

TITLE XXXVII INSURANCE

CHAPTER 404-G INDIVIDUAL HEALTH INSURANCE MARKET

Section 404-G:1

404-G:1 Purpose of Provisions. – The purpose of this chapter is to:

I. Protect the citizens of this state who participate in the individual health insurance market by providing a mechanism to equitably distribute the excessive risk sometimes associated with this market and to enable insurers to better protect against the costs of covering high risk individuals.

II. Create a nonprofit, voluntary organization to facilitate the availability of affordable individual nongroup health insurance by establishing an assessment mechanism and an individual health insurance market mandatory risk sharing plan as a mechanism to distribute the risks associated within the individual nongroup market.

III. Establish a high risk pool that will provide access to health insurance to all residents of the state who are denied health insurance for medical or health reasons. The premiums charged for coverage in the high risk pool shall be affordable and the coverage provided shall be reasonably comprehensive and comparable to coverage available outside of the high risk pool. It is the intent of the legislature that the high risk pool shall be adequately funded through an annual, and if necessary, a special assessment mechanism, that the high risk pool shall utilize cost containment measures, including, but not limited to, providing network based coverage, and that measures shall be taken to avoid inappropriate shifting of costs and risk to the high risk pool.

Source. 1998, 340:6. 2001, 295:4, eff. July 1, 2001.

Section 404-G:1-a

404-G:1-a Study and Biannual Report. – The commissioner shall evaluate the impact and effectiveness of RSA 404-G in effectuating the principles outlined in RSA 404-G:1, III. This review shall be based on data collected from carriers in the individual market and from the association, including but not limited to the following data elements: data on premiums and carrier profitability, carriers entering or exiting the market, products being sold, basis for high risk pool eligibility, and overall denial rate. The study shall be completed within 6 months of the availability of data on the first 2 years of operation of the high risk pool. Upon completion of the study, the commissioner shall make an initial report relative to the findings of the study to the governor, the president of the senate and the speaker of the house of representatives and shall make biannual reports to such persons thereafter.

Source. 2001, 295:15, eff. July 1, 2001.

Section 404-G:2

404-G:2 Definitions. – In this chapter:

I. "Actively marketing" means actively marketing, issuing, and renewing all of the health coverages the respective carrier sells in the individual market to all individuals.

II. "Assessment" means the liability of the member insurer to the association.

III. "Association" means the entity created within this chapter which shall be the same association as that created under the order, defined in paragraph X.

IV. "Commissioner" means the insurance commissioner.

V. "Covered lives" shall include all persons who are:

(a) Covered under an individual health insurance policy issued or delivered in New Hampshire;

(b) Covered under a group health insurance policy that is issued or delivered in New Hampshire;

(c) Covered under a group health insurance policy evidenced by a certificate of insurance that is issued or delivered in New Hampshire;

(d) Protected, in part, by a group excess loss insurance policy where the policy or certificate of coverage has been issued or delivered in New Hampshire, and where coverage has been purchased by a group health insurance plan subject to the Employee Retirement Income Security Act of 1974, Public Law No. 93-406 (ERISA).

V-a. "Group excess loss insurance" means coverage purchased by an employer against the risk that any one claim made against the employer's health plan will exceed a specified dollar amount or coverage purchased by an employer against the risk that the employer's total liability for the health plan will exceed a specified amount.

VI. "Group health insurance" means health insurance coverage other than individual health insurance coverage.

VII. "Health insurance" means health insurance coverage issued in accordance with RSA 415, 420-A, or 420-B. For the purposes of this chapter, health insurance shall not include accident only, credit, dental, vision, Medicare supplement, Medicare Risk, Medicare+Choice, Managed Medicaid, long-term care, disability income, coverage issued as a supplement to a liability insurance, workers' compensation or similar insurance, automobile medical payment insurance, policies or certificates of specified disease, hospital confinement indemnity, limited benefit health insurance or short-term, nonrenewable individual health insurance, coverage provided through the New Hampshire healthy kids association, and coverage provided through the Federal Employees' Program. Nonprofit health service corporations shall exclude coverage provided through national account policies originating outside of New Hampshire to the extent the nonprofit health service corporation assumes no risk for the provision of such insurance. Health insurance does include group excess loss insurance.

VIII. "Individual health insurance" means health insurance sold directly to an individual and not on a group remittance basis. Individual health insurance shall include franchise health insurance.

IX. "Insurer" means any entity licensed pursuant to RSA 402, RSA 420-A, or RSA 420-B.

X. "Order" means the insurance department findings and final order dated November 26, 1997, in the matter of the individual health insurance market in New Hampshire pursuant to RSA 404-C.

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

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

XI. "Writer" means a writing carrier.

Source. 1998, 340:6. 2003, 276:1, 2, eff. July 1, 2003.

Section 404-G:3

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

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

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

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

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

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

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

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

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

(g) Provide for reinsurance of risks incurred.

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

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

(a) Fulfill the plan of operation as approved by the commissioner.
(b) Issue policies of insurance to persons eligible for the high risk pool.
(c) Prepare certificate of eligibility forms and enrollment instruction forms.
(d) Determine and collect assessments for the risk sharing mechanism and for the high risk pool.
(e) Disburse assessment payments, as provided in the plan of operation for the high risk pool.
(f) Establish appropriate rates, rate schedules, rate adjustments, expense allowances, agent referral fees, claim reserve formulas and any other actuarial functions appropriate to the plan of operation for the high risk pool.

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

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

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

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

Source. 1998, 340:6. 2001, 295:7, eff. July 1, 2001.

Section 404-G:4

404-G:4 Association Membership and Governance. –

I. The association shall be comprised of all writers of health insurance.

II. The initial board of directors of the association shall be the same as that set forth in the order. Except as provided in paragraph IV, each successor board shall consist of 9 individuals who are representative of categories of members of the association, health care providers, consumers who have purchased or are likely to purchase coverage from the pool, insurance brokers, small employers, and the commissioner who shall be an ex-officio member. In the initial and in each successor board, 3 directors shall be representative of and elected by qualified writers of group health insurance, 2 directors shall be representative of and elected by qualified writers of individual health insurance, one director shall be representative of the health care provider community and shall be appointed by the commissioner, one director shall be representative of consumers covered through the high risk pool and shall be appointed by the commissioner, one director shall be a representative of insurance brokers and shall be appointed by the commissioner, and one director shall be a representative of small employers and shall be appointed by the commissioner.

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

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

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

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

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

(1) If the total size of the board-elect is 9 or 10, the elected group representative shall remain on the board, but neither as a group or an individual representative, and the group writer with the next highest number of group votes shall join the board as a group representative; but

(2) If the total size of the board-elect is 11, the elected group representative shall not remain on the board and the group writer with the next highest number of group votes shall take the relinquished group seat.

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

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

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

VII. The board of directors shall take action by affirmative vote representing a simple majority of the entire board.

VIII. The board shall elect officers in accordance with the bylaws of the association. The bylaws of the association shall also govern the place and frequency of meetings of directors and their reimbursement for expenses incurred.

Source: 1998, 340:6. 2001, 295:8, July 1, 2001.

Section 404-G:5

404-G:5 Plan of Operation. – The board of directors of the association shall adopt a plan of operation which shall be the same plan of operation as that adopted pursuant to the order. Any amendments to the current plan of operation shall be approved by the commissioner. The plan of operation shall provide substantially the following:

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

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

III. Assessment determination.

(a) Assessment liabilities shall commence on the effective date of this chapter.

(b) Assessments shall be calculated based on the number of covered lives. The number of covered lives shall be determined each month during the calendar year. The assessment shall be calculated as the number of covered lives times a specified amount. The specified amount shall be fixed throughout the calendar year and shall be determined by the board no later than the first day of November preceding the calendar year for which the amount is to be used. The amount shall be subject to approval by the

commissioner. The board shall provide a basis for recommending the specified amount, including a projection of the calculated subsidy and consideration of any prior year shortfalls or overages. For the calendar years 1999 and 2000, the specified amount shall be 18 cents per covered life per month, provided, however, that the board may petition the commissioner for approval of a greater specified amount. The commissioner shall approve such amount if he or she finds, after consideration of the:

- (1) Board's subsidy determination process;
- (2) Number of subsidy-eligible lives;
- (3) Size of the entire non-group market;
- (4) Morbidity experience of the subsidy-eligible lives; and
- (5) Morbidity experience of the entire non-group market; that the amount petitioned by the board

is no greater than is necessary to fulfill the purposes of this chapter. For the purpose of making this determination, the commissioner may, at the expense of the association, seek independent actuarial certification of the need for the increase.

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

IV. Administrative matters. The plan of operation shall further provide for all of the following:

- (a) Responsibility for the handling and accounting of funds and other assets of the association.
- (b) The financial and other records required to be kept, including the annual report to be submitted to the commissioner.
- (c) Such other administrative provisions as are necessary or proper for the execution of the powers and duties of the association.

Source. 1998, 340:6. 2001, 295:9, eff. July 1, 2001.

Section 404-G:5-a

404-G:5-a Plan of Operation for the High Risk Pool. –

I. The board of directors for the association shall adopt a plan of operation for the high risk pool. The high risk pool shall be funded in part through an assessment mechanism whereby writers of health insurance contribute an amount sufficient to cover the expenses and losses of the pool not covered by premiums.

II. The plan of operation for the high risk pool shall establish:

- (a) Procedures for handling and accounting for the assets and moneys of the plan;
- (b) Procedures for selecting and retaining a pool administrator;
- (c) Procedures to establish and maintain public awareness of the plan, including its eligibility requirements and enrollment procedures;
- (d) Procedures to create a fund, under management of the board, for administrative expenses;
- (e) Procedures for handling, accounting and auditing of assets, moneys and claims of the pool;
- (f) Requirements for keeping financial and other records;
- (g) Regular times and places for meetings of the board; and
- (h) Procedures by which applicants and participants can submit utilization review determinations and grievances to the pool administrator. The procedures shall ensure that utilization review determinations and grievances will be processed properly and in accordance with all statutory and regulatory requirements.

III. The assessment for the high risk pool shall be based on the number of covered lives times a specified assessment rate. The association shall specify the basis used to set the assessment rate.

IV. The association shall establish a regular assessment rate which shall be:

- (a) Calculated on a calendar year basis;
- (b) Established no later than November 1 in the year preceding the calendar year for which the carrier's experience shall be used to calculate the assessment; and
- (c) Anticipated to be sufficient to meet the high risk pool's funding needs.

V. In addition to the regular assessment rate, the association may establish a special assessment rate. Notwithstanding RSA 420-G:4, a writer of health insurance may increase the premiums charged by the amount of the special assessment. Any assessment may appear as a separate line item on a policyholder's bill.

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

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

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

VII. The association shall impose and collect assessments from its members.

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

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

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

Source. 2001, 295:10, eff. July 1, 2001.

Section 404-G:5-b

404-G:5-b High Risk Pool. –

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

II. The plans to be issued by the pool, including schedules of benefits, exclusions and other limitations shall be established by the association subject to the approval of the commissioner. In establishing the plans, the association shall take into consideration the levels of health insurance coverage provided in the state and medical economic factors as may be deemed appropriate and shall promulgate benefit levels, deductibles, coinsurance factors, exclusions and limitations determined to be generally reflective of and commensurate with comprehensive, major medical health insurance coverage provided in the state. The association shall, utilizing standard morbidity assumptions, annually place a value on all plans presently being written or issued in the individual market. The association shall average these values, weighed according to each plan's written premium volume, or some other suitable proxy, and utilizing the same standard morbidity assumptions, shall develop 2 coverage options: Option A and Option B.

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

III-a. The association, subject to the approval of the commissioner, may from time to time offer such plans, in addition to the 4 plans required under paragraphs II and III, as its board of directors determines would be helpful to advance the purposes of this chapter.

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

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

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

VI. The high risk pool shall be funded by premiums charged for coverage and by assessments which

the association shall calculate based on the number of covered lives times a specified amount. The high risk pool shall not be funded with state general fund revenue. The high risk pool shall never cease writing policies to eligible individuals.

Source. 2001, 295:10. 2004, 187:11, eff. July 31, 2004.

Section 404-G:5-c

404-G:5-c High Risk Pool Administrator. –

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

- (a) The high risk pool administrator's proven ability to handle health insurance coverage to individuals;
- (b) The efficiency and timeliness of the high risk pool administrator's claim processing procedures;
- (c) An estimate of total charges for administering the pool;
- (d) The high risk pool administrator's ability to apply effective cost containment programs and procedures and to administer the pool in a cost efficient manner; and
- (e) The financial condition and stability of the high risk pool administrator.

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

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

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

- (a) The determination of eligibility;
- (b) The payment of claims and the development of procedures to ensure that each claim is promptly paid;
- (c) The establishment of a premium billing procedure for collection of premium from persons covered under the pool;
- (d) The acceptance of payments of premiums from insureds;
- (e) The development of procedures to ensure that medical utilization reviews and grievance determinations are conducted in a fair and timely manner and in accordance with all statutory and regulatory requirements; and
- (f) Other necessary functions to assure timely payment of benefits to covered persons under the pool.

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

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

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

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

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

Source. 2001, 295:10, eff. July 1, 2001.

Section 404-G:5-d

404-G:5-d Premiums. –

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

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

III. Premium rates for coverage under the plan may not be less than 125 percent and may not exceed 150 percent of the standard risk rate pursuant to paragraph II of this section. The association shall charge high risk pool enrollees a premium charge based on the average rate for the plan adjusted for the attained age of the high risk pool enrollee. The adjustment for attained age shall conform to the provisions of RSA 420-G.

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

Source. 2001, 295:10, eff. July 1, 2001.

Section 404-G:5-e**404-G:5-e Eligibility. –**

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

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

(b) The individual has applied to a carrier of individual health insurance for coverage that is substantially similar to the coverage that is available through the pool, and such application has been accepted, but at a premium rate exceeding the eligibility rate set by the association from time to time and submitted to the commissioner for approval with the premium rates, which eligibility rate shall not be less than 125 percent and shall not exceed 150 percent of the standard risk rate calculated pursuant to RSA 404-G:5-d, II;

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

(d) The individual is an "eligible individual" as defined in section 2741(b) of the Public Health Service Act;

(e) The individual has been certified as eligible for either federal trade adjustment assistance or for pension benefit guarantee corporation, as prescribed by the federal Trade Adjustment Assistance Reform Act of 2002 and the association, in accordance with procedures set forth in its plan of operation, is offering coverage in the high risk pool to such eligible persons at the time of the individual's application; or

(f) The individual has received an offer of coverage from a carrier of individual health insurance that contains a rider or endorsement excluding coverage for a specified condition pursuant to RSA 420-G:5, II.

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

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

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

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

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

(b) The individual is eligible for publicly funded health insurance coverage, including Medicare,

Medicaid or Title XXI; or

(c) The individual's premiums are paid for or reimbursed by the health care provider or the individual's premiums are paid by any government sponsored program or government agency, except if the person is eligible under subparagraphs I(d) or (e). Nothing in this subparagraph shall be construed to prevent the association from receiving or using non-assessment funds, including but not limited to federal, state, foundation, or other grants or donations from any source to further the purposes of this chapter.

VI. Coverage shall cease:

- (a) On the date a person is no longer a resident of this state;
- (b) On the date a person requests coverage to end;
- (c) Upon the date a person dies;
- (d) On the date state law requires cancellation of the policy; or
- (e) After the second of 2 successive inquiries made by the plan concerning the person's place of residence to which the person does not reply, provided the person has 90 days to respond to each inquiry.

Source. 2001, 295:10. 2002, 207:42. 2003, 201:3; 276:12, 13. 2004, 187:2, eff. July 31, 2004. 2007, 289:38, eff. Jan. 1, 2008.

Section 404-G:5-f

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

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

II. All the provisions of title 37 shall apply to the pool to the extent applicable and not inconsistent with the express provisions of this chapter, except for the following: RSA 400-A:29, RSA 400-A:31 through 400-A:35, RSA 404-B, RSA 404-D, RSA 404-H, RSA 408-B, and RSA 420-K. For the purposes of this chapter, the pool shall be deemed an insurer, pool coverage shall be deemed individual health insurance, and pool coverage contracts shall be deemed policies.

Source. 2001, 295:10. 2002, 207:43, eff. July 15, 2002. 2007, 255:10, eff. Jan. 1, 2008.

Section 404-G:6

404-G:6 Commissioner's Powers and Duties. – In addition to duties and powers enumerated elsewhere in this chapter:

I. The commissioner shall upon request of the board of directors, serve a demand upon the member insurer to pay an assessment within a reasonable time; the failure of the member insurer to promptly comply with such demand shall not excuse the association from the performance of its powers and duties under this chapter.

II. The commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any member insurer which fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative, the commissioner may levy a forfeiture on any member insurer which fails to pay an assessment when due. Such forfeiture shall not exceed 5 percent of the unpaid assessment per month, but no forfeiture shall be less than \$100 per month. Any amounts so collected shall be credited to the assessment fund administered by the association.

III. Any action of the board of directors or the association may be appealed to the commissioner by any member insurer if the appeal is taken within 30 days of the final action being appealed. If a member company is appealing an assessment, the amount assessed shall be paid to the association and available to meet association obligations during the pendency of an appeal. If the appeal on the assessment is upheld, the amount paid in error or excess shall be returned to the member company from available funds of the association. Any final action or order of the commissioner shall be subject to judicial review, pursuant to RSA 541.

IV. The commissioner may adopt rules as necessary to carry out the purposes of this chapter.

V. The powers of the commissioner enumerated in this chapter shall be in addition to those established under RSA 404-C.

Source. 1998, 340:6, eff. Aug. 25, 1998.

Section 404-G:7

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

Source. 1998, 340:6. 2001, 295:11, eff. July 1, 2001.

Section 404-G:8

404-G:8 Tax Exemption. – The association shall be exempt from payment of all fees and all taxes levied by this state or any of its subdivisions, except taxes levied on real property.

Source. 1998, 340:6, eff. Aug. 25, 1998.

Section 404-G:9

404-G:9 Immunity for Members and Employees. – There shall be no liability on the part of and no cause of action of any nature shall arise against any member insurer or its agents or employees, the association or its agents or employees, members of the board of directors, or the commissioner or the commissioner's representatives, for any action or omission by them in the performance of their powers and duties under this chapter.

Source. 1998, 340:6, eff. Aug. 25, 1998.

Section 404-G:10

404-G:10 Severability. – If any provisions of this chapter or the application thereof to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the chapter which can be given effect without the invalid provisions or applications, and to this end the provisions of this chapter are severable.

Source. 1998, 340:6, eff. Aug. 25, 1998.