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NEW HAMPSHIRE: BASELINE REPORT

State-Level Field Network Study
of the Implementation of the
Affordable Care Act

January 2015

Rockefeller Institute of Government
State University of New York

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Part 1 – Setting the State Context: “New Hampshire Knows New Hampshire Best”

1.1. Decisions to Date

New Hampshire’s response to the passage of the Affordable Care Act (ACA) reflects both its evolving political landscape and its longstanding tradition of support for limited government. For several decades, New Hampshire embraced a market-oriented approach to health care reform. The absence of state income or sales taxes reflects a strong preference for local control and limited government. As one analysis of the state’s regulatory environment noted: “Citizens remain highly skeptical of the need for public intervention. If intervention is necessary, however, residents express a strong preference for local action rather than state or federal initiatives. The sentiments are echoed by political leaders as well, who regularly campaign on low-tax, small government platforms.”¹

Over the past two decades, however, the political culture of New Hampshire has evolved.² Democrats made huge gains in both chambers of the state legislature in 2012, picking up 116 seats in the 400-member House to claim a majority for the first time since 2010. Democrats also added several seats in the twenty-four member Senate, although Republicans maintained a slim

majority.³ Long considered a conservative Republican bastion, the state's electoral politics and political leadership are now solidly bipartisan. New Hampshire has elected two consecutive Democratic governors, beginning in 2006, and Democrats now control three-fourths of the state's four-person Congressional delegation (in 2014, Senator Kelly Ayotte was the only Republican member). Divided government was reinforced by the November 2014 election, which returned Republicans to solid majorities in both the state House of Representatives and the Senate.

New Hampshire displayed considerable wariness about implementing health care reform after passage of the Affordable Care Act in March 2010. The state declined to create its own health insurance exchange, instead opting for a partnership model with the federal government. New Hampshire also chose not to expand eligibility for its Medicaid program out of concern for the long-term fiscal consequences for the state. In spring 2014, however, a bipartisan coalition of legislators crafted a compromise Medicaid expansion bill (SB 413), which passed both chambers of the state legislature by wide margins. Governor Maggie Hassan, a Democrat, approved the law on March 27, 2014, but the state's proposed expansion plan requires a waiver from federal officials.⁴

Initial Response to the ACA

The history of New Hampshire's response to the Affordable Care Act and the establishment of its insurance exchange spans two gubernatorial administrations. Democratic Governor John Lynch, who held office from 2005 until 2013, was succeeded by Hassan, marking the first election of consecutive Democratic governors in 150 years.

Public opinion polls conducted by the University of New Hampshire's Survey Center demonstrate the contentious state of affairs regarding health care reform in the Granite State in the months leading up to – and immediately after – the Affordable Care Act became law in March 2010. A statewide poll conducted in October 2009 found that 49 percent of New Hampshire adults disapproved of President Barack Obama's handling of health policy. The partisan divide was even wider: While 76 percent of Democrats approved of the administration's handling of health policy, only 10 percent of Republicans shared similar views.⁵ Independents were equally split, as 45 percent approved, compared with 43 percent who disapproved.

Overall, 75 percent of respondents explained that their disapproval of Obama's health policy reflected a belief that the administration tried to "do too much" while only 8 percent maintained that the administration had "not pushed hard enough." Despite the wide partisan divide in presidential approval, Democrats and Republicans in New Hampshire found common ground on this issue, as 80 percent of Democrats and 79 percent of Republicans indicated that the president was trying to "do too much." This shared sentiment reflects the state's unique political climate.

Six months after Obama signed the Affordable Care Act into law in March 2010, a subsequent survey of New Hampshire voters revealed remarkable stability in public attitudes towards health policy. While the proportion of New Hampshire residents who approved of the Obama administration's health policy remained the same (44%), a majority (52%) of those surveyed disapproved of Obama's handling of health policy matters. Democrats, Republicans, and independents all indicated a higher rate of approval for Obama's general handling of health policy than for the Affordable Care Act itself.⁶

This political climate foreshadowed the official response of the Lynch administration. In his third State of the State address, in January 2010, the governor acknowledged the emerging debate about the Affordable Care Act. As he noted, "We have shared goals in New Hampshire: lower health care costs, better health care quality and more insured citizens. Washington is working to meet those same goals. But — as I have made clear — Congress should not pass any bill that piles unreasonable new costs on the states or that hands out special deals to individual states. Every state should be treated fairly. Here in New Hampshire, we aren't waiting for Washington to act. We are changing our health care system now."⁷ ACA implementation, therefore, would occur in a political climate with a strong preference for local control and a well-established tradition of limited government.

In April 2011, Lynch proposed to accept a \$1 million planning grant to fund the creation of a state-operated health insurance exchange. ACA implementation in the Granite State, however, faced strong opposition. The state's historic preference for limited government clashed with the ACA's basic structure, which relied upon new federal mandates to change the behavior of consumers, insurers, and providers. Three months later, Lynch allowed two exchange-related bills — HB 601 and SB 148 — to become law without his signature. HB 601 provided for a federal-state partnership while also requiring the state Department of Health and Human Services (DHHS) commissioner to reject two-thirds of the \$1 million planning grant previously approved by the governor. SB 148 effectively prohibited an individual insurance mandate and its requisite penalties. Lynch argued that the latter bill, which was minimally enforceable, was irrelevant. In October 2011, the DHHS commissioner asked the state's Executive Council and the Legislative Fiscal Committee to approve spending the remaining one-third of the \$1 million planning grant, but the council rejected this request in December 2011.⁸ Thus, more than a year and a half after passage of the ACA, New Hampshire had not allocated any funds for implementing the new federal health care reforms. The Granite State would not be an early adopter in developing new regulations for the private insurance market or in expanding Medicaid eligibility.

In his State of the State address in January 2012, Lynch sought to build support for reforming the state's health insurance

marketplace. Lynch noted, “As we innovate with our health care system here in New Hampshire, we must also consider the impacts of reforms nationally.” Acknowledging that other states would be implementing their own insurance exchanges, Lynch argued that New Hampshire should do the same. He proclaimed that “a well-designed health insurance exchange can make it easier for businesses to compare and obtain affordable health insurance. And I certainly don’t think we want the federal government to design an exchange for us. That is why [we] must move forward – now – with designing our own exchange right here in New Hampshire.”⁹

The governor’s appeal fell on deaf ears. Six months later, Lynch signed HB 1297, which prohibited the state from establishing a state-based health insurance exchange. This essentially reversed the course of action Lynch recommended in his State of the State address. In addition to preserving the “state’s status as the primary regulator of the business of insurance within New Hampshire,” HB 1297 also established guidelines for the state’s interactions with a federally facilitated insurance exchange.¹⁰ Lynch’s decision to sign HB 1297 did not reflect his own opposition to a state-based insurance exchange, but rather a recognition of strong public disapproval of the Affordable Care Act in New Hampshire.¹¹

Pursuing a Partnership Model

On September 15, 2011, Lynch announced that he would not be seeking election after four consecutive terms as governor. Hassan, a three-term state senator and Senate majority leader, won the gubernatorial election and kept the governor’s mansion in Democratic hands. As a candidate Hassan promised to “bring the same priorities of lowering costs and expanding coverage back to Concord. Maggie believes we should accept \$1 billion in available federal funding to help working families afford health insurance, and will work to make sure the state is protected financially into the future.”¹² As state senator, Hassan displayed an interest in health care reform and previously sponsored legislation (SB 505) in 2010 to establish a state commission on health care cost containment.¹³

Soon after taking office in 2013, Hassan submitted a letter to U.S. Health and Human Services Secretary Kathleen Sebelius that fulfilled her campaign promise to secure federal funds to expand access to health insurance in New Hampshire. Rather than developing its own exchange, the Hassan administration pledged to pursue a federal-state partnership. On March 7, 2013, the U.S. Department of Health and Human Services (HHS) gave New Hampshire conditional approval to establish a partnership marketplace.¹⁴ Following the approval of the state’s partnership proposal, New Hampshire received a Level One Establishment grant for \$894,406 from HHS to bolster plan management operations and to begin developing consumer assistance mechanisms.

In April 2013, HHS awarded the state a second Level One Establishment grant totaling \$5.3 million to support further planning, development, and design of a consumer partnership marketplace, but the state rejected these funds, which the Centers for Medicare & Medicaid Services (CMS) subsequently awarded to the New Hampshire Health Plan (NHHP), an entity charged with overseeing the state's high-risk pool.

Mulling Over Medicaid Expansion

The Supreme Court's June 2012 decision in *NFIB v. Sebelius* left the decision about expanding eligibility for Medicaid in the hands of state officials. Until March 2014, New Hampshire was one of twenty-five states that opted not to accept additional federal funds to expand its Medicaid programs, leaving more than 150,000 state residents without health insurance coverage. By early 2013, advocates for the uninsured, health providers, and political leaders expressed concerns that the state was leaving billions of dollars in federal funding on the table by not expanding Medicaid.

Legislators approved the creation of a nine-member commission to study Medicaid expansion as part of the state's FY 2014-15 budget. As Hassan argued in October 2013, "With \$2.5 billion in federal funds available to expand health coverage for up to 50,000 hard-working Granite Staters, we have a significant opportunity to improve the health and financial well-being of our families, strengthen our economy, and improve our state's financial future."¹⁵ Hassan asked the state's Executive Council — a five-member body elected concurrently with the governor that shares decision-making responsibility over state expenditures and appointments — to approve a special legislative session to consider Medicaid expansion in November 2013. Although the special session failed to produce an agreement, by early 2014 a bipartisan compromise over Medicaid expansion gained the endorsement of both Senate President Chuck Morse, a Republican, and Senate Minority Leader Sylvia Larson, a Democrat. The agreement, which embraced a "private option" similar to that used in Arkansas and Pennsylvania, offered state policymakers "a politically feasible way to accept billions in federal dollars and improve the overall health of their residents without embracing 'Obamacare.'"¹⁶ To win support for the proposal, legislators emphasized that their approach reflected the state's traditional values by using federal Medicaid funds to purchase private health insurance coverage instead of expanding eligibility for New Hampshire's existing Medicaid program. Republican leaders such as Morse described the proposal as a bipartisan approach to "take care of those people that need help and give them private health insurance." The plan reflected the state's emphasis on limited government, Morse noted, for it contained "sunset clauses that will end the program if waivers are not approved or if federal funding drops below 100 percent." Indeed, Republican support

for the measure was possible only because the compromise was not defined as an expansion of the state's existing Medicaid program. As Morse noted, the state's approach differed significantly from a traditional Medicaid expansion. "What we did go to was a framework that brought in private health care, brought in health insurance policies that pay 150 cents on the dollar and Medicare rates that pay 85 cents on the dollar. These are all positive things."¹⁷

By late February 2014, momentum for Medicaid reform was palpable. The leadership plan, which was nearly identical to a similar proposal introduced by the Senate's Republican leadership during the November 2013 special session, attracted bipartisan support, including a majority of Senate Republicans. The definition of the expansion as a fresh new approach to Medicaid reform was critical to winning bipartisan support for the measure. As Republican Senator John Reagan argued, "It's not Medicaid expansion. It's a premium payment plan for private insurance for people who now enjoy uncompensated care or have been shut out of the market."¹⁸ After the endorsement of the Senate Health, Human Services and Education Committee by a 4-1 vote, the full Senate approved the Medicaid expansion proposal by an 18-5 margin on March 7, paving the way for Hassan to sign the bill into law on March 26, 2014.¹⁹

Since the state's proposal to use Medicaid funds to purchase private health insurance coverage required a waiver from CMS, the state submitted a formal request for a five-year Section 1115 demonstration waiver on May 30, 2014.²⁰ The governor's press release underscored the state's commitment to fiscally responsible health care reform, noting that the waiver "would protect New Hampshire's budget."²¹ State officials received initial federal approval for the waiver on June 23, 2014, allowing enrollment in the New Hampshire Health Protection Program (NHHPP) to begin on July 1. Adults earning up to 138 percent of the federal poverty level (FPL) were eligible to apply for federally subsidized health insurance coverage.²² As of August 15th, 10,405 individuals (of the roughly 50,000 eligible adults in the state) had signed up for coverage under the new program.²³ At the same time, the state also experienced an unexpected surge in traditional Medicaid enrollments in the first six months of 2014. Medicaid enrollment increased by more than 11,000, contributing to an estimated \$37 million budget shortfall for the state DHHS.²⁴ As 2014 drew to a close, however, New Hampshire had not yet received final approval for its premium assistance waiver proposal. If approval is not granted by March 31, 2015, the state's Medicaid expansion will not go forward in 2016, and the "Voluntary Bridge to Market-place" program will be terminated.²⁵

1.2. Goal Alignment

After initial opposition to the Affordable Care Act in 2011, New Hampshire embraced a wait-and-see response beginning in

2013. Support for the ACA remains conditional, as state officials are less interested in furthering the goals and objectives of the act than in harnessing federal funds to achieve the state's own fiscal goals and expand coverage on its own terms. HB1297, signed into law by Lynch in 2012, prohibited New Hampshire from establishing, or participating in, a state-based health insurance exchange. HB 1297, however, did allow state agencies to "operate specific functions of a federally-facilitated exchange." Legislators were initially reluctant to accept federal funds to build capacity for a state health insurance exchange, but ultimately decided to create a partnership model in 2013 in which New Hampshire officials would retain control over plan management and consumer assistance while delegating responsibility for enrollment to federal officials.²⁶

The state remained on the fence about expanding Medicaid from 2011-13; it rejected a traditional approach to expanding eligibility for Medicaid in favor of a new premium support model. The Medicaid expansion vote also underscores the limits of political support for the ACA in the Granite State. As one of the bill's principal sponsors, Republican Senator Nancy Stiles, noted after Senate passage of SB 413, "This legislation will not expand government, it will not increase the number of residents on Medicaid, and it will not increase spending. On the contrary, I am confident that once implemented, this bill will decrease what we spend each year on uncompensated care and Medicaid by helping more low-income residents access the private insurance market."

New Hampshire's wait-and-see approach is reflected in the sunset clause included in the Medicaid expansion legislation; the provision will expire on December 31, 2016, when the federal government's share of Medicaid funding for newly eligible individuals is slated to decline from 100 percent to 90 percent. In addition, the legislature's support for Medicaid reform is conditional upon approval of the state's request for a Section 1115 waiver by March 31, 2015.²⁷ In sum, implementation of the ACA continues to move forward in New Hampshire with bipartisan support from the legislature and strong support from the governor's office, but policymakers remain committed to a "uniquely New Hampshire" solution that is fiscally conservative and preserves local control over reform.

Part 2 – Implementation Tasks

2.1. Exchange Priorities

The importance of local control is a hallmark of New Hampshire's implementation of the ACA. HB 1297, passed in June 2012, established that "state agency activities relating to any federally-facilitated exchange for New Hampshire shall be consistent with the following objectives:

- (a) Promoting preservation of the private, commercial delivery of health coverage through carriers and

producers to the greatest degree possible under the Act and minimizing interference with the operation of commercial markets.

- (b) Minimizing overhead and administrative expenses.
- (c) Promoting competition and consumer choice, for example, by advocating for allowing all health and dental plans that meet the minimum requirements necessary to be certified as qualified plans under the Act to be offered in the exchange.
- (d) Preserving to the greatest extent possible the state's insurance regulatory authority and the state's flexibility in determining Medicaid eligibility standards and program design and operation."

In addition, HB 1297 noted that "in the event a federally-facilitated exchange is established for New Hampshire, the commissioner shall retain authority with respect to insurance products sold in New Hampshire on the federally-facilitated exchange to the maximum extent possible by law as provided in Title XXXVII, including but not limited to producer and insurer licensing, form and rate approval, reinsurance and other risk-sharing mechanisms, network adequacy, industry assessments, internal grievance standards, external review, and unfair trade practices." Furthermore, the law required "any person who sells, solicits, or negotiates insurance" through a federally facilitated exchange to be licensed as a "producer" and vested the commissioner of insurance with the authority to "establish standards and training requirements for navigators on a federally-facilitated exchange." The law also empowered the commissioner of health and human services "to establish New Hampshire eligibility standards, enrollment procedures, and outreach mechanisms for persons who are enrolled through a federally-facilitated exchange in this state in the Medicaid program under title XIX of the Social Security Act or the Children's Health Insurance Program (CHIP) under title XXI of the Social Security Act."²⁸

2.2. Leadership – Who Governs?

Lynch, Commissioner of Health and Human Services Nicholas Toumpas, and Insurance Commissioner Roger Sevigny nominated and appointed twelve members to the New Hampshire Health Exchange Advisory Board created by HB 1297.²⁹ The board is comprised of:

- 1) Two members on behalf of health insurance carriers (appointed by the insurance commissioner)
- 2) One member on behalf of dental carriers (appointed by the insurance commissioner)
- 3) One member on behalf of producers (appointed by the insurance commissioner).

- 4) One member on behalf of Medicaid recipients (appointed by the commissioner of DHHS).
- 5) One member on behalf of health care providers and health care facilities in New Hampshire (appointed by the commissioner of DHHS).
- 6) One member who is an advocate for the outreach/enrollment of difficult populations, such as substance abusers and those with mental health disorders (appointed by the commissioner of DHHS).
- 7) One public health expert (appointed by the commissioner of DHHS).
- 8) A representative individual who purchases individual coverage through the exchange (appointed by the governor).
- 9) A representative employer who purchases group coverage through the exchange and represents employers who buy group coverage (appointed by the governor).
- 10) One individual representing navigators (appointed by the governor).
- 11) A representative employee of an employer utilizing group coverage purchased through the exchange (appointed by the governor).

The New Hampshire Health Exchange Board held its first meeting in Concord on November 13, 2012 and has met on seventeen occasions over the past two years.³⁰ At the first meeting, Lisa Guertin and Scott Baetz were unanimously elected as co-chairs; both still serve in this role today. Other current board members include: Christine Alibrandi, Dianne Chase, Nancy Clark, Russell Grazier, Lisa Kaplan Howe, Lisa Morris, Karen Poulin, Beth Roberts, Sandra Ruka, and Timothy Soucy.³¹ A majority of board members were drawn from the insurance industry, the business community, and health providers, including the president and general manager of Anthem Blue Cross Blue Shield of New Hampshire (Guertin), small business owners (Baetz), an attorney (Alibrandi), representatives from the insurance health and dental insurance industry (Chase, Guertin, Alibrandi, Roberts), providers (Grazier and Ruka), and the chair of the New Hampshire Health Plan (Roberts). Only three members represented public health, health advocacy groups, or the general public (Howe, Soucy, Morris).

2.3. Staffing

New Hampshire has not committed significant personnel resources to implement health care reform, choosing instead to outsource most responsibilities to existing organizations and consultants. The state hired a full-time bookkeeper to provide

administrative support, and two other state officials — Alain Couture, project director for the New Hampshire Insurance Department's Health Reform Project, and the legal counsel, Jennifer Patterson, contribute time to implementation efforts on an in-kind basis. The majority of tasks associated with establishing the state's navigator and In-Person Assistance Programs, as well as developing consumer education, outreach, and complaints procedures and policies, were contracted out to consultants.

State employees tasked with reform (e.g., the project director) continued to work in their existing positions and received release time to manage the consultants hired by the New Hampshire Insurance Department (NHID). The revised budget for Level One Exchange Establishment, released in May 2013, allocated \$886,550 for consulting fees for a project manager, facilitator/planning consultant, navigator consultant, navigator monitor, and communications consultant. In addition, the grant allocated \$2.3 million for contracts with community organizations to administer the In-Person Assistance Program, along with training and monitoring the performance of navigators. An additional \$2.1 million was dedicated to fund TV, print, radio, and online marketing, outreach to small businesses, and social media, among others.³² The NHID, however, declined to accept the federal planning grant of \$5.4 million, which was not included in the department's FY2014 budget. Instead, Seigny, the insurance commissioner, agreed to transfer the funds awarded to New Hampshire to conduct outreach and education for consumers about signing up for benefits through the new federal marketplace to the New Hampshire Health Plan, a quasi-public agency that operated the state's high-risk insurance pool.³³ As Seigny noted in a letter to the Health Exchange Advisory Board in August 2013, "NHHP has experience in conducting outreach and education and has administered several complex programs funded by federal grants. In sum, NHHP is uniquely situated to administer the Consumer Assistance function."³⁴

2.4. Outreach and Consumer Education

The NHHP did not publish its request for proposals for the consumer assistance program until September 6, 2013, less than one month before the signup process began for residents on HealthCare.gov.³⁵ The state's media consultant, Louis Karno & Company Communications, was not selected to design and implement a comprehensive educational campaign until mid-November 2013. Shortly after signing this \$1.9 million contract, Louis Karno President Jayme Simoes said the firm would target residents "through TV, radio, online outreach, some canvassing, promoting local events and supporting the good work being done on the ground by in-person application assisters."³⁶ NHHP, however, has produced a somewhat limited media campaign to date. On December 24, 2013, NHHP launched its website, coveringnewhampshire.org, which serves as its primary outreach

channel.³⁷ The website provides residents with information regarding the eleven different plan options, as well as the locations of in-person assistors and information about tax credits and financial aid for those between 100-400 percent of the federal poverty level. The website features “success stories” of uninsured individuals who secured insurance through the marketplace and includes several social media links such as Facebook (2,093 likes), Twitter pages (843 followers), and a YouTube channel (3,044 views). All data are current as of October 17, 2014.

Louis Karno & Company was named New Hampshire’s fastest growing business by *Business NH* magazine, but its outreach and consumer education efforts on behalf of Covering New Hampshire have had a limited impact to date. Its media campaign relies on raising consumer awareness via the web, rather than television advertising; its YouTube channel contains seven videos, but only 3,044 total views. The videos highlight the importance of having health insurance and also detail how to sign up through the exchange.³⁸ This low-key marketing effort featured personal testimonials from several newly insured individuals — Dave, Lisa, and Michelle — about the benefits of health insurance and the risks of remaining uninsured.³⁹

While the state has been slow to tout the virtues of its ACA marketplace, critics portrayed New Hampshire’s implementation of the ACA in a negative light. Americans for Prosperity broadcast a political ad criticizing Senator Jeanne Shaheen for voting for the ACA.⁴⁰ This ad — which garnered 15,637 views on YouTube and also aired on New Hampshire TV stations — blames Obamacare for rising premiums, less accessible care, and 22,000 health plan cancellations in the state. Fox News also aired a special report on New Hampshire in August 2014, entitled “Obamacare: Live Free or Die,” that portrayed government subsidies as “bribing” people to sign up for coverage.⁴¹ The program described a host of issues, including consumer complaints about narrow network coverage available on the marketplace, issues with the Small Business Health Options Program (SHOP) exchange, as well as penalties for those who do not sign up for the individual mandate. The report underscored patient and provider resistance to reform in New Hampshire with vivid examples highlighting how medical professionals and residents alike are pushing back against government intervention in the health care system.

NHHP launched a four-phase registration and outreach plan to structure its efforts from October 2013 to July 2014. During Phase I (the period between October and mid-November), NHHP planned to educate the public about the whereabouts of resources they could access to assist them in enrollment, focusing more on outreach than registration. In Phase II (the period between mid-November and February), NHHP intended to pull back on education efforts and focus more on registration. During Phase III (the period between February and April), NHHP chiefly intended

to focus on registration related activities. Finally, in Phase IV (the period between April and July), NHHP planned on refocusing efforts back towards education to identify gaps in its previous outreach efforts. NHHP chose six organizations to partner with as marketplace assistors: ServiceLink, Foundations for Healthy Communities, North County Health Consortium, Planned Parenthood of Northern New England (PPNE), Bhutanese Community of New Hampshire, and Greater Derry Community Health Services. New Hampshire Voices for Health also serves as a key resource for New Hampshire residents, providing information about consumer assistance and navigators as well as audio and video clips.

2.5 Navigational Assistance

The Kaiser Family Foundation's recent survey of consumer assistance programs under the ACA found that health care providers, including federally qualified health centers and nonprofit community-based organizations, sponsored the majority of consumer assistance programs.⁴² New Hampshire fit this mold, as NHHP selected the Bi-State Primary Care Association (BSPCA) and PPNE to serve as the state's official navigators.⁴³ BSPCA is a nonprofit organization, located in both New Hampshire and Vermont, that advocates for universal, affordable, and accessible primary health care and prevention. PPNE is the largest health care provider and educator for sexual health and reproduction in northern New England. The awarding of federal grant money to PPNE proved to be controversial not just in New Hampshire but around the country, with several conservative advocacy organizations voicing their disapproval.⁴⁴

The federal government awarded \$454,839 to BSPCA and \$145,161 to PPNE in 2013. Navigator services are available at PPNE health centers in Keene, Exeter, Derry, Manchester, and Claremont.⁴⁵ In addition, navigators are also available at twelve BSPCA health centers throughout the state as well as the North Country Health Consortium, libraries, schools, and employers. As of December 2013, Bi-State and PPNE maintained twenty-eight navigator office locations throughout the state.⁴⁶ Each organization planned to add additional staffing to fulfill their new navigator responsibilities. As of September 2013, PPNE intended on hiring three additional navigators and training its current staff at all six locations in hopes of having twelve trained navigators on staff.⁴⁷ Similarly, Bi-State planned on hiring an additional eight navigators. In September 2014, BSPCA was awarded a second navigator organization grant of \$454,985 by CMS, and Greater Derry Community Health Services received \$102,786.⁴⁸ While Bi-State supports a statewide consortium of health centers across eight counties in New Hampshire, Greater Derry Community Health Services offers a more targeted approach, serving the residents of Rockingham County.⁴⁹

The licensure and oversight of navigators in New Hampshire remains a topic of debate. In January 2014, Representative Emily Sandblade, a Republican, introduced HB 1328, which proposed that insurance navigators undergo background checks and be licensed by the state Insurance Department.⁵⁰ Referred to the Commerce and Consumer Affairs committee for executive session, the bill was ultimately referred to interim study in March 2014 (per an 11-7 committee vote), pending renewal of the state's navigator organization grants.⁵¹ Speaking for the majority, Sandblade noted that "New Hampshire residents deserve the same quality and safety that state law provides for in the insurance and medical professions." The minority statement, offered by Democratic Representative Chris Muns, maintained that the state lacked the authority to license navigators given its prior decision to participate in a federally facilitated insurance exchange rather than a state-based exchange. Muns argued, "The minority believes that if the sponsors of this bill are concerned about the activities of navigators in the state of New Hampshire, then it would have been more appropriate to include in this bill language to repeal the current prohibition on a state based exchange."⁵²

2.6. Interagency and Intergovernmental Relations

New Hampshire's decision to pursue a partnership exchange model reflects the desire of state officials and voters to retain control over the insurance marketplace. As the NHID noted in an informational alert for consumers, "The NH Insurance Department has regulated insurance carriers in the state for 150 years, and federal health reform hasn't changed that." The NHID reviews all insurance policies sold in the Granite State, and also licenses producers (insurance brokers), who are paid by commission (only licensed producers are authorized to sell or enroll individuals in a policy or recommend specific plans to consumers).

The New Hampshire Department of Health and Human Services operates the state's Medicaid program; the state's new health insurance marketplace insurance portal evaluates individuals' eligibility for Medicaid, in addition to presenting individual policies. The New Hampshire Health Plan, originally established in 2002 to operate the state's high-risk insurance pool, received a new lease on life in 2013. The NHHP was slated to cease operation on December 31, 2013, because the ACA's requirements that insurers offer coverage to all individuals regardless of health status eliminated the need for a dedicated insurance program for "uninsurable" individuals. In 2013, however, NHID recommended that the NHHP assume a new role in conducting outreach and education efforts in New Hampshire.

Since the passage of the ACA in 2010, New Hampshire has received a \$1 million state planning grant and four different Level One establishment grants. The state planning grant was awarded in September 2010, followed by Level One establishment grants in February 2013 (\$894,406), April 2013 (\$5,372,682), January 2014

(\$2,048,237), and May 2014 (\$3,218,753).⁵³ This infusion of federal funds, however, has not been without controversy in the Granite State. Indeed, the backlash against the ACA was evident soon after CMS awarded the state an initial planning grant of \$1 million to help set up its exchange in September 2010. This initial grant award was intended to help “develop a general public education and outreach plan regarding an Exchange.”⁵⁴ After state officials failed to use these funds, HB 601 ordered that the state return \$666,000 previously granted to NHID by HHS by July 1, 2011.⁵⁵

New Hampshire received its first Level One Establishment grant in February 2013.⁵⁶ The budget for its grant application proposed to expand plan management capacity and provide operational assistance for Qualified Health Plan (QHP) certification procedures. In addition, New Hampshire sought to integrate the National Association of Insurance Commissioners (NAIC) SERFF system within the Insurance Department. Consulting fees for hiring a market analyst and examiner, compliance examiner, and project manager constituted the majority (86%) of the total budget.⁵⁷

In March 2013, the Insurance Department drafted a revised budget for consumer assistance. The department applied for a Level One Exchange Establishment Grant of \$5,777,077. Of this \$5,777,077, it budgeted \$2,278,252 for the contracting of nonprofit organizations with the In-Person Assistance Program and \$2.5 million for the state’s marketing and advertising campaign.⁵⁸ The NHID submitted a revised SF-424 application to CMS on March 19th. The updated plan and timeline identified the state’s goals: “The New Hampshire Insurance Department will be able to fully administer all the Consumer Assistance functions, including the day to day management of Navigators, operate an In-Person Assistance Program, and provide outreach and education to consumers.”⁵⁹ The grant would enable the NHID to:

- Partner with CMS to develop a consumer assistance program with divided responsibilities.
- Contract with consultants to plan an outreach and education program, an In-Person Assistance Program, and navigator assistance.
- Provide both federal- and New Hampshire-specific training, regulation, and monitoring of navigators.
- Inform the public about accessibility and affordability of insurance options through an outreach and education program with appropriate language and accessibility for all.
- Develop a consumer referral and complaint reporting system.
- Develop a media outreach program to launch by June 15, 2013, via television, radio, out-of-home, online, and print.

On April 8, 2013, CMS approved New Hampshire’s application and issued a grant of \$5,372,682 to the NHID.⁶⁰ In response,

NHID submitted a new budget for review and developed a new planning timeline on May 8, 2013. The new budget reflected a \$371,702 cut in marketing and advertisement spending as well as minor cutbacks in salaries and wages, fringe benefits, consulting, and “other” expenses.⁶¹ The updated planning timeline was very similar to the previous proposal, but included an anticipated date of June 2013 for the governor and Executive Council to accept the grant and an anticipated date of July 2013 for the committee to begin outreach and education planning for the next two years. The award of the Level One implementation grant, however, did not signal broad-based acceptance of either the ends or the means of health reform in New Hampshire.

On May 13, 2013, in a letter to the Joint Legislative Health Reform Oversight Committee, Joint Legislative Fiscal Committee, and the Senate Finance Committee, Guertin and Baetz, the Health Exchange Advisory Board co-chairs, recommended that NHID should accept the federal grant award. Without federal funding, they argued that “timely, effective education and outreach about the Marketplace to New Hampshire consumers will be impossible.” Nevertheless, accepting federal funds for implementing health care reform was not a straightforward proposition in New Hampshire. In a letter to the Health Exchange Advisory Board in August 2013, Insurance Commissioner Sevigny noted that the although marketplace coverage was scheduled to begin on January 1, 2014, the CMS federal grant could not be used in NHID’s fiscal year 2014 because it was not included in the department’s current year budget. Instead of awarding the funds to the state NHID, Sevigny suggested that the NHHP, which operated the state’s high-risk insurance pool, could accept the federal award and facilitate outreach and education efforts on behalf of the state.⁶² The chair of the NHHP, Roberts, who also served on the Health Exchange Advisory Board, concurred with Sevigny’s recommendation. Roberts indicated that the NHHP was applying to accept the federal grant, which would fully fund New Hampshire’s outreach program and enable the state to plan a smooth transition from the existing high-risk pool to subsidized coverage through the new federal marketplace.

The tenuous nature of ACA implementation in New Hampshire soon became evident in the wake of Sevigny’s recommendation that the NHHP accept the grant on behalf of the state. Senate President Peter Bragdon wrote that he was “disappointed that, despite clear legislative intent to not move forward with this grant, the Department appears determined to take whatever steps necessary to contravene the will of the legislature with regards to this funding.” Bragdon relayed some concerns of other senators regarding this work-around and requested Sevigny not move forward with this effort until the Joint Health Care Reform Committee was notified of NHID’s intentions. In particular, Senate critics of the proposal questioned why the NHHP, “‘a quasi-governmental organization’ ... established by statute would be

permitted to accept federal funds without legislative approval.” In addition, Bragdon challenged the new role for the NHHP under the grant, which “would be significantly different than its current function of ‘insurer of last resort’ for Medically uninsurable New Hampshire residents” and noted that the passage of HB 526 in 2013 raised doubts about the future of the NHHP. In other words, the Senate president wondered how the NHHP could “continue to carry out its responsibilities under this grant when no statutory basis remains for the group’s existence?”⁶³ House Republican leaders echoed similar sentiments and criticized the NHID for “thumbing their nose at the legislative process. It’s not difficult to see what is happening here. We have a department and an administration who are in a rush to spend millions of taxpayer dollars to fund Obamacare related bureaucracy. If their plan has merit, they should play by the rules and let it get an up or down vote by the legislative entities who have oversight. To do an end run around the legislature simply doesn’t pass the smell test. We’ll be exploring every option available to ensure this matter goes through the proper channels.”⁶⁴

2.7. QHP Availability and Program Articulation

Under the terms of New Hampshire’s partnership agreement with CMS, the state retained responsibility for certifying and licensing Qualified Health Plans, collecting and analyzing plans’ rates and benefits, quality monitoring, and managing consumer complaints about carriers or plans. All plans offered for sale in the individual and small group markets must cover Essential Health Benefits (EHBs). Matthew Thornton Blue was chosen as the state’s EHB benchmark plan for the 2014 calendar year. The availability of QHPs in New Hampshire for the first open enrollment period was announced by Sevigny in a press release on August 1, 2013.⁶⁵ All QHPs must be licensed by the state and must offer at least one silver- and one gold-level plan for sale on the marketplace; premium rates cannot differ for plans sold on or off the marketplace.

The NHID applied its existing regulations to assess the adequacy of proposed QHP plans. Insurers must provide attestations regarding the adequacy of their network in each county they seek to serve, including information about participating hospitals, essential community providers, and mental health services available to subscribers.⁶⁶ Each health plan must demonstrate that its network is “sufficient in number and types of providers to assure that all services will be accessible without unreasonable delay” and all network data submitted must be based on signed contracts with providers, not proposed partnerships.

For 2014, only one QHP – Anthem Blue Cross Blue Shield – applied to offer health insurance products on the state’s online marketplace. The company offered eleven different individual plans on the individual marketplace, including a catastrophic direct access plan, five bronze-level plans, three silver-level plans, and two gold-level plans.⁶⁷ Cost sharing and out-of-pocket costs

for the new plans were high: Individuals choosing silver-level plans (the most common choice) faced annual deductibles ranging from \$1,500 to \$3,250 for individuals, while families' deductibles ranged from \$3,000 to \$6,500. Out-of-pocket maximums for silver-level plans varied from \$4,000 to \$6,000 for individuals and from \$8,000 to \$12,000 for families.⁶⁸

State officials were not surprised by the limited number of QHPs during the exchange's first year of operation. As Alexander Feldvebel, the deputy commissioner of the NHID noted, Anthem dominated the individual insurance market before reform, with more than 90 percent of the policies sold. "It's typical in a state with a small population that one or two players constitute the whole market (for individual policies). There aren't enough covered lives out there to sustain more than one or two players."⁶⁹ Anthem also offered three plans (one each at the bronze-, silver-, and gold-levels) on the state's small group (SHOP) marketplace.

To control the cost of its insurance products, Anthem's Pathway plans used a narrow network model; each of the plans offered for sale on the marketplace initially included only sixteen of the state's twenty-six acute care hospitals as participating providers. The state's guidance for consumers noted that "Insurance companies are not required to contract with every medical provider in the state. These are private negotiations between companies, and they are not regulated by the state. The Insurance Department does review the networks to be sure they are "adequate" to meet the needs of most people (approximately 90%) in the state, no matter where they live. Anthem's networks met this standard."⁷⁰

After the plans were unveiled, hospital executives accused Anthem of violating both the letter and spirit of the state's insurance regulations. The CEO of Valley Regional Hospital in Claremont declared, "I don't think people should be bullied into driving an hour to get their health care.... They [Anthem] created a product that maximized the value to their investors. Anthem didn't follow the spirit of the law." Another hospital CEO accused Anthem of discriminating against economically disadvantaged areas in the state, arguing that "the most disadvantaged hospitals were red-lined out of the network."⁷¹ Providers criticized the state's approval process for its lack of transparency. As Al Felgar, the CEO of Frisbie Memorial Hospital, wrote in *New Hampshire Business Review*, "With the state and federal governments' blessing, this narrow network was born outside of public scrutiny. Unlike networks in Massachusetts, where cost and quality data must be included in the public process, New Hampshire's plan was crafted in total secrecy."⁷² Hospitals expressed outrage at the impact of Anthem's decision on patients and physicians and assailed the process of contract negotiations for the company's new narrow network products. "There was no negotiation. Our hospital was given no chance to apply or compete for access into the plan. We were excluded, even though Frisbie Hospital has lower hospital charges than its closest competitors."⁷³

During the first year of ACA implementation in New Hampshire, Anthem Blue Cross Blue Shield's narrow network options created a firestorm of controversy. Anthem's insurance offerings excluded eight of the state's hospitals from its provider network, leading one patient — Margaret McCarthy of Rochester — to challenge the adequacy of the company's network coverage.⁷⁴ McCarthy petitioned the NHID to order Anthem to contract with Frisbie Memorial Hospital, contending that the network was inadequate according to the state's own regulations.⁷⁵ The NHID agreed to hear McCarthy's complaint, which alleged that purchasing coverage through the exchange would require her to change her medical providers.⁷⁶ The department ruled in December 2013 that neither McCarthy nor Frisbie Memorial Hospital, which had been excluded from the Anthem network, had standing and further noted that no state law required that a particular health care provider be included in a health insurance network.⁷⁷ Feldvebel noted, "Anthem has met our adequacy standards. Our regulations set a floor for minimum access. We have never required carriers to sign on every hospital in the state."⁷⁸ As the state insurance commissioner noted in his decision to deny McCarthy's claim, "Based on the evidence before me, the Petitioner has not met her burden of proof.... She has not shown that the Anthem Pathway network is inadequate because it does not include Frisbie."⁷⁹ In particular, the NHID's findings of fact noted that although Section 7 of RSA Chapter 420-J, "Network Adequacy," requires any health carrier offering a health insurance plan that is network-based to "maintain a network that is sufficient in numbers, types, and geographic location of providers to ensure that all services to covered persons will be accessible without unreasonable delay" it does not "require access to providers outside the network." Furthermore, the NHID noted that "nothing in RSA Chapter 420-J requires a health insurance carrier to contract with a particular provider, even if that provider meets the carrier's credentialing standards" and "[n]o provision of RSA Chapter 420-J gives a consumer the right to access medical providers that the health insurance carrier has not included in its provider network."⁸⁰

Beginning in 2015, four new QHPs will join the New Hampshire marketplace, bringing the total number of insurers on the marketplace to five. The five QHPs will offer nearly fifty different plans to consumers. The insurers are Anthem Blue Cross Blue Shield, Assurant Health, Harvard Pilgrim Health Care of New England, and two co-op health insurers — Maine Community Health and Minuteman Health. Harvard Pilgrim's new plans include contracts with virtually all (24/26) hospitals in the state.⁸¹ Roberts, senior vice president for regional markets at Harvard Pilgrim who also serves on the state's Health Exchange Advisory Board, noted that the company "knew we could not launch effectively in 2014 and make our introduction or debut as strong as possible.... The reason it took time to build the full-network is that we worked with all of the hospitals in the state to be sure we

can offer an affordable, full-network product, and we want to give the hospitals full credit for that.” In September 2014, Frisbie Memorial Hospital announced that it had signed contracts with four insurance companies participating in the state’s health insurance exchange – Minuteman Health, Harvard Pilgrim Health Care, Maine Community Health, and Assurant Health. Notably, however, Anthem Blue Cross Blue Shield chose to continue its narrow network plan for the 2015 calendar year.⁸²

New Hampshire uses a federally facilitated exchange. HB 1297, passed by the legislature in 2012, instructed state agencies to adopt policies that would preserve “the private, commercial delivery of health coverage through carriers and producers to the greatest degree possible under the Act and minimizing interference with the operation of commercial markets.” In addition, HB 1297 directed the insurance commissioner to promote “competition and consumer choice” by “allowing all health and dental plans that meet the minimum requirements necessary to be certified as qualified plans under the Act to be offered in the exchange.” Thus, New Hampshire embraced a clearinghouse exchange model, in which the state contracts with all QHPs that meet the minimum standards outlined in the ACA. The state reviews, but does not set, premium rates for QHPs. This position reflects the Granite State’s traditional preference for limited government and its long-standing support for free-market policy solutions.⁸³

Program Articulation

NH EASY, New Hampshire’s electronic application system, serves as the online portal by which residents can determine eligibility status and apply for Medicaid, CHIP, the Medicare Beneficiaries Savings Program, and other financial assistance programs. The Division of Family Assistance, within the state’s Department of Health and Human Services, determines Medicaid eligibility in conjunction with three other state entities: the Office of Medicaid Business and Policy (OMBP), the Bureau of Elderly and Adult Services (BEAS), and the Disability Determination Unit (DDU).

Changes in Insurance Markets

In September 2012, the NHID commissioned a report by Gorman Actuarial LLC to estimate the impact of the ACA on the state’s health insurance marketplace.⁸⁴ The Gorman report provided policymakers with an actuarial model to guide policy decisions (e.g., the future of the state’s high-risk insurance pool).

The Gorman report estimated that in 2011 the New Hampshire insurance market included 42,000 persons with individual insurance policies, 121,000 who purchased insurance in the small group market, and 130,000 uninsured (11.6% of the population, significantly below the national average). The state’s high-risk pool included roughly 4,000 individuals. The Gorman report estimated that health insurance premiums in the individual market

could increase 40 percent as a result of merging the high-risk pool and the existing individual market, as health care costs per for each member of the high-risk pool were an average of 5.7 times higher than the average individual market subscriber.⁸⁵ In addition, the Gorman report estimated that roughly 11,500 new subscribers would purchase coverage in the individual market following the implementation of reform in 2014; 58 percent of uninsured residents were estimated to qualify for premium subsidies under the ACA based on their family income. The Gorman report, however, assumed that New Hampshire would expand Medicaid to include residents earning up to 138 percent of the FPL.

On March 5, 2014, CMS issued an insurance standards bulletin that allowed states to extend the transition period for nongrandfathered health insurance plans in the individual and small-group markets. The NHID adopted these standards and granted a three-year extension for such plans renewed for a policy year beginning on or before October 1, 2016, to address the concerns of individuals whose policies were cancelled by insurers because they did not satisfy the ACA's minimum standards.⁸⁶

In August 2014, the Wakely Consulting Group released its analysis of the state's health insurance market after the conclusion of the first ACA open enrollment period.⁸⁷ This report, commissioned by the NHID, used data on enrollment collected from health insurers to track changes in health insurance status in early 2014. Although the number of insured residents in the Granite State increased by 22,000 as a result of rapid growth in the individual market and an increased number of Medicaid beneficiaries, the state's group-based health insurance market continued to erode.⁸⁸ The number of residents with individual policies increased by 75 percent from December 31, 2013 through April 1, 2014, from 34,817 to 60,795. At the same time, enrollment in the federal and state high-risk pools fell 70 percent during this same period, from 2,613 to 802, while Medicaid enrollment increased 8 percent, from 118,537 to 127,968. Notably, 36 percent of all individual market health insurance policies in New Hampshire were either grandfathered plans or were nongrandfathered plans extended under the CMS insurance standards bulletin adopted by the NHID in March 2014. In addition, the report found that the average age of covered members in the individual insurance market increased by more than three years from December 2013 to April/May 2014, "driven by a significantly higher age in the Exchange plans compared to non-Exchange plans (both ACA and non-ACA compliant)."⁸⁹ Significantly, the Wakely report found the number of New Hampshire residents covered by fully insured group plans (-5%) and self-insured plans (-1%) decreased in 2014. The authors noted that "while it may not be fully attributable to the ACA, the data collected indicated a decrease of 11,700 individuals covered by employers of all sizes in New Hampshire."⁹⁰

2.8. Data Systems and Reporting

The process of upgrading New Hampshire's Medicaid Medical Information System (MMIS) was fraught with difficulty in recent years. Beginning in 2005, New Hampshire embarked on a multiyear process to enhance its aging MMIS, which processes claims data for more than 180,000 Medicaid beneficiaries each year. When it was first awarded in 2004, the \$60 million contract with Affiliated Data Systems (subsequently acquired by Xerox) was the largest in state history. The vendor experienced a series of delays in implementation, missing several consecutive deadlines. Costs also far outstripped the initial budget.⁹¹ In December 2012, the state filed an Implementation Advanced Planning Document (IAPD) that extended the length of the contract with Xerox through 2018, raising the total cost by \$15 million to further develop its functionality for care management, Medicaid hospice and family planning benefits, HIPAA compliance, and other mandated services. Eight years after the state began upgrading its MMIS, the system began processing payments in April 2013 for more than 5,000 providers and 180,000 beneficiaries. The total cost for the upgrade reached \$90 million, but 90 percent of the project costs for design, development, and implementation were assumed by the federal government, which also assumed at least 50 percent of the system's operational costs.⁹²

New Hampshire submitted an IAPD to CMS for the use of enhanced federal matching funds under the ACA to assist in the design, development, and implementation of improvements to the state's eligibility determination and enrollment systems. This project, also known as the New Hampshire Electronic Application System (NH EASY), offers a web-based platform that enables providers and beneficiaries to evaluate their potential eligibility. NH EASY also introduced the ability for clients to perform all of their redetermination and change reporting activities online.⁹³

The NHID website provides links to external websites that present data about the uninsured population by county, but this information was prepared by Enroll America, using publicly available Census data, not state agencies. In March 2011, the state DHHS collaborated with several community groups to create the New Hampshire Health and Equity Partnership. The partnership, in turn, established a State Plan Advisory Work Group to develop a blueprint for improving access to health care among the state's ethnic, racial, and linguistic minorities.⁹⁴

Over the last decade, New Hampshire emerged as a national leader in developing policies to foster competition among health providers. In 2003, the state created a health data collection system, or all-payer claims database known as the New Hampshire Comprehensive Health Care Information System (CHIS). All third party payers are required to submit health insurance claims data. Responsibility for the CHIS is shared by the NHID and the state DHHS. The system includes bundled pricing for more than thirty common services.⁹⁵ As a result, the state's website — New

Hampshire HealthCost – allows both insured and uninsured consumers and employers to compare provider- and payer-specific pricing information for hospitals, ambulatory surgical centers, and physicians.⁹⁶ As recent evaluations of the state’s price disclosure efforts noted, “New Hampshire has played a more active role than nearly any other state in fostering price transparency. Most New Hampshire stakeholders agreed that the state’s actions influenced market dynamics ... by focusing attention on the wide variation in provider prices and thus helping to foster changes in benefit design”⁹⁷

Part 3 — Supplement on Small Business Exchanges

3.1. Organization of Small Business Exchanges

Small businesses are an integral part of New Hampshire’s economy. The U.S. Small Business Administration reports that as of 2011, 29,818 businesses in New Hampshire employed fewer than 500 employees; of these, 26,000 small businesses in New Hampshire employed between 1 and 19 employees.⁹⁸

In late September 2013, the Obama administration announced a one-month delay for the October 1, 2013, opening of SHOP exchanges, followed by a subsequent one-year delay for online enrollment in SHOP exchanges from November 2013 to November 2014. In the interim, small business owners in New Hampshire were eligible to apply for SHOP eligibility and enroll via a paper application process through an agent, broker, or a health insurance company. These delays sowed confusion among members of the New Hampshire business community.⁹⁹ The *Concord Monitor* also reported critically on the uncertainty regarding the availability of tax credits and the implications of New Hampshire employers participating in the SHOP exchange.¹⁰⁰

New Hampshire’s SHOP pool is separate from the individual marketplace pool. Anthem was the only carrier participating in the SHOP marketplace during the initial enrollment period beginning in October 2013, but Harvard Pilgrim Health Plan will also join the SHOP marketplace for the upcoming enrollment period.¹⁰¹ Anthem and Harvard Pilgrim also offer plans on the individual marketplace. Anthem offered three metal options for its SHOP plans – GuidedAccess Plans with primary care physician gatekeepers – that function like traditional HMOs.¹⁰² In June 2014, Harvard Pilgrim announced that “Four HMO plans for small businesses will also be available on the exchange through the Small Business Health Options Program (SHOP). Small business owners will be able to select gold or silver plans for both the ElevateHealth and Harvard Pilgrim’s full multi-state network.”¹⁰³

New Hampshire is currently one of eighteen states that opted not to offer an employee choice model. The state’s largest insurer, Anthem Blue Cross Blue Shield, supported a one year delay for implementing employee choice functionality in the SHOP marketplace until 2016, citing “concern regarding a potential for adverse

selection and perhaps more importantly, its implication for how carriers will address the uncertainties in an employee choice environment.”¹⁰⁴ One of the newest entrants into the state’s small group market – Minuteman Health, Inc. (MHI) – also counseled a “wait and see” approach to implementing employee choice in SHOP. “As a new entrant to the New Hampshire insurance market, MHI believes that it does not have the requisite experience to determine whether it is in the best interest of New Hampshire’s small group health insurance market.”¹⁰⁵ For its part, Harvard Pilgrim warned that “we, like other carriers, have little to no experience with employee choice in the SHOP and the potential for adverse selection is a real one.... Another rollout fraught with problems could very well lead to the SHOP being designated a failure by the small business community.”¹⁰⁶

In a June 2014 letter to Sebelius, the HHS secretary, Sevigny, the state insurance commissioner, requested a one year delay until 2016 to implement the employee choice provision of the SHOP exchange.¹⁰⁷ In his letter, the commissioner argued that implementing employee choice could adversely affect the stability of the state’s small group market. Citing public comment letters from producers, health issuers, and consumer advocacy groups supporting a delay in implementation, Sevigny noted that, “This is not to suggest that FF-SHOP employee choice should never be implemented in New Hampshire, but to recognize that carriers, producers, and even employers themselves have significant concerns about pricing, timing, and clarity.” Further, he argued, “Delaying implementation for one year ... would allow carriers adequate time to resolve those concerns, and to implement employee choice in a manner that will allow its benefits to be fully used and appreciated by FF-SHOP users, without unnecessary pricing impacts.”¹⁰⁸

Though the practice has proven controversial, Anthem limited its provider network for policies sold through the individual exchange, effectively lowering its premium rates by 25 percent. Anthem instituted a similar narrow network model for its SHOP plans, but opted to offer SHOP plans at the market rate to incentivize the participation of New Hampshire hospitals. Tax credits are available for businesses with fewer than twenty-five workers with an average wage below \$50,000. However, small businesses can only get the full 50 percent discount if they employ fewer than ten workers with an average wage of under \$25,000.¹⁰⁹

Part 4: Summary Analysis

Marketplace Enrollment Summary

On October 1, 2013, the HealthCare.gov online portal went live and marketplace enrollment commenced across the country. Almost immediately, the portal launch experienced serious and substantial problems that prevented individuals from accessing the site and enrolling in a health plan. The challenges directly

impacted New Hampshire residents, particularly during the first sixty days of the open enrollment period. Only 269 residents enrolled in coverage in October 2013, followed by 1,300 enrollees in November 2013; actual enrollments were well below CMS enrollment targets of 1,330 and 1,900 residents for October and November, respectively.¹¹⁰ Beginning in December, however, new enrollees far exceeded CMS expectations. CMS established a target of 11,970 sign-ups for the three-month period beginning in December 2013, and data indicated that 20,009 residents selected a plan.¹¹¹ According to data from HHS, a total of 40,262 New Hampshire residents selected a marketplace plan between October 1, 2013, and April 19, 2014. Such enrollment data represent a qualified success, however, as only 29.3 percent of an estimated 137,000 potential marketplace enrollees in the state selected a marketplace plan.¹¹² According to a recent study released by the NHID in September 2014, 22,000 previously uninsured residents gained coverage during the first five months of 2014.¹¹³

In New Hampshire, plan selection by gender closely mirrored national averages with 53 percent of enrollees identifying as female and 47 percent as male. Plan selection by age showed a consistent upward trend with age. Individuals between the ages of eighteen and twenty-five constituted 9 percent of those who selected a marketplace plan and those between the ages of twenty-six and thirty-four constituted 17 percent of enrollees.¹¹⁴ New Hampshire residents between the ages of fifty-five and sixty-four represented the greatest proportion of enrollees at 30 percent. Such data — indicating a greater propensity for older individuals rather than younger “invincibles” to select a marketplace plan — demonstrate a potentially significant shortcoming with wide-ranging implications. Data show that 27 percent of total enrollees in New Hampshire (26% of females and 27% of males) were between the ages of eighteen and thirty-four, falling well short of the Obama administration’s target of 40 percent in order to ensure adequate cross subsidization.¹¹⁵

Marketplace plan selection by metal level demonstrated a clear consumer preference for silver plans (59%) followed by bronze plans (26%). This aligned closely with national averages (65% and 20%, respectively).¹¹⁶ Although no New Hampshire residents selected a platinum plan (none were offered), 14 percent opted for a gold plan — a figure that equaled the combined national figures for gold and platinum enrollments.¹¹⁷ Although 77 percent of individuals who selected a marketplace plan in New Hampshire received financial assistance, this proportion was lower than the U.S. as a whole (85% of national marketplace enrollees qualified for assistance).¹¹⁸ Financial assistance also impacted the type of plan new enrollees selected during the open enrollment period; 91 percent of individuals receiving financial assistance selected either a bronze or silver plan, with the overwhelming majority — 68 percent — selecting a silver plan.¹¹⁹ While 67 percent of New Hampshire residents without financial

assistance also opted for bronze or silver plans, unsubsidized individuals notably were more likely to choose cheaper bronze plans (38% selected bronze and 29% selected silver).¹²⁰

Marketplace enrollment figures in New Hampshire essentially mirrored those at the national level. New Hampshire enrolled 29.3 percent of eligible enrollees in marketplace plans, slightly higher than the national average of 28 percent. Similarly, marketplace enrollment by gender and age was almost identical to national figures with one exception: the fifty-five to sixty-four age bracket. Those between ages eighteen and thirty-four constituted the largest proportion of marketplace enrollees at the national level (28 percent) followed closely by those between the ages of fifty-five and sixty-four (25 percent). In New Hampshire, the largest proportion of marketplace enrollees were between the ages of fifty-five and sixty-four (30%) followed closely by those between eighteen and thirty-four (27%).¹²¹

4.1 Policy Implications

New Hampshire's experience with implementing the ACA in 2013 and 2014 underscores the state's "wait and see" approach to health care reform. Since the passage of the ACA in March 2010, a wide range of national polls demonstrated that the public remains fundamentally split about the law and its effects; unlike other major health care reforms (e.g., the Medicare Modernization Act of 2003) the public has not warmed to the ACA over time. The stability of public attitudes towards the ACA is striking; despite month-to-month variations, surveys by the Kaiser Family Foundation, Gallup, and other major polling organizations reveal that public views of the ACA have changed little over the past four years. This ongoing partisan and policy divide is evident in the Granite State, as Republicans continue to oppose the ACA, while Democrats embrace reform — on New Hampshire's terms. As one Democratic legislator (who was also a practicing physician) noted in January 2014, "The ACA was designed with the fundamental principle that the public would not tolerate public funding of health care."¹²²

The fiscally conservative political culture in New Hampshire, coupled with staunch Republican opposition, contributed to a policy stalemate from 2010-2013. The state's Democratic governors supported implementation of the ACA, but in the face of opposition from the Republican-controlled Senate, neither establishing a state-operated exchange nor expanding Medicaid eligibility were politically viable options.

Pragmatism trumped ideology in spring 2013, as the state's Democratic governor, Hassan, persuaded lawmakers to accept a partnership exchange, which preserved the state's traditional role in regulating the health insurance marketplace, while ceding responsibility for the online exchange to the federal government. Hassan called the legislature into a special session in fall 2013 to consider Medicaid expansion, but lawmakers were unable to

reach an agreement. In spring 2014, New Hampshire followed the lead of Arkansas, Iowa, and Pennsylvania by seeking permission to pursue a “private option” to expand Medicaid eligibility. This approach broke the legislative deadlock in New Hampshire and delivered another key policy win for Hassan, who has now presided over a broad-based expansion of health insurance coverage during her first term in office. Using Medicaid funds to subsidize the purchase of private insurance policies complemented the state’s traditional support for private, free-market solutions to policy problems, offering legislators who opposed the ACA an opportunity to harvest federal dollars while still standing in opposition to “Obamacare.”¹²³

New Hampshire’s decision to expand Medicaid underscored its “wait and see” approach — while the state seized the opportunity to close its coverage gap using federal funds, the legislation expanding Medicaid eligibility contained a sunset clause that expires on December 31, 2016, when the federal government’s share of Medicaid costs drops to 90 percent. As the New Hampshire Fiscal Policy Institute noted in an issue brief, “New Hampshire would ultimately be able to provide affordable health care coverage to at least an additional 48,000 residents without any net cost to the state.”¹²⁴

To date, both hospitals and insurers emerged as clear winners during the first year of ACA implementation in New Hampshire. The state opted for a clearinghouse model and did not pressure the only participating health insurer in the marketplace — Anthem Blue Cross Blue Shield — to control the cost of premiums. Instead, the state allowed Anthem to offer limited “narrow network” plans to keep the price of its exchange offerings affordable. While this decision created an outcry among hospitals excluded from its network, the state ultimately upheld the discretion of insurers to selectively contract with hospitals, despite objections from patients and providers. Hospitals left out of Anthem’s new provider network expressed frustration with the new plan, but sixteen of the twenty-six acute care hospitals in New Hampshire were selected as participating providers. Hospitals participating in the new plans benefited from thousands of newly enrolled paying patients in 2014. Furthermore, all hospitals stood to benefit from New Hampshire’s decision to pursue a private option for Medicaid reform, as the waiver enabled thousands of lower-income residents to purchase subsidized private insurance policies. The state’s new Medicaid waiver will also increase Medicaid reimbursement payment rates for hospitals and community mental health centers.¹²⁵ Insurance brokers (producers) also retained a key role in the post-reform marketplace. Advocates for the poor and supporters of health care reform such as New Hampshire Voices for Health also achieved important policy goals by expanding access to health insurance, despite the state’s tentative “wait and see” approach.

Opinion polls conducted in late 2013 suggested that small business owners remain confused and uncertain about what the state's SHOP exchange means for them. Subsequent SHOP-related delays on the part of the Obama administration led to mutual agreement by carriers, producers, employers, and employees to delay implementation of the employee choice provision until 2016. Employees of small businesses may receive coverage through the SHOP exchange — coverage previously unavailable to some — but employers who do not qualify for SHOP-related tax credits may be hesitant to participate in the SHOP exchange. Anthem offers no “price break” to small business through the SHOP exchange; as Anthem's senior legal counsel in New Hampshire explained in the *New Hampshire Business Review*, hospitals agreed to accept reduced rates on the individual exchange.¹²⁶ The challenge ahead for the SHOP exchange is underscored by an August 2014 insurance market analysis prepared for the NHID, which indicated a 9 percent decrease in small group market enrollment in contrast with a 75 percent increase in individual market enrollment.¹²⁷

Opponents of the ACA exacted significant concessions during the state's implementation of health care reform in 2013 and 2014. Since the passage of HB 1297 in 2012 barred the state from establishing its own insurance marketplace, pursuing a partnership exchange was a compromise that preserved the state's regulatory authority while also providing New Hampshire with an infusion of federal funds. New Hampshire, however, did not seek to build its own internal capacity to manage reform. Most tasks — including outreach and public education along with website development for Covering New Hampshire and NH Easy — were outsourced to private consultants. Although New Hampshire accepted more than \$8.6 million in federal establishment and planning grants, its “wait and see” approach was evident in its limited media campaign promoting the new health insurance marketplace.

New Hampshire's decision to institute a partnership exchange continues to spark debate. Legislation which would repeal the ban on a state-based health insurance exchange (HB 54 — Amended) passed the House in January 2014, but was not considered by the Senate. Similarly, authors of the minority report issued to HB 1328, which proposed state licensure for navigators, argued that state licensure could only occur following a veto of the ban on a state-based exchange.

The November 2014 legislative and gubernatorial races reshaped the health care reform landscape in the Granite State. Ballotpedia identified the New Hampshire House and Senate elections as two of the top twenty legislative “battlegrounds” in 2014, and this prediction was borne out in the November election. Republicans reclaimed a majority in the House of Representatives, winning 239 out of 400 seats.¹²⁸ The 2014 election effectively reversed the previous partisan breakdown, in which Democrats

enjoyed a 213-173 majority. At the same time, Republicans increased their majority in the state Senate and now control fourteen of the twenty-four seats in that chamber. Hassan handily won reelection as governor with 52.5 percent of the vote, creating a classic case of divided government in New Hampshire.¹²⁹ With Republicans in firm control of both the House and the Senate, no movement toward implementing a state-based exchange is expected before 2016. Stability, not change, is the most likely scenario for ACA implementation in New Hampshire in the coming years.

New Hampshire's experience with Medicaid expansion in 2014 may offer a useful model for other states that remain deadlocked on this issue. While the use of a private option raises questions about the availability of "wraparound services" such as transportation for Medicaid-eligible patients, seeking a waiver to use Medicaid funds to purchase private coverage broke the legislative logjam over Medicaid expansion, paving the way for tens of thousands of state residents to obtain coverage.¹³⁰

The short- and long-term affordability of coverage purchased through New Hampshire's marketplace exchange also remains an open question. A June 2014 postenrollment survey conducted by Myers Research & Strategic Services indicated that 86 percent of New Hampshire respondents agreed that plans available through the exchange were affordable, 26 percent indicated that plans were very affordable, and only 8 percent answered that the plans were unaffordable.¹³¹ As noted above, the overwhelming majority of subsidized New Hampshire individuals selected a silver plan (68%), while unsubsidized individuals were more likely to choose bronze plans (38%) with lower premiums but higher deductibles.¹³² Recent national press coverage forecasts a potential affordability conundrum for newly insured individuals: Although lower-cost premiums spurred many to purchase coverage through the exchange, higher deductibles may dissuade some of the newly insured from seeking care to avoid high out-of-pocket costs.¹³³

4.2. Possible Management Changes and Their Policy Consequences

After the initial open enrollment period, state officials examined options to improve New Hampshire's outreach and education efforts. A recent report to the New Hampshire Health Exchange Advisory Board identified a gap in the partnership between producers and assistors in the marketplace. To improve coordination and communication, the report encouraged state officials to (1) increase awareness of the roles and responsibilities of producers and assistors and distribute information to those considering enrollment options; (2) embrace a more inclusive approach by partnering with professional organizations such as the New Hampshire Association of Insurance agents and New Hampshire Association of Health Underwriters; (3) create a

comprehensive and easily accessible list of producers, so that assistors and the public can better identify them.¹³⁴

Local health advocacy groups in New Hampshire also offered recommendations for improving the state's outreach and education efforts. In its post-open enrollment debriefing, New Hampshire Voices for Health emphasized the need to improve collaboration among assistors by creating an organization to coordinate activities of all marketplace assistors, certified application counselors, and navigators; distributing universal flyers that could be customized by different organizations; and establishing an assistor call center.¹³⁵ Nevertheless, state officials expressed a high level of satisfaction with the first year of open enrollment; a representative for Covering New Hampshire declared that "New Hampshire did the best out of any state on the federal exchange in terms of beating expectations."¹³⁶

Since Covering New Hampshire did not begin its outreach campaign until after well after the start of the open enrollment period on October 1, 2013, New Hampshire Voices for Health argued that early outreach to assistors (before the start of the enrollment period) will be crucial for its success in 2015. If assistors had access to information about the open enrollment process ahead of time, they would have had an opportunity to familiarize themselves with the information and procedures and complete trainings prior to meeting with enrollees. As a result, assistors would have been better equipped to help the public.¹³⁷ In addition, New Hampshire Voices for Health also identified a need for Covering New Hampshire to work with news organizations and reporters to counter inaccurate claims about the ACA and dispel misinformation about the enrollment process. As Amy Begalle of Mid-State Health Center stated, "It's a matter of trying to get to the public before the politicians do, as not all the information you see or hear is correct information."¹³⁸

These concerns foreshadowed the challenges New Hampshire now faces in its second open enrollment period. Covering New Hampshire's modest advocacy efforts to date — together with continued anti-Obamacare advocacy within the state (particularly in the context of the hotly contested U.S. Senate race between Republican challenger Scott Brown and incumbent Senator Jeanne Shaheen) — left New Hampshire residents with mixed messages about the ACA as the second open enrollment period began in November 2014. Recognizing a need to revamp its outreach and education efforts, Covering New Hampshire unveiled a new "multichannel media strategy" designed to "educate, inform, and drive consumers to the marketplace." The new campaign steps up the state's marketing efforts and includes television advertising (January-February 2015) along with public service announcements, radio ads, and direct mailings (November 2014-February 2015).¹³⁹

Future outreach and enrollment efforts will need to address several demographic trends that characterize the remaining

uninsured in New Hampshire. A June 2014 post-enrollment survey conducted by Myers Research & Strategic Services indicated that 47 percent of the remaining uninsured in the state are not registered to vote and tend to be politically disengaged; 63 percent are men; 60 percent are under the age of forty; 80 percent are not college graduates; and 38 percent are employed full time.¹⁴⁰

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