payment is available. The pool shall have a right of subrogation for any other health insurance coverage and by all hospital and medical expense benefits paid or payable under any workers' compensation coverage, automobile medical payment or liability insurance whether provided on the basis of fault or nonfault, and by any hospital or medical benefits paid or payables under or provided pursuant to any state or federal law or program.

(b) The pool shall have a cause of action against an eligible person for the recovery of the amount of benefits paid that are not for covered expenses. Benefits due from the plan may be reduced or applied as a set-off against any amount recoverable under this paragraph.

VI. The high risk pool shall be funded by premiums charged for coverage and by assessments which the association shall calculate based on the number of covered lives times a specified amount. The high risk pool shall not be funded with state general fund revenue.

404-G:5-b High Risk Pool Administrator.

I. The board shall select a high risk pool administrator through a competitive bidding process to administer the pool. The board shall evaluate bids submitted based on criteria established by the board which shall include:

(a) The high risk pool administrator's proven ability to handle health insurance coverage to individuals;

(b) The efficiency and timeliness of the high risk pool administrator's claim processing procedures;

(c) An estimate of total charges for administering the pool;

(d) The high risk pool administrator's ability to apply effective cost containment programs and procedures and to administer the pool in a cost efficient manner; and

(e) The financial condition and stability of the high risk pool administrator.

II.(a) The high risk pool administrator shall serve for a period of at least 3 years and shall be subject to removal for cause; and

(b) At least one year prior to the expiration of each period of service by a high risk pool administrator, the association shall invite eligible entities, including the current high risk pool administrator to submit bids to serve as the high risk pool administrator. Selection of the high risk pool administrator for the succeeding period shall be made at least 6 months prior to the end of the current period.

III. The high risk pool administrator shall perform such functions relating to the plan as may be as assigned to it, including:

(a) The determination of eligibility;

(b) The payment of claims, the development of procedures to ensure that each claim is promptly paid;

(c) The establishment of a premium billing procedure for collection of premium from persons covered under the pool;

(d) The acceptance of payments of premiums from insureds;

(e) The development of procedures to ensure that medical utilization reviews and grievance determinations are conducted in a fair and timely manner and in accordance with all statutory and regulatory requirements; and

(f) Other necessary functions to assure timely payment of benefits to covered persons under the pool.

IV. The high risk pool administrator shall submit regular reports to the association and the commissioner regarding the operation of the pool. The frequency, content and form of the report shall be specified in the contract between the association and the high risk pool administrator.

V. Following the close of each calendar year, the high risk pool administrator shall determine net written and earned premiums, the expense of administration, and the paid and incurred losses for the year and report this information to the association and the commissioner on a form prescribed by the commissioner.

VI. The high risk pool administrator shall be paid as provided in the contract between the association and the high risk pool administrator.

VII. The association shall submit the contract between itself and the high risk pool administrator to the commissioner for approval.

VIII. The association may select more than one administrator for the high risk pool.

404-G:5-c Premiums.

I. Premiums charged for the policies issued by the plan shall be based on the standard risk rate calculated pursuant to paragraph II of this section.

II. The standard risk rate shall be calculated using the average rate, based on the lowest allowable health status factor, for health benefit plan or policies which are presently available in New Hampshire and adjusted for the difference in the actuarial value of the pool's plans relative to these available plans using the factors derived pursuant to RSA 404-G:5-a, II.

III. Premium rates for coverage under the plan shall not exceed 150 percent of the standard risk rate established pursuant to paragraph II of this section for Option A–Managed Care and Option B–Managed Care, and 150 percent for the non-managed care versions of Option A and Option B. The association shall charge high risk pool enrollees a premium charge based on the standard rate for the plan adjusted for the attained age of the high risk pool enrollee. The adjustment for attained age shall conform to the provisions of RSA 420-G.

IV. All premium rates and rate schedules shall be submitted to the commissioner for approval.

404-G:5-d Eligibility.

I. An individual who is a New Hampshire resident shall be eligible for coverage through the high risk pool if:

(a) The individual has applied to a carrier of individual health insurance for coverage that is substantially similar to the coverage that is available through the pool, and the carrier has refused to write or issue that coverage to that individual because of his or her health or medical condition;

(b) The individual has applied to a carrier of individual health insurance for coverage that is substantially similar to the coverage that is available through the pool, and such application has been accepted, but at a premium rate exceeding the rate available through the pool; or

(c) The individual has a history of any medical or health condition that is on a list adopted by the association.

II. The association shall promulgate a list of medical or health conditions for which a person shall be eligible for plan coverage without applying for health insurance coverage. Persons who can demonstrate the existence or history of any medical or health conditions on the list promulgated by the association shall not be required to provide evidence of a notice of rejection or refusal. The list shall be effective on the first day of the operation of the pool and may be amended from time to time as may be appropriate.

III. Each resident dependent of a person who is eligible for pool coverage shall also be eligible for pool coverage. If the primary insured is a child, resident family members shall also be eligible for pool coverage.

IV. New Hampshire residents who are presently insured through an individual policy shall be eligible for pool coverage only if the rate assessed by the individual carrier exceeds the pool rate.

V. An individual shall not be eligible for coverage under the pool if:

(a) The individual is eligible for employer sponsored health coverage, including continuation of group coverage, as either an employee or an eligible dependent; or

(b) The individual is eligible for publicly funded health insurance coverage, including Medicare, Medicaid or Title XXI; or

(c) The person's premiums are paid for or reimbursed under any government sponsored program or by any government agency or health care provider, except as an otherwise qualifying full-time employee, or dependent thereof, of a government agency or health care provider.

VI. Coverage shall cease:

(a) On the date a person is no longer a resident of this state;

(b) On the date a person requests coverage to end;

(c) Upon the death of the covered person;

(d) On the date state law requires cancellation of the policy; or

(e) At the option of the plan, 30 days after the plan makes any inquiry concerning the person's eligibility or place of residence to which the person does not reply.

404-G:5-e Application of Provisions of the Insurance Code.

I. The pool shall be subject to examination and regulation by the insurance department.

II. The following provisions of the title 37 shall apply to the pool to the extent applicable and not inconsistent with the express provisions of this chapter: RSA 415:5, 415:6, 415:6-a, 415:6-b, 415:6-c, 415:6-f, 415:6-g, 415:6-h, 415:7, 415:9 – 415:13, 415:22, 415:22-a, 415:22-b, 415:23, RSA 415-A, RSA 417, RSA 420-B:8, 420-B:8-b, 420-B:8-d, 420-B:8-e, 420-B:8-ee, 420-B:8-f, 420-B:8-ff, 420-B:8-g, 420-B:8-gg, 420-B:8-h, 420-B:8-i, 420-B:8-j, 420-B:8-k, 420-B:8-m, 420-B:11-12, RSA 420-C, RSA 420-E:4, RSA 420-G:7, 420-G:8, 420-G:11, RSA 420-H, RSA 420-I, and RSA 420-J:3. For the purposes of this chapter, the pool shall be deemed an insurer, pool coverage shall be deemed individual health insurance, and pool coverage contracts shall be deemed policies.

10 Examination and Annual Report. Amend RSA 404-G:7 to read as follows:

404-G:7 Examination and Annual Report. The association shall be subject to examination by the commissioner. The board of directors shall submit to the commissioner each year, not later than 120 days after the association's fiscal year, a financial report in a form approved by the commissioner and a report of its activities during the proceeding fiscal year. ***The report shall summarize the activities of the risk sharing mechanism and the high risk pool in the preceding calendar year, including the net written and earned premiums, enrollment, the expense of administration, and the paid and incurred losses.*** The association's fiscal year shall be the calendar year.

11 New Paragraphs; Notice to Residents; Unfair Referral to the Pool. Amend RSA 420-G:5 by inserting after paragraph III the following new paragraphs:

IV. Individual health insurance carriers shall be responsible for ascertaining the eligibility of any individual applicant or insured for high risk pool coverage. If a carrier determines that an individual meets any of the eligibility criteria set forth in RSA 404-G:5-d, the carrier shall give the individual written notice, with the declination of coverage, the coverage offering or the renewal rate quote as applicable. The notice shall include information about available benefits and exclusions of high risk pool coverage and the name, address, and telephone number of the pool administrator or the administrator's designee.

V. It shall constitute an unfair trade practice under RSA 417 for an insurer, insurance producer, or third party administrator to refer an individual employee to the pool, or arrange for an individual employee to apply to the pool, for the purpose of separating that employee from group health insurance coverage provided in connection with the employee's employment.

12 Repeal. RSA 420-G:6, IV, relative to high risk pools, is repealed.

13 Emergency Rules. In the event that approvals required for the high risk pool have not been obtained by July 1, 2002, the commissioner of insurance may adopt emergency rules to establish a high risk pool.

14 Effective Date.

I. Section 8 of this act shall take effect July 1, 2001.

II. The remainder of this act shall take effect July 1, 2002, provided that the board established in RSA 404-G has obtained all approvals required for the high risk pool and policies of insurance are available through the high risk pool.

2001-1096s

AMENDED ANALYSIS

This bill establishes the health insurance risk pool for the purposes of individual health insurance coverage.

Insurance
May 2, 2001
2001-1097s
01/09

Amendment to SB 119

Amend the bill by replacing all after the enacting clause with the following:

1 Purpose Revised. Amend RSA 420-G:1, III to read as follows:

III. To [~~prohibit or~~] constrain underwriting and rating practices in the small employer [~~and individual~~] markets, so as to prevent health carriers from excluding higher risk applicants from coverage or charging unaffordable premium rates to those unable to meet selection standards. With the help of the mandatory risk sharing mechanism described in RSA 404-G, nongroup health carriers will be expected to manage the risk of individuals having above average experience.

2 Definitions Added. Amend RSA 420-G:2, I to read as follows:

420-G:2 Definitions. In this chapter:

I. [~~"Community rating"~~] ***"Adjusted community rating"*** means a rating methodology [~~which produces the same premium for every person covered under the same health coverage~~] ***used to establish the premium rates for health plans adjusted to reflect actuarially demonstrated differences in utilization or cost attributable to case characteristics.***

I-a. "Case characteristics" means demographic or other relevant characteristics of a small employer. For purposes of this chapter, allowable case characteristics include only age, family composition, geographical area, and group size. Case characteristics may be considered by the health carrier in the determination of premium rates for the small employer. Claim experience, health status, and duration of coverage since issue are not case characteristics for the purpose of this chapter.

3 Definition of Large Employer. Amend RSA 420-G:2, XII(a) to read as follows:

XII.(a) "Large employer" means an employer that employed on average at least [~~101~~] ***51*** persons, on business days, during the previous calendar year.

4 Definition of Small Employer. 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 [~~100~~] ***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.

5 Premium Rates for Small Employers. RSA 420-G:4, I is repealed and reenacted to read as follows:

I. Health carriers providing health coverage to small employers under this chapter shall be subject to the following:

(a) All premiums charged to small employers shall be based on an adjusted community rating basis and shall be guaranteed for at least 6 months.

(b) An unadjusted community premium rate shall be set by each carrier for each membership (or family composition) type.

(c) Health carriers may modify the unadjusted community premium rate to calculate an adjusted community rate in accordance with the following:

(1) The maximum premium differential for age as determined by ratio shall be 4 to 1 beginning with age 19.

(2) Health carriers modifying such average premium for age may do so only by using the following age brackets:

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

(3) Carriers may use group size as a rating factor; however, the highest factor based on group size shall not exceed the lowest factor based on group size by more than 20 percent.

(4) Carriers may use geographical area as a rating factor; however, the highest factor based on the geographical area of the employer and its employees cannot exceed the lowest factor based on geographical area by more than 20 percent.

(d) The same rating methodology shall apply to new small employers and small employers renewing at each annual renewal date or anniversary date. Rating methodology shall not be construed to include health carrier incentives to individual subscribers or members to participate in wellness and fitness programs provided such incentives are approved by the insurance department.

II. Health carriers providing health coverage to individuals shall be subject to the following:

(a) All premiums charged to individuals shall be based on a modified community rating basis and shall be guaranteed for at least 6 months.

(b) A community premium rate shall be set by each carrier for each membership (or family composition) type.

(c) Health carriers may modify the community premium rate to calculate a modified community rate in accordance with the following:

(1) The maximum premium differential for age as determined by ratio shall be 3 to 1.

(2) Health carriers modifying such average premium for age may do so only by using the following age brackets:

0 - 18
19 – 24
25 – 29

30 – 34
35 – 34
35 – 39
40 – 44
45 – 49
50 – 54
55 – 59
60 – 64
65 +

(3) Carriers may use health status to vary the modified community premium rate; however, the highest factor based on health status shall not exceed the lowest factor associated with health status by more than 20 percent.

(d) The same rating methodology shall apply to new individuals and individuals renewing at each annual renewal date or anniversary date. Rating methodology shall not be construed to include health carrier incentives to individual subscribers or members to participate in wellness and fitness programs provided such incentives are approved by the insurance department.

6 New Paragraph; Small Employer Groups. Amend RSA 420-G:6 by inserting after paragraph III the following new paragraph:

III-a. Health carriers shall not refuse to offer plans to small employer groups solely due to the employer's making other plans available to employees.

7 Open Enrollment and Late Enrollment. Amend RSA 420-G:8 by inserting after paragraph I the following new paragraph:

I-a. A one member small employer group shall be limited to 2 open enrollment periods, which shall occur during the months of June and December of each calendar year. During the open enrollment periods, carriers shall make their plans available to one member employer groups for effective dates of the first day of the month following the open enrollment period. A one member employer group seeking coverage during other times of the year shall be treated as a late enrollee.

8 Qualified Association Trust; Number of Employees Changed From 100 to 50. Amend RSA 420-G:4, I to read as follows:

I. Use the ***adjusted*** community rating methodology outlined in RSA 420-G:4 for all small employer members with [~~100~~] ***50*** or fewer employees based upon the associations group experience;

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

2001-1097s

AMENDED ANALYSIS

This bill revises the laws relative to small group health insurance. The bill changes the definition of small group employer to employers with 1-50 employees. Current law defines small group employers to have 1-100 employees.

Senate Judiciary
May 2, 2001
2001-1095s
09/03

Amendment to HB 203

Amend the bill by replacing section 3 with the following:

3 Effective Date. This act shall take effect July 1, 2001.

Senate Public Institutions, Health and Human Services
May 3, 2001
2001-1114s
08/09

Amendment to SB 167-FN-A

Amend the bill by replacing all after the enacting clause with the following:

1 Intent. The general court recognizes that all providers of long-term care should be paid for services in an equitable, understandable, and predictable manner, subject to federal reimbursement rules. Therefore, the general court hereby establishes a long-term care rate advisory committee to evaluate payments to long-term care providers.

2 New Sections; Long-Term Care Rate Advisory Committee. Amend RSA 151-E by inserting after section 6 the following new sections:

151-E:6-a Long-Term Care Rate Advisory Committee.

I.(a) There is hereby established a long-term care rate advisory committee to advise the department of health and human services regarding long-term care payment rates. The committee shall be appointed by the commissioner of the department of health and human services and shall consist of the following members:

(1) Two persons representing county nursing facilities, recommended by the New Hampshire Association of Counties.

(2) Two persons representing private nursing facilities, recommended by the New Hampshire Health Care Association.

(3) Two persons representing home health care providers, including one for-profit provider and one not-for-profit provider, recommended by the Home Health Care Association of New Hampshire.

(4) Two persons representing adult medical day care providers, recommended by the Adult Medical Day Care Providers Association.

(5) One person representing meals on wheels providers, recommended by the New Hampshire Nutrition Providers Association.

(6) One person representing transportation providers, recommended by the New Hampshire Association of Transportation Providers.

(7) One person representing other qualified agencies that provide personal care services, recommended by any such agencies.

(8) One person who is a geriatric psychiatrist.

(9) One person representing residential care providers, recommended by the Association of Residential Care Homes of New Hampshire.

(10) Two consumer representatives.

(11) Two persons representing ServiceLink New Hampshire, one from a rural area and one from an urban area, recommended by the ServiceLink New Hampshire network.

(12) One direct care provider of personal care.

(13) One certified nurse assistant, recommended by the New Hampshire board of nursing.

(14) One registered nurse, recommended by the New Hampshire board of nursing.

(b) The committee shall review the commissioner's rate setting structure for reimbursement of long-term care providers, required under paragraph II, and submit its report, together with its recommendation for legislation to the president of the senate, the speaker of the house, the governor and the executive council on or before September 1, 2002 and at least every 2 years thereafter.

II. The long-term care rate advisory committee shall evaluate long-term care provider rate payments and make recommendations to the department based on the equitability of reimbursement to providers, the understandablity of the rate structure, and predictability of the rate-setting process. The commissioner shall include the results and outcome of this analysis in the report required in subparagraph I(b). This analysis shall be completed periodically and not less frequently than every 2 years.

III. The commissioner of the department of health and human services shall continue to evaluate the effectiveness of the acuity-based payment system for medicaid payments for nursing facility care. The evaluation shall determine if the payment system is equitable, understandable, and predictable. If the payment system does not meet these criteria, the commissioner shall recommend changes that will meet these criteria by February 1, 2002.

IV. The changes required to the payment system for medicaid services in nursing facilities required in this section shall be completed as quickly as possible but no later than January 1, 2002.

151-E:6-b Memorandum of Agreement. The department of health and human services shall establish, by means of a memorandum of agreement with the New Hampshire Association of Counties, a mechanism for the receipt of input from the Association of Counties regarding the type, cost, utilization, and procedures relative to payments which the counties are obligated to make pursuant to RSA 167:18-b. The memorandum of agreement shall be reviewed annually and amended as may be determined to be necessary by the parties.

151-E:6-c Payment System for Nursing Facilities. The payment system for nursing facility level of care shall include, at a minimum:

I. Rate calculation worksheets for all providers will be provided at least 30 days prior to the effective date of any rate changes.

II. Acuity levels must be updated at least semi-annually, on a regular, predictable basis using the latest available data.

III. Any rate changes due to the updating of acuity or cost data shall occur only with proper prior notification and explanation to affected providers and the affected beneficiary population.

IV. Acuity normalization shall only occur concurrent with rebasing for the same historical time period.

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

2001-1114s

AMENDED ANALYSIS

This bill requires the commissioner of health and human services to develop a revised rate setting structure for medicaid payment of nursing home facility services. This bill also creates a long-term care rate advisory committee, which shall review the rate setting structure for reimbursement of nursing facilities established by the commissioner of health and human services and report on or before September 1, 2002 and at least every 2 years thereafter to the president of the senate, the speaker of the house, and the governor and executive council on the status of the rate setting structure.

HEARINGS

TUESDAY, MAY 8, 2001

BANKS, Room 103, LOB

8:30 a.m. **HCR 7**, urging the federal government to allow a deduction for personal credit card interest from the federal income tax.

8:50 a.m. **SB 51**, relative to financial holding companies.

EDUCATION, Room 105-A, SH

10:00 a.m. **SB 195-FN**, permitting the department of regional community-technical colleges to lease building space from the Pease development authority in exchange for a reduction in Pease development authority's debt owed to the state.

EXECUTIVE SESSION ON PENDING LEGISLATION

INTERNAL AFFAIRS, Room 103, LOB

2:45 p.m. **SB 1**, apportioning state senate districts.

3:00 p.m. **SB 3**, apportioning congressional districts.

3:20 p.m. **HB 707**, establishing a committee to study the usage of 211 as a uniform community service information and referral number.

3:40 p.m. **HB 554-FN**, establishing a division of information technology within the department of safety.

4:00 p.m. **HB 738**, establishing a commission to assess the operating efficiency of state government.

4:20 p.m. **HB 727**, making certain changes concerning the authority and operation of the port authority.

PUBLIC AFFAIRS, Room 105-A, SH

1:00 p.m. **SB 196**, relative to the review of wireless communications facility proposals of state agencies and of proposals received by local land use boards.

1:30 p.m. **HB 482**, relative to airport zoning.

2:00 p.m. **HB 131**, relative to the retention and disposal of certain financial disclosure forms.

2:30 p.m. **HB 226**, relative to instructions to voters for straight-ticket voting.

- **PLEASE NOTE THE FOLLOWING HEARINGS ARE RESCHEDULED FROM MAY 1ST**

PUBLIC INSTITUTIONS, HEALTH & HUMAN SERVICES, Room 101, LOB

1:00 p.m. **HB 332-FN-L**, (New Title) relative to resuscitation protocols for emergency medical care providers and relative to payment of autopsy expenses.

1:20 p.m. **HB 553-FN-L**, requiring background checks for nursing home employees.

1:45 p.m. **HB 635**, relative to family mutual support services.

2:15 p.m. **HB 643-FN**, (New Title) extending the moratorium on new nursing home beds.

TRANSPORTATION, Room 104, LOB

8:30 a.m. **HB 317-FN**, revising the New Hampshire Aeronautics Act.

9:00 a.m. **HB 413**, relative to ownership of rail properties.

9:30 a.m. **HB 258**, establishing a task force to conduct an ongoing study of the feasibility of re-establishing the Lawrence, Massachusetts to Manchester, New Hampshire rail service line and the Concord to Lebanon northern passenger rail service line.

EXECUTIVE SESSION WILL FOLLOW, TIME PERMITTING

WILDLIFE & RECREATION, Room 101, LOB

10:15 a.m. **HB 370**, relative to the regulation of the trapping by the fish and game department.

10:30 a.m. **HB 471-FN**, (New Title) relative to fish and game licenses issued to resident and nonresident minors and relative to complimentary fishing licenses for legally blind persons.

10:45 a.m. **HB 305-FN-A**, establishing a dedicated fund for certain fish and game funds to be expended for the purpose of operation game thief.

EXECUTIVE SESSION TO FOLLOW

WEDNESDAY, MAY 9, 2001

ENVIRONMENT, Room 104, LOB

8:30 a.m. **HB 186-FN-A**, establishing a pesticides training program.

8:45 a.m. **HB 612**, relative to expenditures from the dam maintenance fund by the department of environmental services.

JUDICIARY, Room 103, LOB

10:00 a.m. **SB 197-FN**, restructuring the judicial conduct committee as an independent judicial conduct commission.

10:15 a.m. **HB 120**, (New Title) relative to the membership of the department of youth development advisory board.

10:30 a.m. **HB 156**, relative to the detention of juveniles in delinquency proceedings.

10:45 a.m. **HB 265**, prohibiting the sale of rolling papers to minors.

11:00 a.m. **HB 210**, relative to the penalties for persons convicted of subsequent DWI offenses.

11:15 a.m. **HB 197**, extending the reporting date of the commission to study methods for reducing violent incidents involving children and guns.

11:30 a.m. **HB 446**, relative to spousal and child support enforcement.

THURSDAY, MAY 10, 2001

EXECUTIVE DEPARTMENTS & ADMINISTRATION, Room 104, LOB

1:00 p.m. **HB 302-FN**, relative to an optional retirement allowance for certain spouses upon a retiree's remarriage.

1:20 p.m. **HB 337-FN**, relative to the administration of the public utilities commission and establishing the position of executive director of the public utilities commission.

1:40 p.m. **HB 403**, relative to the effective date of special contracts for telephone utilities.

2:00 p.m. **HB 408-FN**, relative to the regulation of nursing by the board of nursing.

2:20 p.m. **HB 416**, relative to fire safety inspections for foster family homes.

2:40 p.m. **HB 448**, relative to procedures for crews and provision of counseling services following a railway accident.

EXECUTIVE SESSION TO FOLLOW

TUESDAY, MAY 15, 2001

PUBLIC AFFAIRS, Room 105-A, SH

1:00 p.m. **HCR 10**, supporting the electoral college.

1:30 p.m. **HB 376**, allowing county commissioners serving 4-year terms to vote at state party conventions.

2:00 p.m. **HB 723**, relative to vacancies in county offices.

2:30 p.m. **HB 614**, relative to certain duties, responsibilities, and authority of the fiscal committee.

WEDNESDAY, MAY 16, 2001

• PLEASE NOTE THE FOLLOWING HEARINGS HAVE BEEN CANCELLED AND RESCHEDULED FOR MAY 23RD

EDUCATION, Room 105-A, SH

Cancelled **HB 412**, (New Title) relative to requiring the public higher education study committee to study the feasibility of granting of state franchise rights to providers of on-line education courses.

Cancelled **HB 748-FN-A-L**, (New Title) relative to the distribution of aid to pupils eligible for free or reduced-price meals.

EXECUTIVE DEPARTMENTS & ADMINISTRATION, Room 104, LOB

1:15 p.m. **HB 206-FN-A**, establishing an equipment depository and disabled person's employment fund in the department of administrative services.

1:35 p.m. **HB 275**, relative to the expenditure of funds received pursuant to the Workforce Investment Act.

1:55 p.m. **HB 373**, (New Title) relative to surety bonds for detective agencies and security services.

2:15 p.m. **HB 387**, relative to the regulation of dentistry by the board of dental examiners.

2:35 p.m. **HB 453**, establishing a 4-year term for the commissioner of the department of corrections.

2:55 p.m. **HB 477-FN**, relative to supplemental allowances for certain retired group I members of the New Hampshire retirement system.

EXECUTIVE SESSION TO FOLLOW

INSURANCE, Room 101, LOB

8:45 a.m. **HB 394**, relative to short-term health insurance policies for certain persons.

9:15 a.m. **HB 488**, (New Title) establishing a task force to study certain issues regarding privacy.

9:35 a.m. **HB 595**, relative to single producer licensing.

JUDICIARY, Room 103, LOB

10:15 a.m. **HB 703**, relative to durable powers of attorney.

10:30 a.m. **HB 509**, (New Title) establishing a statute of limitations on spousal support orders.

10:45 a.m. **HB 620**, relative to arrangements between birth parents and adoptive parents.

11:00 a.m. **HB 764**, relative to interference with custody.

11:15 a.m. **HB 699**, relative to the rights of non-offending parents in the context of abuse and neglect cases.

11:30 a.m. **HB 680**, (New Title) relative to foreign reinsurers.

WAYS & MEANS, Room 103, SH

10:15 a.m. **SB 198-FN-A**, expanding the authority of the sweepstakes commission to establish a 2-year pilot program for video lottery games at state liquor stores, and making an appropriation therefor.

TUESDAY, MAY 22, 2001

PUBLIC AFFAIRS, Room 105-A, SH

1:00 p.m. **HB 224,** relative to persons who may sign nomination papers.

1:30 p.m. **HB 154**, (New Title) relative to candidates of parties nominated by nomination papers and relative to vacancies for office on a party ticket.

2:00 p.m. **HB 639**, (New Title) relative to the preparation of town ballots.

2:30 p.m. **HB 435**, relative to assessment of service charges by municipalities and counties that accept credit cards for payment of local taxes, utility charges, or other fees.

WEDNESDAY, MAY 23, 2001

• PLEASE NOTE THE FOLLOWING HEARINGS HAVE BEEN RESCHEDULED FROM MAY 16TH

EDUCATION, Room 105-A, SH

1:00 p.m. **HB 412**, (New Title) relative to requiring the public higher education study committee to study the feasibility of granting of state franchise rights to providers of on-line education courses.

1:15 p.m. **HB 748-FN-A-L**, (New Title) relative to the distribution of aid to pupils eligible for free or reduced-price meals.

MEETINGS

TUESDAY, MAY 8, 2001

JOINT LEGISLATIVE HISTORICAL COMMITTEE (RSA 17-I:1) Room 105-A, SH

9:00 a.m. Regular Meeting

GUARDIANS AD LITEM BOARD (SB 448, Chapter 321, Laws of 2000) Room 102, LOB

3:30 p.m. Regular Meeting

WEDNESDAY, MAY 9, 2001

• PLEASE NOTE THE FOLLOWING MEETING HAS BEEN CANCELLED AND RESCHEDULED FOR MAY 23RD

FISCAL COMMITTEE OF THE GENERAL COURT Rooms 210-211, LOB

Cancelled Regular Business

NH DEPARTMENT OF TRANSPORTATION (Colebrook 13255& 13256 NH Route 26 bridge replacements) Executive Council Chambers, SH

12:00 p.m. Special Committee Meeting

TOBACCO USE ADVISORY COMMITTEE (RSA 126-K:19) Department of Health and Human Services, 105 Pleasant Street, Concord, NH

2:30 p.m. - 4:30 p.m. Regular Meeting

FRIDAY, MAY 11, 2001

PRIMARY PREVENTION & WELLNESS (RSA 126-M:3) Room 207, LOB

10:00 a.m. Regular Meeting

MONDAY, MAY 14, 2001

SENATE FINANCE COMMITTEE WORK SESSION ON HB 1 AND HB 2 Room 103, SH

9:00 a.m.- 12:00 p.m. Work session

1:00 p.m. - 3:30 p.m. Work session

PERINATAL ALCOHOL, TOBACCO & OTHER DRUG USE TASK FORCE (RSA 132:19) Room 101, LOB

9:30 a.m. Regular Meeting

BOARD OF MANUFACTURED HOUSING (RSA 205-A:25) Room 201, LOB

1:00 p.m. Complaint Hearings

NH DEPARTMENT OF TRANSPORTATION (Acworth 13036, NH Route 123A/Cold River) Acworth Town Hall, Town Hall Road

7:00 p.m. Public Officials/Informational

TUESDAY, MAY 15, 2001

NH CIVIL WAR MEMORIALS COMMISSION (RSA 21-K:18) Room 203, LOB

2:00 p.m. Regular Meeting

NH DEPARTMENT OF TRANSPORTATION (Keene-Swanzey 10309, NH Route 9,19,12 & 101 Upgrade) Keene Public Library, 60 Winter Street, Keene, NH

6:30 p.m. Final Design/ATF Meeting

WEDNESDAY, MAY 16, 2001

SENATE FINANCE COMMITTEE WORK SESSION ON HB 1 AND HB 2 Room 103, SH

9:00 a.m. - 12:00 p.m. Work session

1:00 p.m. - 3:30 p.m. Work session

CAPITAL BUDGET Room 101, LOB

1:00 p.m. Agency Briefings on HB 25-FN-A

DAM MANAGEMENT REVIEW COMMITTEE (RSA 482:93) Room 305, LOB

1:00 p.m. Regular Meeting

NH DEPARTMENT OF TRANSPORTATION (Salem-Manchester 10418-C I-93 widening) West Running Brook School, 1 West Running Brook Lane, Derry, NH

4:00 p.m. Resource Agency Meeting

THURSDAY, MAY 17, 2001

SENATE FINANCE COMMITTEE WORK SESSION ON HB 1 AND HB 2 Room 103, SH

9:00 a.m. - 12:00 p.m. Work session

1:00 p.m. - 3:30 p.m. Work session

FRIDAY, MAY 18, 2001

JOINT LEGISLATIVE COMMITTEE ON ADMINISTRATIVE RULES Rooms 306-308, LOB

9:00 a.m. Regular Meeting

WORKERS COMPENSATION ADVISORY COUNCIL (RSA 281-A:62) Room 307, LOB

9:00 a.m. Regular Meeting

GOVERNOR'S COMMISSION ON ALCOHOL AND DRUG ABUSE PREVENTION INTERVENTION AND TREATMENT (RSA 12-J:1) Rooms 202-204, LOB

9:30 a.m. - 11:30 a.m. Regular Meeting

COMMISSION ON EDUCATION OF DEAF AND HARD OF HEARING (HB 1283, Chapter 43, Laws of 2000) Room 205, LOB

10:00 a.m. Regular Meeting

NH LAND & COMMUNITY HERITAGE AUTHORITY BOARD OF DIRECTORS (RSA 227-m:4) Community Development Authority, 14 Dixion Ave, Concord, NH

12:00 p.m. Regular Meeting

POSTSECONDARY EDUCATION AND TEMPORARY ASSISTANCE RECIPIENTS RELATIONSHIP COMMISSION (SB 313, Chapter 122, Laws of 2000) Room 205, LOB

1:00 p.m. Regular Meeting

SENATE FINANCE COMMITTEE WORK SESSION ON HB 1 AND HB 2 Room 103, SH

1:00 p.m. - 4:00 p.m. Work session

KIDS CABINET MEETING Governor and Council Chambers

2:00 p.m. Regular Meeting

MONDAY, MAY 21, 2001

OIL FUND DISBURSEMENT BOARD (RSA 146-D:4) Room 305, LOB

9:00 a.m. Regular Meeting

SEED STERILIZATION OR "TERMINATOR" TECHNOLOGY STUDY COMMITTEE (HB 291, Chapter 282, Laws of 1999) Room 303, LOB

10:00 a.m. Regular Meeting

TUESDAY, MAY 22, 2001

EXCAVATING & DREDGING PERMITS APPLICATION PROCEDURES STUDY COMMITTEE (HB 1127, Chapter 86, 2000) Room 303, LOB

2:00 p.m. Regular Meeting

WEDNESDAY, MAY 23, 2001

FISCAL COMMITTEE OF THE GENERAL COURT Rooms 210-211, LOB

9:00 a.m. Regular Business

CAPITAL BUDGET Room 103, SH

1:00 p.m. Agency Briefings on HB 25-FN-A

THURSDAY, MAY 24, 2001

NH DEPARTMENT OF TRANSPORTATION (Bike/Ped Conference) Wayfarer Inn, Bedford, NH

8:00 a.m. - 4:00 p.m. 3rd Annual Conference

NH DEPARTMENT OF TRANSPORTATION (Salem-Manchester 10418-C I-93 widening) Londonderry High School Cafeteria, 295 Mammoth Road, Londonderry, NH

6:00 p.m. Advisory Task Force Meeting

MONDAY, JUNE 4, 2001

JOINT HEALTH COUNCIL (RSA 326-B:10-b) NH Board of Nursing Room 17, 78 Regional Drive, Building 2, Concord, NH

5:30 p.m. Public Meeting

FRIDAY, JUNE 8, 2001

BOARD OF CLAIMS (RSA 541-B:3) Room 202, LOB

9:00 a.m. Regular Meeting

MONDAY, JUNE 11, 2001

PERINATAL ALCOHOL, TOBACCO & OTHER DRUG USE TASK FORCE (RSA 132:19) Room 101,LOB

9:30 a.m. Regular Meeting

FRIDAY, JUNE 15, 2001

JOINT LEGISLATIVE COMMITTEE ON ADMINISTRATIVE RULES Rooms 306-308, LOB

9:00 a.m. Regular Meeting

KIDS CABINET MEETING Governor and Council Chambers

2:00 p.m. Regular Meeting

WEDNESDAY, JUNE 20, 2001

NH DEPARTMENT OF TRANSPORTATION (Salem-Manchester 10418-C, I-93 widening) West Running Brook School, 1 West Running Brook Lane, Derry, NH

4:00 p.m. Resource Agency Meeting

THURSDAY, JUNE 28, 2001

NH DEPARTMENT OF TRANSPORTATION (Salem-Manchester 10418-C, I-93-widening) Londonderry High School Cafeteria, 295 Mammoth Road, Londonderry, NH

6:00 p.m. Advisory Task Force Meeting

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FISCAL NOTES NOW AVAILABLE IN THE SENATE CLERK'S OFFICE:

SB 72, SB 73, SB 76, SB 81, SB 90, SB 101, SB 105, SB 115, SB 117, SB 134, SB 140, SB 142, SB 143, SB 151, SB 160, SB 164, SB 167, SB 169, SB 170, SB 171, SB 172, SB 174, SB 176, SB 177, SB 178, SB 189, SB 191

NOTICES

WEDNESDAY, MAY 9, 2001

The New Hampshire Wellness and Primary Prevention Council, the New Hampshire Children's Trust Fund and the New Hampshire Department of Health and Human Services invites you to join them for a Legislative Breakfast to celebrate Strengths of Family Resource Centers in New Hampshire. Keynote speaker will be Lew Feldstein, President of the New Hampshire Charitable Foundation. The breakfast will take place on Wednesday, May 9, 2001 from 7:45 a.m. to 9:00 a.m. at St. Paul's Church. Family Resource Center staff from around the state will be present to share information about their programs.

Senator Katherine Wells Wheeler

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WEDNESDAY, MAY 9, 2001

The New Hampshire Women's Lobby is pleased and honored to announce that Senator Katherine Wells Wheeler, and Representative Barbara French will receive Meritorious Service Awards. Commissioner Don Shumway will receive the Citizen Award at our annual "Spring Celebs" on Wednesday, May 9th from 4:30 p.m. to 6:30 p.m. at the Holiday Inn in Concord. All are invited to join us in honoring three outstanding New Hampshire Citizens. Tickets are $10.00 for members and $15.00 for non-members and are available from members or from the New Hampshire Women's Lobby Office at 224-9105.

Senator Caroline McCarley

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TUESDAY, MAY 15, 2001

WHAT'S UP WITH THE COURTS? Come and hear Attorney Stanley Mullaney's presentation at the meeting of Legislators for Limited Spending on Tuesday, May 15 at Noon. Upham-Walker House. All House and Senate members invited.

Senator Carl R. Johnson

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FRIDAY, MAY 18, 2001

In recognition of your support, the NH Law Enforcement Officers Memorial Committee cordially invites you to the annual NH Law Enforcement Officers' Memorial Ceremony. The ceremony will be held on Friday, May 18, 2001, beginning promptly at 10 a.m. on the memorial site in front of the Legislative Office Building. The ceremony will proceed rain or shine. Refreshments will be provided immediately following the event. Please contact either Captain Timothy J. Acerno of Fish and Game at 271-3129 or Chief John Curran of the Meredith Police Department at 279-4561 if you have any questions.

Senator Arthur P. Klemm, Jr.

Senator John S. Barnes, Jr.

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MONDAY, JUNE 11, 2001

The **28th Annual Bill White Memorial Legislative Golf Tournament** is scheduled for Monday, June 11, 2001 at Androscoggin Valley Country Club in Gorham, New Hampshire. The entry fees for this annual tourney is $60.00 per person and includes greens fee, cart, barbecue and prizes. A shotgun start is scheduled for 9:00 a.m. The format is "Captain and Crew." Sign-up as a foursome or sign-up by yourself and be placed in a foursome. A maximum of 120 players will be allowed. Please return your entry and payment not later than May 29th to Sandy Wheeler at the LOB Lobby Desk. Please Make Checks payable to Legislative Golf Tournament c/o David Saltmarsh.

For your convenience, arrangements have been made with the Town & Country Motor Inn (located directly across the street from the golf course) for special lodging rates of $44.00 plus tax per person, per night for those of you who my choose to come up early or stay late. If you choose to stay over you must book your room in advance by calling the Inn at 1-800-325-4386. Currently, we are planning other events for Sunday and Monday, details to follow.

Senator Arthur P. Klemm Jr.

Senator Robert K. Boyce

28th ANNUAL BILL WHITE MEMORIAL

LEGISLATIVE GOLF TOURNAMENT

NAME: (1) _____

(2) _____

(3) _____

(4) _____

TELEPHONE NO: **AMOUNT ENCLOSED:**

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VISITORS' CENTER SCHEDULE - MAY

As a convenience to the members of the NH General Court, the Visitors' Center offers the following schedule of schools and other groups visiting the State House in **May 2001**. Please contact the Visitors' Center concerning additional information. Thank you for your continued participation with your School Visitation Program.

Kenneth Leidner, Director

DATE	TIME	GROUP	CLASS/Size
May 8	8:00	Kimball Elem – Concord	4/28
May 8	10:00	D.J.Bakie Elem – Kingston	4/45
May 8	11:00	Henniker Elem	4/25
May 9	9:30 & 11:00	Weston Elem – Manchester	4/50
May 9	12:30	Moore School – Candia	4/50
May 10	9:30	Maple Ave Elem – Goffstown	4/25
May 10	11:00	New Franklin School-Portsmouth	4/40
May 10	1:00	Bow Elem	4/25
May 11	10:00	Little Harbor Elem – Portsmouth	4/50
May 11	11:00	Dublin Consolidated School	4/15
May 11	11:00	Sandwich Central School	4/15
May 11	1:00	Conway Elem	4/55
May 14	8:30	Rumford Elem – Concord	4/22
May 14	10:00	St Elizabeth Seton – Rochester	4/50
May 14	11:00	Lisbon Elem	4/40
May 15	9:30 & 11:00	Bridgewater Hebron Elem	4/50
May 16	9:30 & 11:00	Thornton's Ferry Elem – Merrimack	4/50
May 17	9:30 & 11:00	Thornton's Ferry Elem – Merrimack	4/50
May 18	9:30 & 11:00	Thornton's Ferry Elem – Merrimack	4/75
May 18	12:30	Faith Christian Academy – Belmont	3&4/12
May 18	12:30 & 1:30	No. Londonderry Elem	4/50
May 21	9:00	Epsom Central School	4/50
May 21	11:00 & 12:30	John Fuller Elem – N. Conway	4/50
May 22	9:30 & 11:00	Plymouth Elem	4/75
May 23	10:00	Groveton Elem	4/50
May 23	11:00	Dondero Elem – Portsmouth	4/45
May 23	1:00	Pierce Elem – Bennington	4/20
May 24	9:30	Salem Christian School	4/25
May 24	11:00	Campton Elem School	4/45
May 24	1:00	St. Mary's – Claremont	4 & 6-8/35
May 25	9:30 & 11:00	Hanover St. School – Lebanon	4/85
May 25	12:30	Ed Fenn School – Gorham	4/50
May 29	9:30 & 11:00	Green Acres School – Manchester	4/75
May 30	9:30 & 11:00	Green Acres School – Manchester	4/50
May 30	1:00	Berlin Jr High	8/35
May 31	9:30 & 11:00	Hillsboro Deering Elem School	4/60
May 31	11:00	Mt. Shadow School – Dublin	6/12
May 31	1:00	Bartlett School – Berlin	3/50

June 1	**9:30 & 11:00**	**Hillsboro Deering Elem School**	**4/75**