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Tenacity, Creativity and Results are the three words that best describe Shaheen & Gordon's approach to addressing complex legal issues. Our health care team closely monitors the rapidly changing legal environment so that our clients are prepared to meet the challenges of today as well as tomorrow. Relying on a wealth of experience, we offer practical advice and assist in implementing recommendations tailored specifically to meet the needs of both large and small health care clients.

FEDERAL DEVELOPMENTS

Trump Administration Releases 2019 Budget Proposal

On February 12, the Trump administration released its fiscal year 2019 budget request. The budget request proposes $95.4 billion in discretionary funding and $1,120 billion in mandatory funding for the Department of Health and Human Services ("HHS"). This amounts to a funding reduction of $17.9 billion from 2017 funding levels (a 21% decrease).

One priority emphasized in the budget is the opioid epidemic. The HHS budget proposal includes $5 billion in new funding over 5 years focused on a five-part strategy addressing the epidemic that includes: (1) improving access to prevention, treatment, and recovery services, including medication assisted therapies; (2) targeting availability and distribution of overdose-reversing drugs; (3) strengthening understanding of the epidemic through better public health data and reporting; (4) supporting cutting edge research on pain and addiction; and (5) advancing better practices for pain management.

Another focus of the budget is reducing wasteful Medicare and Medicaid spending. For Medicare reforms, proposals include reducing coverage of bad debt from 65% to 25%; reforming the Medicare appeals process, equalizing Medicare reimbursement for physician practices and off-campus facilities; and expanding the ability of Medicare Advantage organizations to pay for telehealth services. With respect to Medicaid, the budget proposes to allow states to modify eligibility requirements and to increase co-payments for non-emergency use of the emergency department.

The budget also presents several proposals aimed at reducing high drug prices, including measures to assist the entry of generic drugs, requiring Part D plans to share rebates from drug manufactures with beneficiaries, and eliminating cost-sharing for generic drugs for low-income seniors. There is also a proposal to modify the 340B prescription drug discount program to improve 340B program integrity by reducing payments to hospitals that do not meet a certain threshold of charity care and rewarding hospitals that do meet the threshold (.

The budget also takes aim at repealing and replacing the Affordable Care Act (ACA) by advocating for legislation that would replace federal health care subsidies to the states with block grants and rolling back Medicaid expansion. It also proposes to cut the grace period for individual marketplace purchasers to make premium payments from 90 to 30 days. Finally, it provides a mandatory appropriation for cost-sharing reduction ("CSR") payments for FY 2018 through the end of 2019.

Other notable characteristics of the budget include increased funding for fraud and abuse enforcement efforts and reducing the budget for the Office of the National Coordinator for Health Information Technology ("ONC")

by 36% by essentially eliminating the ONC's role in certain areas like health IT adoption.

A link to the FY 2019 HHS Budget is here: https://www.hhs.gov/sites/default/files/fy-2019-budget-in-brief.pdf

Proposed Rule Expands Access to Non-ACA Compliant Plans

On February 21, the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury issued a proposed rule (83 Fed. Reg 4347) to amend the definition of short-term, limited duration insurance ("STLDI") for purposes of its exclusion from the definition of individual insurance coverage, effectively expanding access to insurance plans that do not comply with the Affordable Care Act ("ACA"). Currently, the maximum coverage period for STLDI plans is three months, while the proposed rule would allow consumers to purchase STLDI plans with coverage periods up to 12 months. The ACA limitation on STLDI plans was put into place in October 2016 under the theory that the plans would be used as primary coverage and that they would adversely affect the risk pool for ACA marketplaces. The proposed rule is in response to President Trump's Executive Order issued last October where he called on federal agencies to issue regulations that would expand availability of alternative plans like STLDI. In the proposed rule, the Departments acknowledge that because STDLI plan can be priced so that the premium paid by an individual reflects the risks with insuring that particular individual, "individuals who are likely to purchase short-term, limited duration insurance are likely to be relatively young or healthy" and that "[a]llowing such individuals to purchase policies that are not in compliance with PPACA may impact the individual market single risk pools." Comments to the proposed rule are due April 23, 2018.

In February, the Urban Institute published a study on the impacts of the proposed rule, titled "The Potential Impact of Short-Term Limited-Duration Policies on Insurance Coverage, Premiums, and Federal Spending." Along with analysis of the impacts of the proposed rule, the study also analyzes the impact of other changes being made to the ACA, including the elimination of the individual mandate, withdrawal of cost-sharing reduction payments, and diminution of federal investments in advertising and enrollment assistance. The Urban Institute found that these changes will result in the following consequences: an increase in the uninsured population of 6.4 million people; an increase in the number of people without minimum essential coverage of 2.5 million people; an 18.2% average increase in ACA-compliant nongroup insurance; and a 9.3% increase in Federal spending.

The proposed rule may be read in full here: https://www.gpo.gov/fdsys/pkg/FR-2018-02-21/pdf/2018-03208.pdf

The Urban Institute study is available at: https://www.urban.org/sites/default/files/publication/96781/stld_draft_0226_finalized_0.pdf.

CMS Issues New Policy Removing Arbitrary Threshold for Intensive Level of Therapy in Review of Therapy Claims

On February 23, 2018, the Centers for Medicare & Medicaid Services ("CMS") issued Transmittal 771, which amends the Medicare Program Integrity Manual to change how therapy claims are reviewed by CMS contractors. Currently, reviews of therapy claims include a determination of whether the patient met the intensive level requirements by participating in a minimum of 3 hours of therapy per day for at least five days per week. Claims in which the patient failed to meet this threshold are automatically denied. The new policy change from CMS eliminates the automatic denial and provides instead that "When the current industry standard of generally 3 hours of therapy . . . per day at least 5 days per week or at least 15 hours of

intensive rehabilitation therapy within a 7 consecutive day period is not met, the claim shall undergo further review." The new policy provides further that on further review the contractor must "use clinical review judgment to determine medical necessity of the intensive rehabilitation therapy program based on the individual facts and circumstances of the case, and not on the basis of any threshold of therapy time." This new policy goes into effect March 23, 2018.

CMS Transmittal 771 is available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R771PI.pdf.

After Elimination of Individual Mandate Penalty, 20 States File Lawsuit Challenging ACA Constitutionality

On February 26, 2018, twenty-six states filed a lawsuit against the federal government challenging the constitutionality of the Affordable Care Act ("ACA"). This move comes after the recent Tax Cuts and Jobs Act that was signed into law on December 22, 2017 eliminated the ACA's tax penalty that was formerly imposed on individuals who failed to maintain health insurance. The lawsuit is rooted in the U.S. Supreme Court's decision in *National Fed. of Independent Bus. v. Sebelius* (June 28, 2012) which upheld the ACA's tax penalty as a proper exercise of Congress's power to tax, thus saving the individual mandate. The plaintiff states argue that now that the tax penalty has been eliminated, the remaining individual mandate is a Congressional overreach.

The Complaint filed in the lawsuit is available at: https://www.texasattorneygeneral.gov/files/epress/Texas_Wisconsin_et_al_v._U.S._et_al_-_ACA_Complaint_%2802-26-18%29.pdf.

DOJ Launches Prescription Interdiction & Litigation Task Force to Combat Opioid Epidemic

On February 27, 2018, the U.S. Department of Justice ("DOJ") announced the creation of the Prescription Interdiction & Litigation ("PIL") Task Force, which "will aggressively deploy and coordinate all available criminal and civil law enforcement tools to reverse the tide of opioid overdoses in the United States, with a particular focus on opioid manufacturers and distributors." The PIL Task Force will include personnel from the offices of the Attorney General, the Deputy Attorney General, and the Associate Attorney General, as well as senior officials from the Executive Office for U.S. Attorneys, the Civil Division, the Criminal Division, and the Drug Enforcement Administration. The Task Force's stated goals include holding opioid manufacturers and distributors accountable for unlawful practices, strengthening existing initiatives aimed at ensuring truthful marketing of opioids, and working with the U.S. Department of Health and Human Services to combat unlawful prescribing practices among providers.

On the same day it announced the PIL Task Force, the DOJ also announced that it would be filing a statement of interest in a current multi-district litigation brought by various cities, municipalities, and medical institutions against opioid manufacturers and distributors. The plaintiffs allege that the defendants used false deceptive, or unfair marketing practices for prescription opioid drugs. They hope to recover damages for the costs of the opioid crises that they have had to bear.

The DOJ announcement of the PIL Task Force is available at: https://www.justice.gov/opa/pr/attorney-general-sessions-announces-new-prescription-interdiction-litigation-task-force.

The DOJ announcement of its participation in the multi-district litigation is available at: https://www.justice.gov/opa/pr/justice-department-file-statement-interest-opioid-case.

Anthem Pulls Back on Planned Modifier 25 Policy

On February 23, Anthem's Executive Vice President and Chief Clinical Officer, Craig E. Samitt, M.D., MBA, wrote to the American Medical Association ("AMA") Chair-Elect, Jack Resneck, Jr., M.D., that it had decided against moving forward with its reimbursement policy slated to take effect on March 1, 2018. The proposed policy related to physician use of modifier 25. The proposed policy would cut payments to providers by 25% for significant, separately identifiable evaluation and management ("E/M") procedures provided on the same day a procedure is performed or a wellness exam is conducted. The proposed policy received considerable push-back from the AMA and state medical associations. The letter from Anthem states: "[w]hile Anthem is confident that duplication of payment for fixed/indirect practice expenses exist when physicians bill an E/M service appended with a modifier 25 along with a minor surgical procedure (0 or 10 day global) performed on the same day, the company believes making a meaningful impact on rising health care costs requires a different dialogue and engagement between payers and providers."

Settlement of Congressional ACA Challenge Stalls in Court of Appeals

On March 5, the Court of Appeals for the D.C. Circuit placed a temporary hold on what otherwise looked to be a smooth path to settlement for a lawsuit challenging payments to insurers under the Affordable Care Act's ("ACA") cost-sharing reduction ("CSR") program. On December 15, 2017, the Trump administration, the House of Representatives, and state intervenors announced a settlement of the House of Representatives' challenge. That same day, the parties filed a motion with the United States District Court for the District of Columbia seeking an indicative ruling that the District Court would vacate its prior ruling against the CSR payments if the case was remanded from the Court of Appeals. On January 16, 2018, the District Court issued an order indicating that it would vacate its previous order if the case was remanded back from the Court of Appeals. On January 19, the parties filed a joint motion with the Court of Appeals to remand the case back to the District Court. On March 5, the Court of Appeals ordered the parties to file within 30 days a supplement in support of their joint motion. In particular, the Court of Appeals is seeking an explanation of the "exceptional circumstances" cited by the parties in support of their motion.

CMS Launches Initiatives to Provide Patients Greater Access to Their Medical Data

On March 6, in remarks at the Healthcare Information and Management Systems Society Annual Conference in Las Vegas, Centers for Medicare & Medicaid Services ("CMS") Administrator Seema Verma announced the launch of two technological initiatives aimed at modernizing how patients access their own medical data.

The first – MyHealthEData – "will work to make clear that patients deserve to not only electronically receive a copy of their entire health record, but also be able to share their data with whomever they want, making the patient the center of the healthcare system," according to CMS. The MyHealthEData initiative is in response to President Trump's executive order from October that directed federal agencies to "re-inject competition into healthcare markets" and "improve access to and the quality of information that Americans need to make informed healthcare decisions."

The second initiative – Blue Button 2.0 – is a new and secure way for Medicare beneficiaries to access and share their personal health data in a universal digital format and will enable them to connect their claims data to secure applications, providers, services, and research programs they trust. According to CMS, more than 100 organizations, "including some of the most notable names in technological innovation,

have signed on to use Medicare's Blue Button 2.0 to develop applications that will provide innovative new tools to help these patients manage their health."

CMS' press release on these initiatives is available at: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2018-Press-releases-items/2018-03-06.html.

CMS Intervenes to Stop Idaho from Allowing Non-ACA-Compliant Health Plans

On March 8, 2018, the Centers for Medicare & Medicaid Services ("CMS") sent a letter to the Governor of Idaho and the Director of Idaho's Department of Insurance, informing them that Idaho's proposal to allow for health plans that do not comply with the Affordable Care Act would force CMS to intervene and enforce the ACA's provisions. CMS' letter comes after Governor Butch Otter issued an executive order in January that prompted the state's Department of Insurance to issue guidelines for so-called "state-based health benefit plans" that would not comply with the ACA's benefits requirements. CMS notified the governor and director that Idaho's proposal would be treated as a failure to enforce the ACA, and that in such a case CMS is obligated to step in and enforce the law despite CMS' belief that the ACA "is failing to deliver quality health care options to the American people and has damaged health insurance markets across the nation, including Idaho's." CMS' stated its belief that "with certain modifications" Idaho's proposed "state-based plans" could qualify as short-term, limited duration plans that are exempt from complying with the ACA under CMS' recently-proposed rule that increased the allowable length of such plans to twelve months.

CMS' letter is available at: https://www.cms.gov/CCIIO/Resources/Letters/Downloads/letter-to-Otter.pdf.

STATE DEVELOPMENTS

REMINDERS:

- **Annual Reports for New Hampshire business entities are due to the Secretary of State by April 1, 2018.**

NH DHHS Seeking Waiver for Expanded Access to Treat SUD

In a press release published February 28, the New Hampshire Department of Health and Human Services ("DHHS") is planning to file a federal waiver with the Centers for Medicare and Medicaid Services ("CMS") seeking to expand access to residential treatment for substance use disorder (SUD) services. If approved, the State could receive federal funds for adults and adolescents who are Medicaid-eligible and receive residential SUD treatment in an Institution for Mental Disease for as long as is medically necessary. This means that more behavioral health facilities that provide residential and inpatient hospital SUD treatment services to Medicaid beneficiaries would be eligible for reimbursement. DHHS Commissioner Jeffrey A. Meyers has commented, "[w]ith some of the highest rates of youth alcohol and drug use, it is particularly important that New Hampshire expand both the outpatient and residential capacity for residents under 18 years of age." DHHS is seeking public comment about the waiver. Comments must be received by 12:00 pm on March 30.

N.H. Senate Passes Bill to Continue Expanded Medicaid

On March 8, 2018, the New Hampshire Senate voted 17-7 to continue the state's expansion of Medicaid under the Affordable Care Act, which was set to expire at the end of the year if it is not reauthorized by the General Court. As part of the reauthorization bill, the expanded program will move to a

managed care model, instead of simply subsidizing plans on the individual market. The bill also includes a "work and community engagement requirements" as a condition of coverage. Opponents of the bill cited increasing insurance costs in the individual market, increasing costs to the state, and a lack of efficacy as reasons not to reauthorize the expansion. The bill will now move to the House. Governor Sununu is supportive of the bill and is expected to be integral in obtaining passage in the House.

Governor Sununu Supports Legislation for Recovery Friendly Workplaces

On March 8, Governor Sununu expressed his support for legislation passed by the Senate that allows "Recovery Friendly Workplaces" to apply for CDFA tax credits "that will assist them in implementing the policies and practices that improve health and safety in the workplace." Calling the legislation "historic," the Governor noted that it would help guide the 60,000 Granite Staters already in recovery to businesses that support individuals and families in recovery. Senate Bill 563 now moves onto the House.

The text of the Bill may be found at
http://www.gencourt.state.nh.us/bill_Status/billText.aspx?sy=2018&id=1904&txtFormat=pdf&v=current

2018 LEGISLATIVE UPDATES

HB 1102-FN This bill authorizes the commissioner of the department of health and human services to contract with a physician certified by the Academy Society of Addiction Medicine to review medication assisted treatment in New Hampshire. **Introduced and referred to House HHS Committee. Voted Ought to Pass by the Committee and by the full House. The amendment allows the HHS Commissioner to contract with multiple physicians, permits the physician(s) to be certified from one of multiple accrediting bodies, and describes the consultant's role in more general terms.**

HB 1241: This bill establishes a commission to study the benefits and cost of a "health care for all" program for New Hampshire. **Introduced and referred to House Commerce Committee. Voted Inexpedient to Legislate by the Committee and the full House.**

HB 1362: This bill authorizes individuals and certain businesses to purchase health insurance from out-of-state companies. The bill grants rulemaking authority to the insurance commissioner for the purposes of the bill. **Introduced and referred to House Commerce Committee. Referred to interim study by the full House.**

HB 1367: This bill declares that children do not have to be immunized against tetanus. **Introduced and referred to House HHS Committee. Voted Inexpedient to Legislate by the Committee and the full House.**

HB 1418-FN This bill requires the commissioner of the department of health and human services, in consultation with the insurance commissioner, to develop a list of certain critical prescription drugs for purposes of cost control and transparency. Under this bill, the commissioner shall make an annual report on prescription drugs and their role in overall health care spending in the New Hampshire. **Introduced and referred to House Commerce Committee and sent to subcommittee. Voted Ought to pass with Amendment by the Committee and the full House. The amendment provides for the creation of a Commission to Study Greater Transparency in Pharmaceutical Costs and Drug Rebate Programs.**

HB 1462-FN: This bill requires employers who offer health or dental benefits, or both, to its employees to maintain that coverage for an employee who has filed a compensable claim under the workers' compensation law for 24 months or until the employee has returned to work, whichever is shorter. **Introduced and referred to House Labor Committee. Voted Inexpedient to Legislate by the Committee.**

HB 1465: This bill requires Medicare supplemental insurance policies to provide coverage for hearing aids. **Introduced and referred to House Commerce Committee. Referred for interim study by the full House.**

HB 1468: This bill establishes a commission to study legislative oversight activities related to the department of health and human services. **Introduced and referred to House HHS Committee. Voted Ought to Pass with Amendment by the Committee and the full House. The amendment extends the date for the study committee to report by one year to November 1, 2019.**

HB 1471: This bill clarifies the law relating to telemedicine services. **Introduced and referred to House HHS Committee. Voted Ought to Pass with Amendment by the Committee and by the full House. Referred to House Commerce and Consumer Affairs Committee. The amendment clarifies that the reimbursement rates will be the same as for services provided in the provider's office or facility, "provided that such rates do not exceed rate for in-person consultation at the originating site."**

HB 1506-FN This bill: I. Establishes the regulation and licensure of assistant physicians by the board of medicine. II. Regulates their practice through assistant physician collaborative practice arrangements. III. Establishes a grant program in the department of health and human services to provide matching funds for primary care clinics in medically underserved areas utilizing assistant physicians. **Introduced and referred to House HHS Committee. Voted Ought to Pass with Amendment by the Committee and the full House. The amendment replaces "assistant physicians" with "graduate physicians."**

HB 1516: This bill establishes a commission to examine the feasibility of the New England states entering into a compact for a single payer health care program. **Introduced, referred to House Commerce Committee and sent to subcommittee. Voted Inexpedient to Legislate by the Committee and the full House.**

HB 1530: This bill adds a requirement for submission of criminal history records prior to licensure or certification by an allied health professional governing board. **Introduced, referred to House Executive Departments and Administration Committee and sent to subcommittee. Voted Ought to Pass with Amendment by the Committee and the full House. The amendment permits applicants for licensure to be employed in an allied health profession on a conditional basis for up to 90 days while awaiting the results of a criminal history record check, subject to certain requirements.**

HB 1560: This bill provides that sex reassignment drug or hormone therapy or surgery shall not be covered under the state Medicaid plan. **Introduced and referred to House HHS Committee. Voted Inexpedient to Legislate by the Committee and the full House.**

HB 1571: This bill authorizes the board of nursing to operate or contract for an alternative recovery monitoring program for nurses impaired by substance use disorders or mental or physical illness.

Introduced and referred to House Executive Departments and Administration Committee. Voted Ought to Pass with Amendment by the Committee and the full House. The amendment reconfigures the proposed statutory language and adds a provision for the board of nursing to promulgate rules to implement the statute.

HB 1577: This bill provides for the regulation of the use of general anesthesia, deep sedation, or moderate anesthesia by dentists and the reporting of adverse events. **Introduced and referred to House HHS Committee. Voted Ought to Pass with Amendment by the Committee and the full House. The amendment adds a provision for dental insurance coverage for children under 13 years of age for dental procedures requiring anesthesia.**

HB 1606: This bill makes various changes to the regulation of doctors of naturopathic medicine including the scope of practice of naturopaths and the procedures of the naturopathic board of examiners. **Introduced and referred to House Executive Departments and Administration Committee. Voted Ought to Pass with Amendment by the Committee and the full House. The amendment provides for the election of a chairperson of the board of examiners, changes the quorum for the board from four members to three, and increases the frequency of submission by the licensee of proof of continuing education.**

HB1617: This bill inserts definitions in the RSA chapter relating to communicable disease for clarification purposes. **Introduced and referred to House HHS Committee. Voted Inexpedient to Legislate by Committee and the full House.**

HB 1625: This bill requires facilities licensed under RSA 151 which perform digital foot scanning of patients and newborns to provide patients and the parents of the newborn an opportunity to "opt out" of such procedure. **Introduced and referred to House HHS Committee. Voted Inexpedient to Legislate by the Committee and the full House.**

HB 1643: This bill prohibits balance billing under the managed care law. **Introduced, referred to House Commerce Committee and sent to subcommittee. Voted Inexpedient to Legislate by the Committee and the full House.**

HB1654: This bill prohibits holding an injured driver or passenger responsible for medical costs determined to not be reasonable. **Introduced and referred to House Commerce Committee. Voted Ought to Pass by the Committee and the full House.**

HB1664: This bill clarifies the eligibility to reappoint a member of a governing board of an allied health profession to an additional full term. **Introduced and referred to House Executive Departments and Administration Committee. Voted Ought to Pass by the Committee and the full House.**

HB1665: This bill clarifies the authority of the governing boards of allied health professionals concerning individuals who are certified by such boards. **Introduced and referred to House Executive Departments and Administration Committee. Voted Ought to Pass by the Committee and the full House.**

HB 1672-FN: This bill requires a search warrant issued by a judge based upon probable cause for any federal request for information relative to users of therapeutic cannabis created by the registry. **Introduced and referred to House Judiciary Committee. Voted Ought to Pass by the Committee.**

HB 1707-FN: This bill requires the physician who performs an abortion, or the referring physician, to provide the pregnant woman with certain information at least 24 hours prior to the abortion, and to obtain her consent that she has received such information. **Introduced and referred to House HHS Committee, which voted to refer the bill for interim study.**

HB 1732-FN: This bill establishes a nursing professionals' health program for aiding nurses impaired or potentially impaired by mental or physical illness including substance abuse or disruptive behavior. **Introduced and referred to House Executive Departments and Administration Committee. Voted Inexpedient to Legislate by the Committee and the full House.**

HB 1740: This bill repeals the provision relating to the costs of blood testing orders when certain individuals have been exposed to another person's bodily fluids. **Introduced and referred to House Commerce Committee. Voted Ought to Pass with Amendment by the Committee and the full House. The amendment does not repeal the current statute but rather eliminates the requirement that private health or automobile insurance be responsible for payment when there is no workers' compensation coverage.**

HB 1741: This bill allows an insured to pay the least amount for covered prescription medication under the managed care law. **Introduced and referred to House Commerce Committee. Voted Ought to Pass with Amendment by the Committee and the full House. The amendment deletes the entire bill and provides only for a new definition for "contracted copayment."**

HB 1743: This bill increases the percentage of money distributed to the alcohol abuse prevention and treatment fund. This bill also repeals the ability of the commissioner to get fiscal committee approval to use certain funds to pay for the operational costs of the Sununu Youth Services Center. **Introduced and referred to House Finance Committee. Voted Ought to Pass with Amendment by the Committee and the full House. The amendment requires funding transfer out of or within the Sununu Youth Services Center to get the prior approval of the Fiscal Committee, clarifies the procedure for filling unfunded positions within the Department of Health and Human Services, and requires the Commissioner to make a monthly report to the Fiscal Committee.**

HB 1746: This bill prohibits certain practices of pharmacy benefit managers. **Introduced, referred to House Commerce Committee and sent to subcommittee. Voted Ought to Pass with Amendment by the Committee and the full House. The amendment adds a repeal of the prohibition to take effect on June 30, 2020.**

HB 1751: This bill requires insurance coverage for treatment for pediatric autoimmune neuropsychiatric disorders. **Introduced, referred to House Commerce Committee and sent to subcommittee. Referred for interim study by the full House.**

HB 1755-FN: This bill establishes an office of the inspector general to independently advocate for the people and provide assistance in the exercise of their Article 14 rights. **Introduced and referred to House Executive Departments and Administration Committee. Voted Inexpedient to Legislate by the Committee and the full House.**

HB 1769-FN: This bill prohibits discrimination against physicians based on maintenance of certification. **Introduced and referred to House HHS Committee. Voted Ought to Pass with Amendment by the**

Committee and the full House. The amendment makes a small change to those entities that are prohibited from differentiating between physicians based on a physician's maintenance of certification.

HB 1787-FN: This bill prohibits discrimination against health care providers who conscientiously object to participating in certain medical procedures. **Introduced and referred to House HHS Committee where it was vacated and referred to House Judiciary Committee. Voted Inexpedient to Legislate by the Committee.**

HB 1790-FN-A: This bill establishes a New Hampshire health access corporation and health access fund. **Introduced and referred to House Commerce Committee. Voted Inexpedient to Legislate by the Committee and the full House.**

HB 1791-FN: This bill declares that a contract between an insurance carrier or pharmacy benefit manager and a contracted pharmacy shall not contain a provision prohibiting the pharmacist from providing certain information to an insured. **Introduced and referred to House Commerce Committee. Voted Ought to Pass by Committee. Voted Ought to Pass by the Committee and the full House.**

HB 1806: This bill clarifies the notification procedure if the federal match falls below a certain percentage for the New Hampshire health protection program. **Introduced and referred to House HHS Committee. Voted Inexpedient to Legislate by the Committee and the full House.**

HB 1809-FN: This bill prohibits balance billing under the managed care law. This bill is the result of the committee established in 2017, 20. **Introduced, referred to House Commerce Committee and sent to subcommittee. Voted Ought to Pass with Amendment by the Committee and the full House. The amendment moves the new statutory language to a different chapter and updates internal references.**

HB 1811-FN-A: This bill: I. Extends the New Hampshire Health Protection Program. II. Requires the commissioner of the department of health and human services to apply to the Centers for Medicare and Medicaid Services for a waiver to develop a screening process for medically complex persons who are enrolled in the New Hampshire health protection program. III. Allows the use of general funds to fund the New Hampshire health protection program. **Introduced and referred to House HHS Committee. Voted by Committee and House to refer to Interim Study.**

HB 1813-FN: This bill requires the commissioner of the department of health and human services to seek a waiver from the Centers for Medicare and Medicaid Services to reduce eligibility for benefits under the New Hampshire health protection program from 138 percent of the poverty level to 100 percent. This bill also requires the commissioner to develop and implement enhanced eligibility screening procedures. **Introduced, referred to House HHS Committee and sent to subcommittee. Voted Inexpedient to Legislate by the Committee and the full House.**

HB 1816-FN: This bill requires the commissioner of the department of health and human services to adjust the Medicaid managed care program by requesting a certain waiver from the Centers for Medicare and Medicaid Services, implementing enhanced eligibility screening, and requiring managed care organizations to meet the federal medical loss ratio provision with any surplus to be deposited into the general fund. This bill also eliminates certain provisions under step 2 of the program. **Introduced, referred to House HHS**

Committee and sent to subcommittee. Voted Ought to Pass with Amendment by the Committee. The bill as amended declares that the remaining unimplemented phases of step 2 of the program shall not be implemented and requires the commissioner to implement enhanced eligibility screening and require managed care organizations to meet the Federal medical loss ratio provision with any nonfederal surplus to be deposited into the general fund.

HB 1822-FN: This bill allows pharmacists to dispense hormonal contraceptives pursuant to a standing order entered into by health care providers. This bill is the result of the commission established pursuant to 2017, 23. **Introduced and referred to House HHS Committee where it was voted Inexpedient to Legislate. The full House rejected the Committee's vote and instead voted Ought to Pass. It was then sent to the House Commerce Committee to assess its economic impact.**

SB 313-FN: This bill establishes the New Hampshire Granite Advantage Health Care Program which shall replace the current New Hampshire health protection program. Under this program, those individuals eligible to receive benefits under the Medicaid program and newly eligible adults shall choose coverage offered by one of the managed care organizations contracted as vendors under the Medicaid program. **Introduced and referred to Senate Finance Committee. Voted Ought to Pass with Amendment by the Committee and the full House. The bill as amended provides for the establishment of the Granite Workforce Pilot Program and increases the amount of liquor revenues to be deposited into the Alcohol Abuse Prevention and Treatment fund and provides that moneys deposited into the fund shall be transferred to the Granite Advantage Health Care Trust Fund for substance use disorder prevention, treatment, and recovery.**

SB 327: This bill removes the requirement that a member of the medical review subcommittee be from the Board of Medicine and reduces the time limitation for allegations of professional misconduct enforced by the Board of Medicine. **This bill is a request of the Board of Medicine. Introduced and referred to Senate Executive Departments and Administration. Voted Ought to Pass by the Committee and the full Senate.**

SB 332: This bill requires insurers offering health insurance policies with prescription drug coverage to allow covered persons to synchronize the dispensing dates of their prescription drugs**. Introduced and referred to Senate HHS Committee. Voted Ought to Pass with Amendment by the Committee and the full Senate. The amendment revises the bill by adding specificity to the circumstances under which the synchronization is available.**

SB 354: This bill prohibits a pharmacy benefits manager or insurer from charging or holding a pharmacy responsible for a fee related to a claim under certain circumstances. This bill also prohibits a pharmacy benefits manager or insurer from charging higher copayments and or inserting gag clauses in contracts. **Introduced and referred to the Senate Commerce Committee.**

SB 374: This bill exempts the adoption of emergency medical and trauma services protocols from the rulemaking process under RSA 541-A. **Introduced and referred to Senate Executive Departments and Administration. Voted Ought to Pass by the Committee and the full Senate.**

SB 377: This bill makes various changes to the regulation of dentists and dental hygienists, including requiring criminal history records checks for new applicants and establishing a professionals' health program

for impaired dentists. This bill is a request of the board of dental examiners. **Introduced and referred to Senate HHS Committee. Voted Ought to Pass by the Committee and the full Senate.**

SB 378-FN: This bill exempts certain health care facilities from the requirement of employing registered medical technicians. **Introduced and referred to Senate HHS Committee. Voted Ought to Pass by the Committee and the full Senate.**

SB 379: This bill changes the time frame for insurance companies and managed care organizations to recover payments from a health care provider for services completed. As introduced, the bill would have reduced the time period for retroactive denials from 18 months to 6 months. The amended bill changes the time frame to 12 months. **Voted Ought to Pass by the Senate.**

SB 381: This bill declares that a parent or legal guardian shall not be required to have their child immunized against Hepatitis B or other sexually transmitted diseases. **Introduced and referred to Senate HHS Committee. Voted Inexpedient to Legislate by the Committee and the full Senate.**

SB 383: This bill establishes a commission to study the benefits and costs of a "health care for all" program for New Hampshire. **Introduced and referred to Senate HHS Committee.**

SB 421: This bill clarifies insurance coverage for prescription contraceptive drugs and prescription contraceptive devices and for contraceptive services. **Introduced and referred to Senate Commerce Committee.**

SB 475: This bill requires health care providers to provide certain information to persons being tested for Lyme disease. **Introduced and referred to Senate HHS Committee. Voted Ought to Pass with Amendment by the Committee. The amendment changes the notice to be provided to patient who are screened for Lyme disease and adds a repeal of the newly-added chapter effective July 1, 2023.**

SB 480: This bill prohibits the use of electroconvulsive therapy on persons under 16 years of age and individuals who are involuntary patients but who have not yet had a competency hearing. The bill requires adults and guardians to sign a detailed written consent form before electroconvulsive therapy is administered. **Introduced and referred to Senate HHS Committee. Voted Inexpedient to Legislate by the Committee and the full Senate.**

SB 502-FN: This bill clarifies the standards for acquisition transactions involving health care charitable trusts and the review required by the director of charitable trusts. **Introduced and referred to Senate Judiciary Committee. Voted Ought to Pass by the Committee and the full Senate.**

SB 531-FN: This bill provides for the office of professional licensure and certification to establish by rule and collect the fees for boards and commissions administered by the office, and to deposit the fees collected in the office of professional licensure and certification fund for payment of the costs and salaries of the office. This bill is a request of the office of professional licensure and certification. **Introduced and referred to Senate Executive Departments and Administration which voted Ought to Pass. Senate voted Ought to Pass. Referred to Senate Finance Committee which voted Ought to Pass. Senate voted Ought to Pass.**

SB 573: This bill allows the chief medical examiner and designees to register and access the controlled drug prescription health and safety program. This bill also makes an appropriation to the controlled drug prescription health and safety program. This bill is a request of the controlled drug prescription health and safety program, established in RSA 318-B:32. **Introduced and referred to Senate HHS Committee which voted Ought to Pass with Amendment. Senate voted Ought to Pass with Amendment. Referred to Senate Finance Committee. The amendment clarifies the access by the Chief Medical Examiner and delegates.**

SB 576-FN: This bill repeals the provision suspending home health services rate setting established in 2017, 156. **Introduced and referred to Senate Finance Committee. Voted Inexpedient to Legislate by the Committee. Senate voted to lay on table.**

SB 578-FN: This bill clarifies the terms of appointment and salary for the following positions in the department of health and human services: deputy commissioner, associate commissioner of human services and behavioral health, associate commissioner of operations, and associate commissioner for population health. The bill is a request of the department of health and human services. **Introduced and referred to Senate Executive Departments and Administration which voted Ought to Pass. Senate voted Ought to Pass. Referred to Senate Finance Committee.**

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Cinde Warmington, Kara J. Dowal, and Alexander W. Campbell contributed to this month's Legal Update.

BIOS

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