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CHAPTER 39

HB 1639-FN - FINAL VERSION

11Mar2020... 0956h

06/16/2020 1435s

06/16/2020 1513s

30Jun2020... 1633EBA

2020 SESSION

20-2493

01/05

HOUSE BILL *1639-FN*

AN ACT relative to health care.

SPONSORS: Rep. Snow, Hills. 19; Rep. Danielson, Hills. 7; Sen. Rosenwald, Dist 13

COMMITTEE: Health, Human Services and Elderly Affairs

AMENDED ANALYSIS

This bill:

I. Requires the department of health and human services to amend the income standard used for eligibility for the "in and out" medical assistance policy.

II. Clarifies the prior authorization procedures under group health insurance policies and managed care.

III. Clarifies non-covered dental services under the managed care law.

IV. Requires the commissioner of the department of health and human services to develop a state health assessment and a state health improvement plan and establishes the state health assessment and state health improvement plan advisory council to assist the commissioner with the plan.

V. Requires that boards regulating practitioners prescribing, administering, and dispensing controlled substances adopt rules for management of chronic pain.

VI. Defines chronic pain for the purposes of the controlled drug prescription health and safety program.

VII. Requires insurance coverage for long-term antibiotic therapy for tick-borne illness.

VIII. Adds physician assistants to the law governing advance directives.

IX. Clarifies the licensure of physician assistants and provides for biennial renewal of physician assistant licenses.

X. Establishes the New Hampshire drug overdose fatality review commission to review information and data related to drug overdose fatalities in New Hampshire.

XI. Establishes an opioid abatement trust fund. The department of health and human services, in consultation with the New Hampshire opioid abatement advisory commission, shall use the fund to support programs associated with the prevention, treatment, and recovery of substance use disorders.

XII. Authorizes pharmacists to administer a COVID-19 vaccine if one is available.

XIII. Clarifies the deposits to be made into the New Hampshire granite advantage health care trust fund.

XIV. Requires the superintendent of a county correctional facility to provide a prisoner with medication-assisted treatment for substance use disorders where medically appropriate.

XV. Clarifies the patients' bill of rights.

XVI. Prohibits a physician, surgeon, nurse, physician assistant, APRN, or student undertaking a course of professional instruction from performing certain examinations on an anesthetized or unconscious patient without consent unless such examination meets certain specific criteria.

XVII. Requires an applicant seeking to construct certain health care facilities for licensure under RSA 151 to submit a written notice of such intent to the chief executive officer of a nearby critical access hospital. If the critical access hospital notifies the department of health and human services that it objects to the proposed health care facility, then an expert report shall be prepared.

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20-2493

01/05

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Twenty

AN ACT relative to health care.

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

39:1 Department of Health and Human Services; Income Eligibility for "In and Out Medical Assistance." The commissioner of the department of health and human services shall amend the income eligibility requirement for "in and out medical assistance" defined in section 625 of the department's medical assistance manual as less than or equal to 133 1/3 percent of the section 1931 income limit or using methodology as described in section 1902(r)(2) of the federal Social Security Act.

39:2 Communicable Disease; Administration of Certain Prescription Medication for Treatment or Prevention of a Communicable Disease. Amend RSA 141-C:15-a to read as follows:

141-C:15-a Administration of Certain Prescription Medication for Treatment or Prevention of a Communicable Disease.

I. Notwithstanding the provisions of RSA 326-B:2, I-a, and RSA 329:1-c, a health care professional authorized to prescribe prescription medication for the treatment or prevention of a communicable disease may prescribe, dispense, or distribute directly or by standing order, ~~an antimicrobial medication~~ drugs and testing to a patient he or she did not evaluate and with whom there is no established health care provider-patient relationship to empirically treat for, or provide an agent or prophylaxis to prevent, a communicable disease that poses a threat to public health. Any such prescription shall be regarded as being issued for a legitimate medical purpose and in accordance with established clinical practice guidelines, when available.

II. Communicable diseases that pose a threat to public health for the purposes of paragraph I shall be limited to the following:

(a) Bordetella pertussis, Chlamydia trachomatis, Neisseria gonorrhea, and Neisseria meningitis; or

(b) Diseases that constitute an immediate threat to public health and for which the commissioner, or designee, declares a public health incident under RSA 508:17-a or issues clinical guidance that requests providers to consider prescribing, dispensing, or distributing ~~antimicrobial~~ immunizing agents or drugs under paragraph I in order to control a disease outbreak.

III. No health care professional who, acting in good faith and with reasonable care, prescribes, dispenses, or distributes an ~~antimicrobial medication~~ agent or drug and testing for the treatment or prevention of a communicable disease as described in paragraph I, shall be subject to any criminal or civil liability, or any professional disciplinary action, for any action authorized by this section or any outcome resulting from an action authorized by this section.

39:3 Coverage for Emergency Services; Prior Authorization. Amend RSA 417-F:3 to read as follows:

417-F:3 Prior Authorization.

I. A participating provider or other authorized representative of the plan that gives prior authorization shall not rescind or modify the authorization after the health care provider has rendered the authorized emergency services care in good faith and the enrollee's, insured's, or subscriber's coverage was effective on the date of service.

II. When emergency services are a covered benefit under a health plan subject to this chapter, no prior authorization shall be required for emergency services necessary to screen and stabilize an individual.

III. No health benefit plan shall require a prior authorization for medically necessary interfacility transports for services related to the treatment and diagnosis of certain biologically-based mental illnesses.

39 :4 Applicability. All prior authorizations under group health insurance policies and managed care issued prior to the New Hampshire state of emergency, declared on March 13, 2020, and its extensions, that were set to expire during the period between March 13, 2020 and May 4, 2020, when providers were allowed to resume elective procedures pursuant to the issuance of the "Stay at Home Order 2.0," shall be granted an automatic extension of 120 days from May 4, 2020.

39:5 Repeal. RSA 137-J:5, V(e), as inserted by section 29 of this act, relative to the authority to consent to experimental treatment for severe or advanced COVID-19 symptoms, is repealed.

39:6 Repeal. 2015, 263:14, relative to the January 1, 2021 repeal of RSA 415:6-t and RSA 415:18-y, regarding insurance coverage for oral anti-cancer therapies, is repealed.

39:7 Health Services Corporations; Applicable Statutes. RSA 420-A:2 is repealed and reenacted to read as follows:

420-A:2 Applicable Statutes. Every health service corporation shall be governed by this chapter and the relevant provisions of RSA 161-H, and shall be exempt from this title except for the provisions of RSA 400-A:39, RSA 401-B, RSA 402-C, RSA 404-F, RSA 415-A, RSA 415-F, RSA 415:6, II(4), RSA 415:6-g, RSA 415:6-k, RSA 415:6-m, RSA 415:6-o, RSA 415:6-r, RSA 415:6-t, RSA 415:6-u, RSA 415:6-v, RSA 415:6-w, RSA 415:6-x, RSA 415:18, V, RSA 415:18, XVI and XVII, RSA 415:18, VII-a, RSA 415:18-a, RSA 415:18-i, RSA 415:18-j, RSA 415:18-o, RSA 415:18-r, RSA 415:18-t, RSA 415:18-u, RSA 415:18-v, RSA 415:18-w, RSA 415:18-y, RSA 415:18-z, RSA 415:18-aa, RSA 415:18-bb, RSA 415:22, RSA 417, RSA 417-E, RSA 420-J, and all applicable provisions of title XXXVII wherein such corporations are specifically included. Every health service corporation and its agents shall be subject to the fees prescribed for health service corporations under RSA 400-A:29, VII.

39:8 Health Maintenance Organizations; Applicable Statutes. RSA 420-B:20, III is repealed and reenacted to read as follows:

III. The requirements of RSA 400-A:39, RSA 401-B, RSA 402-C, RSA 404-F, RSA 415:6-g, RSA 415:6-m, RSA 415:6-o, RSA 415:6-r, RSA 415:6-t, RSA 415:6-u, RSA 415:6-v, RSA 415:6-w, RSA 415:6-x, RSA 415:18, VII-a, RSA 415:18, XVI and XVII, RSA 415:18-i, RSA 415:18-j, RSA 415:18-r, RSA 415:18-t, RSA 415:18-u, RSA 415:18-v, RSA 415:18-w, RSA 415:18-y, RSA 415:18-z, RSA 415:18-aa, RSA 415:18-bb, RSA 415-A, RSA 415-F, RSA 420-G, and RSA 420-J shall apply to health maintenance organizations.

39:9 New Paragraph; Pharmacy Rights During Audit; Response. Amend RSA 318:62 by inserting after paragraph VI the following new paragraph:

VI-a. To have the same number of days to respond to a claim in an audit that have passed since the origination of the claim.

39:10 Pharmacy Rights During Audit; Claims Period. Amend RSA 318:62, X to read as follows:

X. To have the period covered by an audit limited to ~~24~~ 6 months from the date a claim was submitted to, or adjudicated by, a managed care company, an insurance company, a third-party payer, or any entity that represents responsible parties, unless a longer period is permitted by a federal plan under federal law.

39:11 Appeals Process. Amend RSA 318:63 to read as follows:

318:63 Mandatory Appeals Process.

I. Each entity that conducts an audit of a pharmacy shall establish an appeals process under which a pharmacy may appeal within 30 days after the report an unfavorable audit report to the entity.

II. If, following the appeal, the entity finds that an unfavorable audit report or any portion of the unfavorable audit report is unsubstantiated, the entity shall dismiss the unsubstantiated portion of the audit report without any further proceedings unless outlined in the contract.

III. Each entity conducting an audit shall provide a copy, if required under contractual terms, of the audit findings to the plan sponsor after completion of any appeals process.

IV. If any portion of an unfavorable audit report is not dismissed within 30 days after an appeal is made under paragraph I, the pharmacy may request a hearing from the insurance department pursuant to RSA 400-A:17.

39:12 Recoupment; Charges. Amend RSA 318:64, III to read as follows:

III. The entity conducting the audit ~~may~~ shall not charge or assess the responsible party, directly or indirectly, based on amounts recouped ~~if both of the following conditions are met:~~

~~(a) The responsible party and the entity conducting the audit have entered into a contract that explicitly states the percentage charge or assessment to the responsible party.~~

~~(b) A commission or other payment to an agent or employee of the entity conducting the audit is not based, directly or indirectly, on amounts recouped~~.

39:13 New Paragraph; Powers of Health Maintenance Organizations. Amend RSA 420-B:7 by inserting after paragraph X the following new paragraph:

XI. The power to act as a health care insurer as defined in RSA 420-C:2, IV only when offering a Medicare Advantage plan in accordance with 42 U.S.C. sections 1395w-21 through1395w-29.

39:14 New Section; Managed Care Law. Amend RSA 420-J by inserting after section 8-e the following new section:

420-J:8-f Non-Covered Dental Services.

I No insurer, health care service contractor, health maintenance organization, dental insurer, or any other similar entity, including Delta Dental Plan of New Hampshire Inc., subject to regulation by the insurance department that covers dental services, and no contract or participating provider agreement with a dentist shall require, directly or indirectly, that a dentist who is a participating provider provide services to an enrolled participant at a fee set by, or at a fee subject to the approval of, the regulated entity unless the dental services are covered services.

II No person providing third party administrator services shall make available for any customers a plan that sets dental fees for providers in its provider network for any services except covered services.

III. In this paragraph "covered services" means dental care service for which reimbursement is available under an enrollee's plan contract, or for which reimbursement would be available but for the application of contractual limitations such as deductibles, copayments, coinsurance, waiting periods, annual or lifetime maximums, frequency limitations, alternative benefit payments, or any other limitation.

IV. Fees for covered services shall be set in good faith and shall not be nominal.

39:15 Purpose Statement; Intent. The general court hereby recognizes the health and wellness priorities set forth by the state health assessment and state health improvement plan advisory council which was charged with developing the New Hampshire state health improvement plan. Established in 2019 by the commissioner of the department of health and human services, the council seeks to develop a plan to attain equitable opportunity for all New Hampshire families and individuals, regardless of age, to flourish and achieve optimal mental, physical, social, and emotional wellness in their communities, where they live, learn, work, play and age. The purpose of the state health improvement plan is to improve health outcomes, reduce disparities and strengthen public health and human services delivery systems with a focus on the social determinants of health. Bringing both their experience and dedication, it is also the legislative intent that current members serving on the ad hoc state health assessment and state health improvement plan advisory council shall continue their membership and be appointed to serve on the newly established council coterminous with their remaining term.

39:16 New Subdivision; State Health Improvement Plan. Amend RSA 126-A by inserting after section 80 the following new subdivision:

State Health Improvement Plan

126-A:81 State Health Improvement Plan.

I. The commissioner of the department of health and human services shall, in consultation with the state health assessment and state health improvement plan advisory council established in RSA 126-A:82, develop a state health assessment and a state health improvement plan.

II. The state health assessment shall:

(a) Describe the status of health and well-being in New Hampshire.

(b) Utilize input from state and local level stakeholders obtained through public forums.

(c) Identify disparities in social determinants that impact health, health outcomes, and access to care.

(d) Map health care service delivery, utilization, inter-entity collaboration, and identification of gaps or redundancies.

(e) Utilize existing data for statewide and local planning.

(f) Identify priorities for the state health improvement plan.

III. The state health improvement plan shall guide the department in assessing, planning, implementing, and monitoring improvement in the health and well-being of New Hampshire’s population.

IV. The state health improvement plan shall focus on strategies to:

(a) Improve health outcomes and reduce inequities; and

(b) Strengthen public health and human service delivery systems.

V. The state health improvement plan shall identify priorities and evidence-based practices, integrate services, and leverage resources across the state.

VI. The department shall make publicly available through an Internet website an analysis pertaining to state health assessment indicators, identification of state health priorities, goals, and the development of the state health improvement plan.

VII. The information made available shall be maintained as a public resource for decision making and policy analysis by state and local health and human service entities, housing developers, municipalities, policy makers, the public, and other entities as they consider health improvement planning and health in all policies.

VIII. The information shall also be used by the department to align planning, integrate services, and leverage resources across the department.

IX. The commissioner, in consultation with the state health assessment and state health improvement plan advisory council, shall release to the public, the state health assessment no later than 12 months and the state health improvement plan no later than 24 months after the effective date of this section. The plan shall be reviewed annually and updated every 5 years, or earlier if determined necessary to carry out the charge of the plan.

126-A:82 State Health Assessment and State Health Improvement Plan Advisory Council Established.

I. There is hereby established a state health assessment and state health improvement plan advisory council. The membership of the council shall be diverse with respect to race, ethnicity, geography, and age as follows:

(a) Two members of the house of representatives, one of whom shall be appointed by the speaker of the house of representatives and one of whom shall be appointed by the minority leader.

(b) Two members of the senate, one of whom shall be a member of the minority party, appointed by the senate president.

(c) The commissioner of the department of health and human services, or designee.

(d) The commissioner of the department of education, or designee.

(e) The commissioner of the department of insurance, or designee.

(f) The commissioner of the department of safety, or designee.

(g) The commissioner of the department of corrections, or designee.

(h) The New Hampshire attorney general, or designee.

(i) The director of the division of public health services, department of health and human services, or designee.

(j) The chairperson of state commission on aging, or designee.

(k) The director of the Manchester health department, or designee.

(l) A representative from the New Hampshire Public Health Association, appointed by the association.

(m) A representative of the New Hampshire Alliance for Healthy Aging, appointed by the alliance.

(n) A representative of the North Country Health Consortium, appointed by the consortium.

(o) A representative of the New Hampshire Fiscal Policy Institute, appointed by the institute.

(p) Two representatives from housing entities, one appointed by the New Hampshire Housing Finance Authority, and one appointed by the New Hampshire Housing Authorities Corporation.

(q) Two representatives of hospitals located in New Hampshire, one from a large health care system and one from a critical care hospital, appointed by the New Hampshire Hospital Association.

(r) A representative of a federally qualified community health center, appointed by the Bi-State Primary Care Association.

(s) A psychiatrist or psychologist licensed in New Hampshire, appointed by the commissioner of the department of health and human services.

(t) A physician, appointed by the New Hampshire Medical Society.

(u) An advanced practice nurse practitioner licensed in New Hampshire, appointed by the New Hampshire Nurse Practitioners Association.

(v) A representative of municipal government, appointed by the New Hampshire Municipal Association.

(w) A school superintendent, appointed by the New Hampshire School Administrators Association.

(x) A representative of a peer recovery program, appointed by the commissioner of the department of health and human services.

(y) An environmental health researcher from a New Hampshire college or university, appointed by the commissioner of the department of health and human services.

(z) A representative of a philanthropic organization, appointed by the commissioner of the department of health and human services.

(aa) A substance use disorder treatment provider, appointed by the NH Providers Association.

(bb) A community action program representative, appointed by the New Hampshire Community Action Partnership.

(cc) The director of the Nashua health department, or designee.

(dd) A health officer, appointed by the New Hampshire Health Officers Association.

II. The council may solicit information and participation from any person or entity determined necessary by the council in the performance of its duties. The council shall be administratively attached to the department.

III. Members of the council appointed under subparagraphs II(a) through (j) in this section shall serve a term coterminous with their term in office. The members appointed pursuant to subparagraphs II(k) through (dd) in this section shall serve 6-year terms provided that initial appointments shall be for staggered terms of one to 6 years. Legislative members shall receive mileage at the legislative rate when attending to the duties of the council. The first-named senate member shall convene the organizational meeting of the council within 45 days of the effective date of this section for the purpose of electing officers. The chairperson shall be elected upon a majority vote of the council. Seventeen members shall constitute a quorum.

IV. The chairperson may establish subcommittees upon majority vote of the council. Membership of the subcommittees shall be established by the chairperson upon majority vote of the council. If any member of the council is absent without previously being excused by the chairperson for 3 or more regular meetings, the member may be removed upon a majority vote of the council.

V. The commissioner, in collaboration with the council, shall submit an annual report to the president of the senate, the speaker of the house of representatives, the governor, the chairpersons of the house and senate committees having jurisdiction over finance and health and human services, and chairperson of the oversight committee on health and human services, established under RSA 126-A:13, by November 1 of each year, commencing on November 1, 2021, on its activities and including recommendations for legislation.

39:17 Applicability. To the extent possible, the members currently serving on the commissioners of the department of health and human services' ad hoc state health assessment and state health improvement advisory council shall continue their membership on the council established by RSA 126-A:82 in section 16 of this act.

39:18 New Paragraph; Definition Added; Controlled Drug Prescription Health and Safety Program. Amend RSA 318-B:31 by inserting after paragraph I the following new paragraph:

I-a.(a) "Chronic pain" means a state in which pain persists beyond the usual course of an acute disease or healing of an injury, or that might or might not be associated with an acute or chronic pathologic process that causes continuous or intermittent pain over months or years. It also includes intermittent episodic pain that might require periodic treatment.

(1) For the purpose of this subdivision, chronic pain does not cover or in any way determine treatment for pain from terminal disease.

(2) For the purpose of this subdivision, chronic pain includes but may not be limited to pain defined as "chronic," "intractable," "high impact," "chronic episodic," and "chronic relapsing."

(b) A diagnosis of chronic pain made by a practitioner licensed in any of the states in the United States or the District of Columbia and supported by written documentation of the diagnosis by the treating practitioner shall constitute proof that the patient suffers from chronic pain.

39:19 New Subparagraph; Controlled Drug Prescription Health and Safety Program; Standards for Treatment of Chronic Pain. Amend RSA 318-B:41, II by inserting after subparagraph (c) the following new subparagraph:

(d) In addition to the provisions of subparagraph (c), standards for the use of opioids for the management or treatment of chronic pain, which shall include the following:

(1) All decisions regarding the treatment of patients experiencing chronic pain shall be made by the treating practitioner even when the treatment is determined to require the prescribing of opioid analgesics. Treating practitioners shall administer care sufficient to treat a patient's chronic pain based on ongoing, objective evaluations of the patient without fear of reprimand or discipline.

(2) Ordering, prescribing, dispensing, administering, or paying for controlled substances, including opioid analgesics, shall not in any way be pre-determined by specific Morphine Milligram Equivalent (MME) guidelines.

(3) Ongoing treatment of those patients who experience chronic pain can be determined, managed, and administered by:

(A) A pain management practitioner who specializes in the treatment of chronic pain; or

(B) A practitioner who specializes in the illness or injury from which the patient suffers; or

(C) The patient's primary care practitioner who shall document the consideration of a consultation with a practitioner who specializes in the treatment of the patient's specific illness or injury or a pain management practitioner.

(4) For the patient who experiences chronic illness or injury and resulting chronic pain, documentation of the health issue must be provided and held in the patient's file.

(5) When treating a patient who experiences chronic illness or injury and resulting chronic pain, the prescribing of opioid analgesics shall be done in a measured and monitored manner and administered in the lowest amount necessary to control pain.

(6) Once an opioid analgesic is prescribed to treat chronic illness or injury and resulting chronic pain, the prescription shall be monitored closely by the prescriber and titrated as ongoing, objective evaluations of said patient's injury or illness requires for ongoing, successful treatment.

(7) For those patients who experience chronic illness or injury and resulting chronic pain who are on a managed and monitored regimen of opioid analgesic treatment and have increased functionality and quality of life as a result of said treatment, treatment shall be continued if there remains no indication of misuse or diversion.

(8) Proper documentation from the practitioner related to the filling of a prescription under this subparagraph shall be provided to the pharmacist upon the initial filling of the prescription, or upon request of the pharmacist.

(9) The rules necessary to effectuate the provisions of this subparagraph governing pain management associated with chronic pain shall:

(A) Take into consideration the individualized needs of patients covered by this subparagraph;

(B) Make provisions for practitioners, acting in good faith, and in the course of their profession, and managing chronic pain associated with their patients' illness to use their best judgment notwithstanding any statute or rule to the contrary; and

(C) Ensure that patients covered by this section are treated with dignity and not unduly denied the medications needed to treat their conditions.

39:20 New Section; Accident and Health Insurance; Coverage for Long-Term Antibiotic Therapy for Tick-Borne Illness; Individual. Amend RSA 415 by inserting after section 6-x the following new section:

415:6-y Coverage for Long-Term Antibiotic Therapy for Tick-Borne Illness. Each insurer that issues or renews any individual policy of accident or health insurance providing benefits for medical or hospital expenses, shall provide to certificate holders of such insurance, who are residents of this state, coverage for long-term antibiotic therapy for tick-borne illness when determined to be medically necessary and ordered by a licensed infectious disease physician after making a thorough evaluation of the patient's symptoms, diagnostic test results or response to treatment. Benefits provided under this section shall not be subject to any greater co-payment, deductible, or coinsurance than any other similar benefits provided by the insurer. In this section, "long-term antibiotic therapy" means the administration of oral, intramuscular, or intravenous antibiotics singly or in combination, for periods of time in excess of 4 weeks.

39:21 New Section; Accident and Health Insurance; Coverage for Long-Term Antibiotic Therapy for Tick-Borne Illness; Group. Amend RSA 415 by inserting after section 18-bb the following new section:

415:18-cc Coverage for Long-Term Antibiotic Therapy Tick-Borne Illness. Each insurer that issues or renews any policy of group or blanket accident or health insurance providing benefits for medical or hospital expenses, shall provide to certificate holders of such insurance, who are residents of this state, coverage for long-term antibiotic therapy for tick-borne illness when determined to be medically necessary and ordered by a licensed infectious disease physician after making a thorough evaluation of the patient's symptoms, diagnostic test results or response to treatment. Benefits provided under this section shall not be subject to any greater co-payment, deductible, or coinsurance than any other similar benefits provided by the insurer. In this section, "long-term antibiotic therapy" means the administration of oral, intramuscular, or intravenous antibiotics singly or in combination, for periods of time in excess of 4 weeks.

39:22 Health Services Corporations; Applicable Statutes. Amend RSA 420-A:2 to read as follows:

420-A:2 Applicable Statutes. Every health service corporation shall be governed by this chapter and the relevant provisions of RSA 161-H, and shall be exempt from this title except for the provisions of RSA 400-A:39, RSA 401-B, RSA 402-C, RSA 404-F, RSA 415-A, RSA 415-F, RSA 415:6, II(4), RSA 415:6-g, RSA 415:6-k, RSA 415:6-m, RSA 415:6-o, RSA 415:6-r, RSA 415:6-t, RSA 415:6-u, RSA 415:6-v, RSA 415:6-w, RSA 415:6-x, RSA 415:6-y, RSA 415:18, V, RSA 415:18, XVI and XVII, RSA 415:18, VII-a, RSA 415:18-a, RSA 415:18-i, RSA 415:18-j, RSA 415:18-o, RSA 415:18-r, RSA 415:18-t, RSA 415:18-u, RSA 415:18-v, RSA 415:18-w, RSA 415:18-y, RSA 415:18-z, RSA 415:18-aa, RSA 415:18-bb, RSA 415:18-cc, RSA 415:22, RSA 417, RSA 417-E, RSA 420-J, and all applicable provisions of title XXXVII wherein such corporations are specifically included. Every health service corporation and its agents shall be subject to the fees prescribed for health service corporations under RSA 400-A:29, VII.

39:23 Health Services Corporations; Applicable Statutes; Effective January 2021. Amend RSA 420-A:2 to read as follows:

420-A:2 Applicable Statutes. Every health service corporation shall be governed by this chapter and the relevant provisions of RSA 161-H, and shall be exempt from this title except for the provisions of RSA 400-A:39, RSA 401-B, RSA 402-C, RSA 404-F, RSA 415-A, RSA 415-F, RSA 415:6, II(4), RSA 415:6-g, RSA 415:6-k, RSA 415:6-m, RSA 415:6-o, RSA 415:6-r, RSA 415:6-u, RSA 415:6-v, RSA 415:6-w, RSA 415:6-x, RSA 415:6-y, RSA 415:18, V, RSA 415:18, XVI and XVII, RSA 415:18, VII-a, RSA 415:18-a, RSA 415:18-i, RSA 415:18-j, RSA 415:18-o, RSA 415:18-r, RSA 415:18-t, RSA 415:18-u, RSA 415:18-v, RSA 415:18-w, RSA 415:18-z, RSA 415:18-aa, RSA 415:18-bb, RSA 415:18-cc, RSA 415:22, RSA 417, RSA 417-E, RSA 420-J, and all applicable provisions of title XXXVII wherein such corporations are specifically included. Every health service corporation and its agents shall be subject to the fees prescribed for health service corporations under RSA 400-A:29, VII.

39:24 Health Maintenance Organizations; Statutory Construction. Amend RSA 420-B:20, III to read as follows:

III. The requirements of RSA 400-A:39, RSA 401-B, RSA 402-C, RSA 404-F, RSA 415:6-g, RSA 415:6-m, RSA 415:6-o, RSA 415:6-r, RSA 415:6-t, RSA 415:6-u, RSA 415:6-v, RSA 415:6-w, RSA 415:6-x, RSA 415:6-y, RSA 415:18, VII-a, RSA 415:18, XVI and XVII, RSA 415:18-i, RSA 415:18-j, RSA 415:18-r, RSA 415:18-t, RSA 415:18-u, RSA 415:18-v, RSA 415:18-w, RSA 415:18-y, RSA 415:18-z, RSA 415:18-aa, RSA 415:18-bb, RSA 415:18-cc, RSA 415-A, RSA 415-F, RSA 420-G, and RSA 420-J shall apply to health maintenance organizations.

39:25 Health Maintenance Organizations; Statutory Construction; Effective January 1, 2021. Amend RSA 420-B:20, III to read as follows:

III. The requirements of RSA 400-A:39, RSA 401-B, RSA 402-C, RSA 404-F, RSA 415:6-g, RSA 415:6-m, RSA 415:6-o, RSA 415:6-r, RSA 415:6-u, RSA 415:6-v, RSA 415:6-w, RSA 415:6-x, RSA 415:6-y, RSA 415:18, VII-a, RSA 415:18, XVI and XVII, RSA 415:18-i, RSA 415:18-j, RSA 415:18-r, RSA 415:18-t, RSA 415:18-u, RSA 415:18-v, RSA 415:18-w, RSA 415:18-z, RSA 415:18-aa, RSA 415:18-bb, RSA 415:18-cc, RSA 415-A, RSA 415-F, RSA 420-G, and RSA 420-J shall apply to health maintenance organizations.

39:26 Advance Directives; Purpose and Policy. Amend RSA 137-J:1 to read as follows:

I. The state of New Hampshire recognizes that a person has a right, founded in the autonomy and sanctity of the person, to control the decisions relating to the rendering of his or her own medical care. In order that the rights of persons may be respected even after such persons lack the capacity to make health care decisions for themselves, and to encourage communication between patients and their attending physicians, PAs, or APRNs, the general court declares that the laws of this state shall recognize the right of a competent person to make a written directive:

(a) Delegating to an agent the authority to make health care decisions on the person's behalf, in the event such person is unable to make those decisions for himself or herself, either due to permanent or temporary lack of capacity to make health care decisions;

(b) Instructing his or her attending physician, PA, or APRN to provide, withhold, or withdraw life-sustaining treatment, in the event such person is near death or is permanently unconscious.

39:27 Advance Directives; Definitions. Amend RSA 137-J:2, IV to read as follows:

IV. "Attending physician, PA, or APRN" means the physician, physician assistant, or advanced practice registered nurse, selected by or assigned to a patient, who has primary responsibility for the treatment and care of the patient. If more than one physician, physician assistant, or advanced practice registered nurse shares that responsibility, any one of those physicians, physician assistants, or advanced practice registered nurses may act as the attending physician, PA, or APRN under the provisions of this chapter.

39:28 Advance Directives; Definitions. Amend RSA 137-J:2, XIII-XXII-a to read as follows:

XIII. "Life-sustaining treatment" means any medical procedures or interventions which utilize mechanical or other medically administered means to sustain, restore, or supplant a vital function which, in the written judgment of the attending physician, PA, or APRN, would serve only to artificially postpone the moment of death, and where the person is near death or is permanently unconscious. "Life-sustaining treatment" includes, but is not limited to, the following: medically administered nutrition and hydration, mechanical respiration, kidney dialysis, or the use of other external mechanical or technological devices. Life sustaining treatment may include drugs to maintain blood pressure, blood transfusions, and antibiotics. "Life-sustaining treatment" shall not include the administration of medication, natural ingestion of food or fluids by eating and drinking, or the performance of any medical procedure deemed necessary to provide comfort or to alleviate pain.

XIV. "Living will" means a directive which, when duly executed, contains the express direction that no life-sustaining treatment be given when the person executing said directive has been diagnosed and certified in writing by the attending physician, PA, or APRN to be near death or permanently unconscious, without hope of recovery from such condition and is unable to actively participate in the decision-making process.

XV. "Medically administered nutrition and hydration" means invasive procedures such as, but not limited to the following: Nasogastric tubes; gastrostomy tubes; intravenous feeding or hydration; and hyperalimentation. It shall not include the natural ingestion of food or fluids by eating and drinking.

XVI. "Near death" means an incurable condition caused by injury, disease, or illness which is such that death is imminent and the application of life-sustaining treatment would, to a reasonable degree of medical certainty, as determined by 2 physicians, or a physician and a PA, or a physician and an APRN, only postpone the moment of death.

XVII. "Permanently unconscious" means a lasting condition, indefinitely without improvement, in which thought, awareness of self and environment, and other indicators of consciousness are absent as determined by an appropriate neurological assessment by a physician in consultation with the attending physician or an appropriate neurological assessment by a physician in consultation with an APRN or PA.

XVIII. "Physician" means a medical doctor licensed in good standing to practice in the state of New Hampshire pursuant to RSA 329.

XVIII-a. "Physician assistant" or "PA" means a physician assistant licensed in good standing to practice in the state of New Hampshire pursuant to RSA 328-D.

XIX. "Principal" means a person 18 years of age or older who has executed an advance directive pursuant to the provisions of this chapter.

XX. "Qualified patient" means a patient who has executed an advance directive in accordance with this chapter and who has been certified in writing by the attending physician, PA, or APRN to lack the capacity to make health care decisions.

XXI. "Reasonable degree of medical certainty" means a medical judgment that is made by a physician, PA, or APRN who is knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved.

XXII. "Residential care provider" means a "facility" as defined in RSA 161-F:11, IV, a "nursing home" as defined in RSA 151-A:1, IV, or any individual or facility licensed, certified, or otherwise authorized or permitted by law to operate, for profit or otherwise, a residential care facility for adults, including but not limited to those operating pursuant to RSA 420-D.

XXII-a. "Surrogate decision-maker" or "surrogate" means an adult individual who has health care decision-making capacity, is available upon reasonable inquiry, is willing to make health care decisions on behalf of a patient who lacks health care decision-making capacity, and is identified by the attending physician, PA, or APRN in accordance with the provisions of this chapter as the person who is to make those decisions in accordance with the provisions of this chapter.

39:29 Advance Directives; Scope and Duration of Agent's Authority. Amend RSA 137-J:5, II-V to read as follows:

II. An agent's or surrogate's authority under an advance directive shall be in effect only when the principal lacks capacity to make health care decisions, as certified in writing by the principal's attending physician, PA, or APRN, and filed with the name of the agent or surrogate in the principal's medical record. When and if the principal regains capacity to make health care decisions, such event shall be certified in writing by the principal's attending physician, PA, or APRN, noted in the principal's medical record, the agent's or surrogate's authority shall terminate, and the authority to make health care decisions shall revert to the principal.

III. If the principal has no attending physician, PA, or APRN for reasons based on the principal's religious or moral beliefs as specified in his or her advance directive, the advance directive may include a provision that a person designated by the principal in the advance directive may certify in writing, acknowledged before a notary or justice of the peace, as to the lack of decisional capacity of the principal. The person so designated by the principal shall not be the agent, or a person ineligible to be the agent.

IV. The principal's attending physician, PA, or APRN shall make reasonable efforts to inform the principal of any proposed treatment, or of any proposal to withdraw or withhold treatment. Notwithstanding that an advance directive or a surrogacy is in effect and irrespective of the principal's lack of capacity to make health care decisions at the time, treatment may not be given to or withheld from the principal over the principal's objection unless the principal's advance directive includes the following statement initialed by the principal, "Even if I am incapacitated and I object to treatment, treatment may be given to me against my objection."

V. Nothing in this chapter shall be construed to give an agent or surrogate authority to:

(a) Consent to voluntary admission to any state institution;

(b) Consent to a voluntary sterilization;

(c) Consent to withholding life-sustaining treatment from a pregnant principal, unless, to a reasonable degree of medical certainty, as certified on the principal's medical record by the attending physician, PA, or APRN and an obstetrician who has examined the principal, such treatment or procedures will not maintain the principal in such a way as to permit the continuing development and live birth of the fetus or will be physically harmful to the principal or prolong severe pain which cannot be alleviated by medication; or

(d) Consent to psychosurgery, electro-convulsive shock therapy, sterilization, or an experimental treatment of any kind.

(e) Notwithstanding the prohibition in subparagraph V(d), for any patient experiencing severe, advanced COVID-19 symptoms or COVID-19 complications who does not have the capacity to consent himself or herself to an experimental treatment, an agent or surrogate shall have the authority to consent to experimental treatments, authorized by an institutional review board, on the patient for COVID-19 symptoms or complications.

(1) For an agent or surrogate to approve the use of an experimental treatment, approved by an institutional review board, the agent or surrogate must be informed of all risks and side effects and follow all institutional review board instructions regarding consent as if the agent or surrogate were the individual receiving the treatment, including the completion of all consent documentation required by the Food and Drug Administration. An agent or surrogate shall not consent unless the following factors exist:

(A) The patient is confronted by a life-threatening situation necessitating the use of the experimental treatment; and

(B) Informed consent cannot be obtained from the patient because of an inability to communicate with, or obtain legally effective consent from, the patient; and

(C) There is no alternate method of approved or generally recognized therapy available that provides an equal or greater likelihood of saving the life of the patient.

(2) If a patient has a living will, the agent shall follow the directions of the living will. In addition, if the agent or surrogate has actual knowledge that the patient wished to decline the experimental treatment, the agent or surrogate shall not have the authority to consent to treatment.

39:30 Advance Directives; Requirement to Act in accordance With Principal's Wishes and Best Interests. Amend RSA 137-J:6 to read as follows:

137-J:6 Requirement to Act in Accordance With Principal's Wishes and Best Interests. After consultation with the attending physician, PA, or APRN and other health care providers, the agent or surrogate shall make health care decisions in accordance with the

agent's or surrogate's knowledge of the principal's wishes and religious or moral beliefs, as stated orally or otherwise communicated by the principal, or, if the principal's wishes are unknown, in accordance with the agent's or surrogate's assessment of the principal's best interests and in accordance with accepted medical practice.

39:31 Advance Directives; Physician, PA, APRN, and Provider's Responsibilities. Amend RSA 137-J:7, I-II to read as follows:

I. A qualified patient's attending physician, PA, or APRN, or a qualified patient's health care provider or residential care provider, and employees thereof, having knowledge of the qualified patient's advance directive shall be bound to follow, as applicable, the dictates of the qualified patient's living will and/or the directives of a qualified patient's designated agent to the extent they are consistent with this chapter and the advance directive, and to the extent they are within the bounds of responsible medical practice.

(a) An attending physician, PA, or APRN, or other health care provider or residential care provider, who is requested to do so by the principal shall make the principal's advance directive or a copy of such document a part of the principal's medical record.

(b) Any person having in his or her possession a duly executed advance directive or a revocation thereof, if it becomes known to that person that the principal executing the same is in such circumstances that the terms of the advance directive might become applicable (such as when the principal becomes a "qualified patient"), shall forthwith deliver an original or copy of the same to the health care provider or residential care provider with which the principal is a patient.

(c) The principal's attending physician, PA, or APRN, or any other physician, PA, or APRN, who is aware of the principal's execution of an advance directive shall, without delay, take the necessary steps to provide for written verification of the principal's lack of capacity to make health care decisions (in other words, to certify that the principal is a "qualified patient"), and/or the principal's near death or permanently unconscious condition, as defined in this chapter and as appropriate to the principal's medical condition, so that the attending physician, PA, or APRN and the principal's agent may be authorized to act pursuant to this chapter.

(d) If a physician, PA, or an APRN, because of his or her personal beliefs or conscience, is unable to comply with the terms of the advance directive or surrogate's decision, he or she shall immediately inform the qualified patient, the qualified patient's family, or the qualified patient's agent. The qualified patient, or the qualified patient's agent or family, may then request that the case be referred to another physician, PA, or APRN.

II. An attending physician, PA, or APRN who, because of personal beliefs or conscience, is unable to comply with the advance directive or the surrogate's decision pursuant to this chapter shall, without delay, make the necessary arrangements to effect the transfer of a qualified patient and the appropriate medical records that document the qualified patient's lack of capacity to make health care decisions to another physician, PA, or APRN who has been chosen by the qualified patient, by the qualified patient's agent or surrogate, or by the qualified patient's family, provided, that pending the completion of the transfer, the attending physician, PA, or APRN shall not deny health care treatment, nutrition, or hydration which denial would, within a reasonable degree of medical certainty, result in or hasten the qualified patient's death against the express will of the qualified patient, the advance directive, or the agent or surrogate.

39:32 Advance Directives; Withholding or Withdrawal of Life-Sustaining Treatment. Amend RSA 137-J:10, I(a) and (b) to read as follows:

(a) The principal's attending physician, PA, or APRN shall certify in writing that the principal lacks the capacity to make health care decisions.

(b) Two physicians or a physician and an APRN or PA shall certify in writing that the principal is near death or is permanently unconscious.

39:33 Advance Directives; Withholding or Withdrawal of Life-Sustaining Treatment. Amend RSA 137-J:10, IV(a) to read as follows:

(a) The consent to withhold or withdraw life-sustaining treatment from a pregnant principal, unless, to a reasonable degree of medical certainty, as certified on the principal's medical record by the attending physician, PA, or APRN and an obstetrician who has examined the principal, such treatment or procedures will not maintain the principal in such a way as to permit the continuing development and live birth of the fetus or will be physically harmful to the principal or prolong severe pain which cannot be alleviated by medication.

39:34 Advance Directives; Withholding or Withdrawal of Life-Sustaining Treatment. Amend RSA 137-J:10, VII to read as follows:

VII. Nothing in this chapter shall be construed to create a presumption that in the absence of an advance directive, a person wants life-sustaining treatment to be either taken or withdrawn. This chapter shall also not be construed to supplant any existing rights and responsibilities under the law of this state governing the conduct of physicians, PAs, or APRNs in consultation with patients or their families or legal guardians in the absence of an advance directive.

39:35 Advance Directives; Execution and Witnesses. Amend RSA 137-J:14 to read as follows:

137-J:14 Execution and Witnesses.

I. The advance directive shall be signed by the principal in the presence of either of the following:

(a) Two or more subscribing witnesses, neither of whom shall, at the time of execution, be the agent, the principal's spouse or heir at law, or a person entitled to any part of the estate of the principal upon death of the principal under a will, trust, or other testamentary instrument or deed in existence or by operation of law, or attending physician, PA, or APRN, or person acting under the direction or control of the attending physician, PA, or APRN. No more than one such witness may be the principal's health or residential care provider or such provider's employee. The witnesses shall affirm that the principal appeared to be of sound mind and free from duress at the time the advance directive was signed and that the principal affirmed that he or she was aware of the nature of the document and signed it freely and voluntarily; or

(b) A notary public or justice of the peace, who shall acknowledge the principal's signature pursuant to the provisions of RSA 456 or RSA 456-A.

II. If the principal is physically unable to sign, the advance directive may be signed by the principal's name written by some other person in the principal's presence and at the principal's express direction.

III. A principal's decision to exclude or strike references to PAs or APRNs and the powers granted to PAs or APRNs in his or her advance directive shall be honored.

39:36 Advance Directives; Revocation. Amend RSA 137-J:15, II to read as follows:

II. A principal's health or residential care provider who is informed of or provided with a revocation of an advance directive or surrogacy shall immediately record the revocation, and the time and date when he or she received the revocation, in the principal's medical record and notify the agent, the attending physician, PA, or APRN, and staff responsible for the principal's care of the revocation. An agent or surrogate who becomes aware of such revocation shall inform the principal's health or residential care provider of such revocation. Revocation shall become effective upon communication to the attending physician, PA, or APRN.

39:37 Advance Directives; Durable Power of Attorney; Disclosure Statement. Amend RSA 137-J:19 to read as follows:

137-J:19 Durable Power of Attorney; Disclosure Statement. The disclosure statement which must accompany a durable power of attorney for health care shall be in substantially the following form:

INFORMATION CONCERNING THE DURABLE POWER OF ATTORNEY FOR HEALTH CARE

THIS IS AN IMPORTANT LEGAL DOCUMENT. BEFORE SIGNING IT, YOU SHOULD KNOW THESE IMPORTANT FACTS:

Except if you say otherwise in the directive, this directive gives the person you name as your health care agent the power to make any and all health care decisions for you when you lack the capacity to make health care decisions for yourself (in other words, you no longer have the ability to understand and appreciate generally the nature and consequences of a health care decision, including the significant benefits and harms of and reasonable alternatives to any proposed health care). "Health care" means any treatment, service or procedure to maintain, diagnose or treat your physical or mental condition. Your health care agent, therefore, will have the power to make a wide range of health care decisions for you. Your health care agent may consent (in other words, give permission), refuse to consent, or withdraw consent to medical treatment, and may make decisions about withdrawing or withholding life-sustaining treatment. Your health care agent cannot consent to or direct any of the following: commitment to a state institution, sterilization, or termination of treatment if you are pregnant and if the withdrawal of that treatment is deemed likely to terminate the pregnancy, unless the treatment will be physically harmful to you or prolong severe pain which cannot be alleviated by medication.

You may state in this directive any treatment you do not want, or any treatment you want to be sure you receive. Your health care agent's power will begin when your doctor certifies that you lack the capacity to make health care decisions (in other words, that you are not able to make health care decisions). If for moral or religious reasons you do not want to be treated by a doctor or to be examined by a doctor to certify that you lack capacity, you must say so in the directive and you must name someone who can certify your lack of capacity. That person cannot be your health care agent or alternate health care agent or any person who is not eligible to be your health care agent. You may attach additional pages to the document if you need more space to complete your statement.

Under no conditions will your health care agent be able to direct the withholding of food and drink that you are able to eat and drink normally.

Your agent shall be directed by your written instructions in this document when making decisions on your behalf, and as further guided by your medical condition or prognosis. Unless you state otherwise in the directive, your agent will have the same power to make decisions about your health care as you would have made, if those decisions by your health care agent are made consistent with state law.

It is important that you discuss this directive with your doctor or other health care providers before you sign it, to make sure that you understand the nature and range of decisions which could be made for you by your health care agent. If you do not have a health care provider, you should talk with someone else who is knowledgeable about these issues and can answer your questions. Check with your community hospital or hospice for trained staff. You do not need a lawyer's assistance to complete this directive, but if there is anything in this directive that you do not understand, you should ask a lawyer to explain it to you.

The person you choose as your health care agent should be someone you know and trust, and he or she must be at least 18 years old. If you choose your health or residential care provider (such as your doctor, advanced practice registered nurse, or an employee of a hospital, nursing home, home health agency, or residential care home, other than a relative), that person will have to choose between acting as your health care agent or as your health or residential care provider, because the law does not allow a person to do both at the same time.

You should consider choosing an alternate health care agent, in case your health care agent is unwilling, unable, unavailable or not eligible to act as your health care agent. Any alternate health care agent you choose will then have the same authority to make health care decisions for you.

You should tell the person you choose that you want him or her to be your health care agent. You should talk about this directive with your health care agent and your doctor or advanced practice registered nurse and give each one a signed copy. You should write on the directive itself the people and institutions who will have signed copies. Your health care agent will not be liable for health care decisions made in good faith on your behalf.

EVEN AFTER YOU HAVE SIGNED THIS DIRECTIVE, YOU HAVE THE RIGHT TO MAKE HEALTH CARE DECISIONS FOR YOURSELF AS LONG AS YOU ARE ABLE TO DO SO, AND TREATMENT CANNOT BE GIVEN TO YOU OR STOPPED OVER YOUR CLEAR OBJECTION. You have the right to revoke the power given to your health care agent by telling him or her, or by telling your health care provider, orally or in writing, that you no longer want that person to be your health care agent.

YOU HAVE THE RIGHT TO EXCLUDE OR STRIKE REFERENCES TO APRNS IN YOUR ADVANCE DIRECTIVE AND IF YOU DO SO, YOUR ADVANCE DIRECTIVE SHALL STILL BE VALID AND ENFORCEABLE.

Once this directive is executed it cannot be changed or modified. If you want to make changes, you must make an entirely new directive.

THIS POWER OF ATTORNEY WILL NOT BE VALID UNLESS IT IS SIGNED IN THE PRESENCE OF A NOTARY PUBLIC OR JUSTICE OF THE PEACE OR TWO (2) OR MORE QUALIFIED WITNESSES, WHO MUST BOTH BE PRESENT WHEN YOU SIGN AND WHO WILL ACKNOWLEDGE YOUR SIGNATURE ON THE DOCUMENT. THE FOLLOWING PERSONS MAY NOT ACT AS WITNESSES:

___The person you have designated as your health care agent;

___Your spouse or heir at law;

___Your attending physician, PA, or APRN, or person acting under the direction or control of the attending physician, PA, or APRN;

ONLY ONE OF THE TWO WITNESSES MAY BE YOUR HEALTH OR RESIDENTIAL CARE PROVIDER OR ONE OF YOUR PROVIDER'S EMPLOYEES.

39:38 Advance Directives; Durable Power of Attorney and Living Will. Amend RSA 137-J:20, II to read as follows:

II. LIVING WILL

Declaration made this ___ day of _____, 20___.

I, _____, being of sound mind, willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, do hereby declare:

If at any time I should have an incurable injury, disease, or illness and I am certified to be near death or in a permanently unconscious condition by 2 physicians or a physician and an APRN or PA, and 2 physicians or a physician and an APRN or PA have determined that my death is imminent whether or not life-sustaining treatment is utilized and where the application of life-sustaining treatment would serve only to artificially prolong the dying process, or that I will remain in a permanently unconscious condition, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication, the natural ingestion of food or fluids by eating and drinking, or the performance of any medical procedure deemed necessary to provide me with comfort care. I realize that situations could arise in which the only way to allow me to die would be to discontinue medically administered nutrition and hydration.

(Initial below if it is your choice)

In carrying out any instruction I have given under this section, I authorize that even if all other forms of life-sustaining treatment have been withdrawn, medically administered nutrition and hydration continue to be given to me. _____

In the absence of my ability to give directions regarding the use of such life-sustaining treatment, it is my intention that this declaration shall be honored by my family and health care providers as the final expression of my right to refuse medical or surgical treatment and accept the consequences of such refusal.

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

Signed this ___ day of _____, 2___.

Principal's

Signature: _____

[If you are physically unable to sign, this directive may be signed by someone else writing your name, in your presence and at your express direction.]

THIS LIVING WILL DIRECTIVE MUST BE SIGNED BY TWO WITNESSES OR A NOTARY PUBLIC OR A JUSTICE OF THE PEACE.

We declare that the principal appears to be of sound mind and free from duress at the time the living will is signed and that the principal affirms that he or she is aware of the nature of the directive and is signing it freely and voluntarily.

Witness: _____ Address: _____

Witness: _____ Address: _____

STATE OF NEW HAMPSHIRE

COUNTY OF _____

The foregoing living will was acknowledged before me this ___ day of _____, 20___, by _____ (the "Principal").

_____

Notary Public/Justice of the Peace

My commission expires:

39:39 Advance Directives; Civil Action. Amend RSA 137-J:22, II to read as follows:

II. A copy of any such action shall be given in hand to the principal's attending physician, PA, or APRN and, as applicable, to the principal's health care provider or residential care provider. To the extent they are not irreversibly implemented, health care decisions made by a challenged agent shall not thereafter be implemented without an order of the probate court or a withdrawal or dismissal of the court action; provided, that this paragraph shall not be construed to authorize any violation of RSA 137-J:7, II or III.

39:40 Advance Directives; Presumed Consent to Cardiopulmonary Resuscitation; Health Care Providers and Residential Care Providers Not Required to Expand to Provide Cardiopulmonary Resuscitation. Amend RSA 137-J:25, I(c) to read as follows:

(c) A person who lacks capacity to make health care decisions is near death and admitted to a health care facility, and the person's agent is not available and the facility has made diligent efforts to contact the agent without success, or the person's agent is not legally capable of making health care decisions for the person, and the attending physician, PA, or APRN and a physician knowledgeable about the patient's condition, have determined that the provision of cardiopulmonary resuscitation would be contrary to accepted medical standards and would cause unnecessary harm to the person, and the attending physician, PA, or APRN has completed a do not resuscitate order; or

39:41 Advance Directives; Issuance of a Do Not Resuscitate Order; Order to be Written by the Attending Physician or APRN. Amend RSA 137-J:26 to read as follows:

137-J:26 Issuance of a Do Not Resuscitate Order; Order to be Written by the Attending Physician, PA, or APRN.

I. An attending physician, PA, or APRN may issue a do not resuscitate order for a person if the person, or the person's agent, has consented to the order. A do not resuscitate order shall be issued in writing in the form as described in this section for a person not present or residing in a health care facility. For persons present in health care facilities, a do not resuscitate order shall be issued in accordance with the policies and procedures of the health care facility and in accordance with the provisions of this chapter.

II. A person may request that his or her attending physician, PA, or APRN issue a do not resuscitate order for the person.

III. An agent may consent to a do not resuscitate order for a person who lacks the capacity to make health care decisions if the advance directive signed by the principal grants such authority. A do not resuscitate order written by the attending physician, PA, or APRN for such a person with the consent of the agent is valid and shall be respected by health care providers and residential care providers.

IV. If an agent is not reasonably available and the facility has made diligent efforts to contact the agent without success, or the agent is not legally capable of making a decision regarding a do not resuscitate order, an attending physician, PA, or APRN may issue a do not resuscitate order for a person who lacks capacity to make health care decisions, who is near death, and who is admitted to a health care facility if a second physician who has personally examined the person concurs in the opinion of the attending physician, PA, or APRN that the provision of cardiopulmonary resuscitation would be contrary to accepted medical standards and would cause unnecessary harm to the person.

V. For persons not present or residing in a health care facility, the do not resuscitate order shall be noted on a medical orders form or in substantially the following form on a card suitable for carrying on the person:

Do Not Resuscitate Order

As attending physician, PA, or APRN of _____ and as a licensed physician, physician assistant or advanced practice registered nurse, I order that this person SHALL NOT BE RESUSCITATED in the event of cardiac or respiratory arrest.

This order has been discussed with _____ (or, if applicable, with his/ her agent,) _____, who has given consent as evidenced by his/her signature below.

Attending physician, PA, or APRN Name

Attending physician, PA, or APRN

Signature

Address

Person

Signature

Address

Agent

Signature (if applicable)

_____

Address _____

VI. For persons residing in a health care facility, the do not resuscitate order shall be reflected in at least one of the following forms:

(a) Forms required by the policies and procedures of the health care facility in compliance with this chapter;

(b) The do not resuscitate card as set forth in paragraph V; or

(c) The medical orders form in compliance with this chapter.

39:42 Advance Directives; Compliance With a Do Not Resuscitate Order. Amend RSA 137-J:27, I(a)-(c) to read as follows:

(a) A do not resuscitate order completed by the attending physician, PA, or APRN on a form as specified in RSA 137-J:26;

(b) A do not resuscitate order for a person present or residing in a health care facility issued in accordance with the health care facility's policies and procedures in compliance with the chapter; or

(c) A medical orders form on which the attending physician, PA, or APRN has documented a do not resuscitate order in compliance with this chapter.

39:43 Advance Directives; Protection of Persons Carrying Out in Good Faith a Do Not Resuscitate Order; Notification of Agent by Attending Physician or APRN Refusing to Comply With Do Not Resuscitate Order; Revocation of Do Not Resuscitate Order. Amend RSA 137-J:28 and 137-J:29 to read as follows:

137-J:28 Protection of Persons Carrying Out in Good Faith a Do Not Resuscitate Order; Notification of Agent by Attending Physician, PA, or APRN Refusing to Comply With Do Not Resuscitate Order.

I. No health care provider or residential care provider, or any other person acting for the provider or under the provider's control, shall be subjected to criminal or civil liability, or be deemed to have engaged in unprofessional conduct, for carrying out in good faith a do not resuscitate order authorized by this chapter on behalf of a person as instructed by the person, or the person's agent, or for those actions taken in compliance with the standards and procedures set forth in this chapter.

II. No health care provider or residential care provider, or any other person acting for the provider or under the provider's control, or other individual who witnesses a cardiac or respiratory arrest shall be subjected to criminal or civil liability for providing cardiopulmonary resuscitation to a person for whom a do not resuscitate order has been issued; provided, that such provider or individual:

(a) Reasonably and in good faith is unaware of the issuance of a do not resuscitate order; or

(b) Reasonably and in good faith believed that consent to the do not resuscitate order has been revoked or canceled.

III.(a) Any attending physician, PA, or APRN who, because of personal beliefs or conscience, refuses to issue a do not resuscitate order at a person's request or to comply with a do not resuscitate order issued pursuant to this chapter shall take reasonable steps to advise promptly the person or agent of the person that such attending physician or APRN is unwilling to effectuate the order. The attending physician, PA, or APRN shall thereafter at the election of the person or agent permit the person or agent to obtain another attending physician, PA, or APRN.

(b) If a physician, PA, or APRN, because of his or her personal beliefs or conscience, is unable to comply with the terms of a do not resuscitate order, he or she shall immediately inform the person, the person's agent, or the person's family. The person, the person's agent, or the person's family may then request that the case be referred to another physician, PA, or APRN, as set forth in RSA 137-J:7, II and III.

137-J:29 Revocation of Do Not Resuscitate Order.

I. At any time a person in a health care facility may revoke his or her previous request for or consent to a do not resuscitate order by making either a written, oral, or other act of communication to the attending physician, PA, or APRN or other professional staff of the health care facility.

II. At any time a person residing at home may revoke his or her do not resuscitate order by destroying such order and removing do not resuscitate identification on his or her person. The person is responsible for notifying his or her attending physician, PA, or APRN of the revocation.

III. At any time an agent may revoke his or her consent to a do not resuscitate order for a person who lacks capacity to make health care decisions who is admitted to a health care facility by notifying the attending physician, PA, or APRN or other professional staff of the health care facility of the revocation of consent in writing, or by orally notifying the attending physician, PA, or APRN in the presence of a witness 18 years of age or older.

IV. At any time an agent may revoke his or her consent for a person who lacks capacity to make health care decisions who is residing at home by destroying such order and removing do not resuscitate identification from the person. The agent is responsible for notifying the person's attending physician, PA, or APRN of the revocation.

V. The attending physician, PA, or APRN who is informed of or provided with a revocation of consent pursuant to this section shall immediately cancel the do not resuscitate order if the person is in a health care facility and notify the professional staff of the health care facility responsible for the person's care of the revocation and cancellation. Any professional staff of the health care facility who is informed of or provided with a revocation of consent pursuant to this section shall immediately notify the attending physician, PA, or APRN of such revocation.

VI. Only a physician, physician assistant, or advanced practice registered nurse may cancel the issuance of a do not resuscitate order.

39:44 Advance Directives; Do Not Resuscitate Identification. Amend RSA 137-J:33 to read as follows:

137-J:33 Do Not Resuscitate Identification. Do not resuscitate identification as set forth in this chapter may consist of either a medical condition bracelet or necklace with the inscription of the person's name, date of birth in numerical form and "NH Do Not Resuscitate" or "NH DNR" on it. Such identification shall be issued only upon presentation of a properly executed do not resuscitate order form as set forth in RSA 137-J:26, a medical orders form in which a physician, physician assistant, or advanced practice registered nurse has documented a do not resuscitate order, or a do not resuscitate order properly executed in accordance with a health care facility' s written policy and procedure.

39:45 Advance Directives; Surrogate Decision-making. Amend RSA 137-J:35 to read as follows:

137-J:35 Surrogate Decision-making.

I. When a patient lacks capacity to make health care decisions, the physician, PA, or APRN shall make a reasonable inquiry pursuant to 137-J:7 as to whether the patient has a valid advance directive and, to the extent that the patient has designated an agent, whether such agent is available, willing and able to act. When no health care agent is authorized and available, the health care provider shall make a reasonable inquiry as to the availability of possible surrogates listed under this paragraph. A surrogate decision-maker may make medical decisions on behalf of a patient without court order or judicial involvement in the following order of priority:

(a) The patient's spouse, or civil union partner or common law spouse as defined by RSA 457:39, unless there is a divorce proceeding, separation agreement, or restraining order limiting that person's relationship with the patient.

(b) Any adult son or daughter of the patient.

(c) Either parent of the patient.

(d) Any adult brother or sister of the patient.

(e) Any adult grandchild of the patient.

(f) Any grandparent of the patient.

(g) Any adult aunt, uncle, niece, or nephew of the patient.

(h) A close friend of the patient.

(i) The agent with financial power of attorney or a conservator appointed in accordance with RSA 464-A.

(j) The guardian of the patient's estate.

II. The physician, PA, or APRN may identify a surrogate from the list in paragraph I if the physician, PA, or APRN determines he or she is able and willing to act, and determines after reasonable inquiry that neither a legal guardian, health care agent under a durable power of attorney for health care, nor a surrogate of higher priority is available and able and willing to act. The surrogate decision-maker, as identified by the attending physician, PA, or APRN, may make health care decisions for the patient. The surrogacy provisions of this chapter shall take effect when the decision-maker names are recorded in the medical record. The physician, PA, or APRN shall have the right to rely on any of the above surrogates if the physician, PA, or APRN believes after reasonable inquiry that neither a health care agent under a durable power of attorney for health care or a surrogate of higher priority is available or able and willing to act.

39:46 Advance Directives; Determining Priority Among Multiple Surrogates. Amend RSA 137-J:36, I to read as follows:

I. Where there are multiple surrogate decision-makers at the same priority level in the hierarchy, it shall be the responsibility of those surrogates to make reasonable efforts to reach a consensus as to their decision on behalf of the patient regarding any health care decision. If 2 or more surrogates who are in the same category and have equal priority indicate to the attending physician, PA, or APRN that they disagree about the health care decision at issue, a majority of the available persons in that category shall control, unless the minority or any other interested party initiates guardianship proceedings in accordance with RSA 464-A. There shall not be a recognized surrogate when a guardianship proceeding has been initiated and a decision is pending. The person initiating the petition for guardianship shall immediately provide written notice of the initiation of the guardianship proceeding to the health care facility where the patient is being treated. This process shall not preempt the care of the patient. No health care provider or other person shall be required to seek appointment of a guardian.

39:47 Advance Directives; Limitations of Surrogacy. Amend RSA 137-J:37, II-IV to read as follows:

II. No physician, PA, or APRN shall be required to identify a surrogate, and may, in the event a surrogate has been identified, revoke the surrogacy if the surrogate is unwilling or unable to act.

III. A physician, PA, or APRN may, but shall not be required to, initiate guardianship proceedings or encourage a family member or friend to seek guardianship in the event a patient is determined to lack capacity to make health care decisions and no guardian, agent under a health care power of attorney, or surrogate has been appointed or named.

IV. Nothing in this chapter shall be construed to require a physician, PA, or APRN to treat a patient who the physician, PA, or APRN reasonably believes lacks health care decision-making capacity and for whom no guardian, agent, or surrogate has been appointed.

39:48 Physician Assistants; Licensure. Amend RSA 328-D:2 to read as follows:

328-D:2 License Required.

I. No person shall practice as ~~or hold himself out to be~~ a physician assistant ~~or use any letters designating himself as a physician assistant~~ in the state of New Hampshire unless he or she is licensed by the board of medicine in accordance with this chapter.

II. This section shall not be construed to prohibit students enrolled in physician assistant training programs approved by the board, from performing work incidental to their respective courses of study or supervised clinical work while under the supervision of a ~~physician~~ designated preceptor.

III. The board shall license each applicant who satisfies the requirements under RSA 328-D:3. Upon payment of a license fee, the board shall issue to such person a license, which shall be prima facie evidence of the right to practice as a physician assistant. ~~A licensed physician assistant may use the letters "P.A." in connection with his name to denote his licensure under this chapter.~~

39:49 Physician Assistants; License Renewal. Amend RSA 328-D:5 to read as follows:

328-D:5 Renewal of Licenses. Every person licensed to practice under this chapter shall apply to the board for ~~annual~~ biennial renewal of license on forms provided by the ~~board~~ office of professional licensure and certification and shall pay a renewal fee as established by the ~~board~~ office of professional licensure and certification. Applications for renewal shall be filed no later than December 31 of ~~each~~ every other year and shall include ~~a photocopy~~ proof of the applicant's current national certification ~~card~~. A license issued under this chapter shall not expire until the board has taken final action upon the application for renewal.

39:50 Physician Assistants; Transition of License Renewals. For the transition from annual to biennial renewal under RSA 328-D:5 as amended by section 49 of this act, licensees who were initially licensed in odd-numbered years prior to 2021 shall renew by December 31, 2021 and every 2 years thereafter, and licensees who were initially licensed in even-numbered years shall renew by December 31, 2022 and every 2 years thereafter. The office of professional licensure and certification shall prorate the renewal fee for those who receive a one-year renewal during this transition. Notwithstanding RSA 318-B:40, those who receive a one-year renewal during this transition shall only be required to obtain 1.5 contact hours of continuing education in pain management and addiction disorder as a condition of the renewal during the transition.

39:51 New Paragraph; Coverage for Certain Biologically-Based Mental Illnesses; Reimbursement Parity Required. Amend RSA 417-E:1 by inserting after paragraph V-a the following new paragraph:

V-b.(a) Health insurers, health service corporations, and health maintenance organizations shall include in their contracts with participating providers as defined under 420-J:3, reimbursement terms for mental health and substance use disorder treatment services that are on average, at least as favorable as those in their contracts for professional services provided by non-hospital affiliated primary care providers.

(1) Reimbursements for services paid to mental health and substance use disorder treatment providers shall meet the required standard if the reimbursement are, on average, equal to or greater than the relative Medicare reimbursements for the same service.

(2) Services considered in the comparison shall be those provided on an in-network basis in New Hampshire, and shall only consider comparisons for those services commonly provided by both non-hospital affiliated physicians and mental health and substance use disorder providers.

(3) Consistent with Medicare standards, professional licensure, certification, and telemedicine policies shall be recognized as factors warranting adjustment to reimbursement

(b) Compliance with subparagraph (a) shall not constitute compliance with the Mental Health Parity and Addiction Equity Act in 42 U.S.C. 300gg-26 and its implementing and related regulations in 45 C.F.R. 146.136, 45 C.F.R. 147.160, and 45 C.F.R. 156.115(a)(3). Health insurers, health service corporations, and health maintenance organizations shall, pursuant to 45 C.F.R. 146.136(c)(4)(i) and 45 C.F.R. 146.136(c)(4)(ii), ensure that when setting reimbursement rates for mental health and substance use disorder treatment providers, as written and in effect, any processes, strategies, evidentiary standards, or other factors used in establishing such reimbursement rates are comparable to, and are applied no more stringently than, any processes, strategies, evidentiary standards, or other factors used in establishing reimbursement rates for medical/surgical providers in the classification of benefits.

39:52 Managed Care Law: Authorization for Medication- Assisted Treatment. Amend RSA 420-J:18 to read as follows:

420-J:18 Authorization for Medication-Assisted Treatment. Whenever substance use disorder services are a covered benefit under a health benefit plan subject to this chapter, a health carrier ~~that has authorized or otherwise approved medication-assisted treatment for such services shall not require a renewal of such authorization more frequently than once every 12 months.~~ shall:

I. Be required to offer at least one medication-assisted treatment therapy option approved by the federal Food and Drug Administration for treatment of substance use disorders without a requirement for prior authorization.

II. Not require a renewal of a prior authorization for a medication-assisted treatment therapy for treatment of substance use disorders more frequently than once every 12 months.

39:53 Statement of Purpose. The general court finds that the ongoing addiction epidemic has resulted in the deaths of thousands of New Hampshire residents. It has cost the state billions of dollars in health care costs, lost worker productivity, and other charges, and it has strained state and community resources and policies. Greater investigation into the circumstances of overdose fatalities can help New Hampshire continue to develop more effective policies and effectively fight this public health crisis. Therefore, the general court hereby establishes the New Hampshire drug overdose fatality review commission.

39:54 New Chapter; New Hampshire Drug Overdose Fatality Review Commission. Amend RSA by inserting after chapter 126-AA the following new chapter:

CHAPTER 126-BB

NEW HAMPSHIRE DRUG OVERDOSE FATALITY REVIEW COMMISSION

126-BB:1 Commission Established.

I. There is established a commission to review information and data related to drug overdose fatalities in New Hampshire. The members of the commission shall be as follows:

(a) One member of the senate, appointed by the president of the senate.

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

(c) The attorney general, or designee.

(d) The chief medical examiner, or designee.

(e) The commissioner of the department of health and human services, or designee.

(f) The commissioner of the department of safety, or designee.

(g) The chairperson of the governor's commission on alcohol and drug abuse prevention, treatment, and recovery, or designee.

(h) A representative of the New Hampshire Association of Chiefs of Police, appointed by the association.

(i) A representative of the New Hampshire Association of Fire Chiefs, appointed by the association.

(j) A health official from a city health department, appointed by the governor.

(k) A victim/witness advocate, appointed by the attorney general.

(l) A representative of the New Hampshire Hospital Association, appointed by the association.

(m) A representative of the recovery community, appointed by the governor.

(n) A representative of the treatment community, appointed by the governor.

(o) A representative of the prevention community, appointed by the governor.

(p) A representative of New Futures, appointed by that organization.

(q) A representative from American Medical Response, appointed by that organization.

(r) A representative of the Drug Enforcement Administration, appointed by the administration.

(s) The governor's advisor on addiction and behavioral health.

(t) A suicide prevention specialist, appointed by NAMI-New Hampshire.

(u) A representative of the New Hampshire Medical Society, appointed by the society.

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

(b) A member of the commission appointed under subparagraphs I(a)-(g) or (s) shall serve a term conterminous with their term in office. A member appointed under subparagraph I(h)-(r) or (t) shall serve a 6-year term, provided that initial appointments shall be for staggered terms of one to 6 years.

(c) Members of the commission shall sign confidentiality statements that prohibit any unauthorized dissemination of information except when disclosures may be necessary to enable the commission to carry out its duties under this subdivision. No material shall be used for reasons other than for which it was intended.

III.(a) The commission shall:

(1) Review trends and patterns of overdose-related fatalities in New Hampshire.

(2) Identify high-risk factors, current practices, and gaps in system responses.

(3) Recommend policies, practices, and services that will encourage collaboration and reduce overdose fatalities.

(4) Improve sources of data collection by developing a system to share information between agencies and offices that work with individuals struggling with addiction.

(5) Educate the public, policy makers, and funders about overdose-related fatalities and about strategies for intervention and effective prevention, treatment, and recovery.

(6) Review laws and programs enacted in other states, counties, or municipalities.

(b)(1) Upon the request of the chairperson of the commission and as necessary to carry out the commission's duties, the chairperson shall be provided, within 5 days excluding weekends and holidays, with access to information and records regarding a drug overdose fatality that is being reviewed by the commission or regarding the person who overdosed on drugs. The commission may request the information and records from any of the following:

(A) A provider of medical, dental, or behavioral health care.

(B) Any state or a political subdivision of this state that might assist the commission in reviewing the fatality.

(2) A law enforcement agency, with the approval of the prosecuting attorney, may withhold from a review team investigative records that may interfere with a pending criminal investigation or prosecution.

IV.(a) The members of the commission shall elect a chairperson from among the members. The first meeting of the commission shall be called by the senate member. The first meeting of the commission shall be held within 45 days of the effective date of this section. Eleven members of the commission shall constitute a quorum.

(b) The department of health and human services shall provide administrative support to the commission.

V. The commission shall:

(a) Meet no fewer than 6 times per year to conduct reviews of overdose fatalities.

(b) Study the adequacy of statutes, rules, training, and services to determine what changes are needed to decrease the incidence of preventable overdose fatalities and, as appropriate, take steps to implement these changes.

(c) Educate the public regarding the incidence and causes of overdose fatalities and the public's role in preventing these deaths.

(d) Review all overdose fatalities except for fatalities of children under 18 years of age and fatalities related to women while pregnant or with one year of the end of pregnancy.

(e) Complete an annual statistical report on the incidence and causes of overdose fatalities in this state during the past fiscal year and submit a copy of this report, including its recommendations for proposed legislation and actions, to the governor, the senate president, and the speaker of the house of representatives. The commission shall submit the report on or before December 15 of each year commencing on December 15, 2021.

VI. The commission shall not:

(a) Call witnesses or take testimony from individuals who have been identified by the department of justice as potential witnesses in any criminal prosecution arising from an overdose death until the completion of such prosecution.

(b) Enforce any public health standard or criminal law or otherwise participate in any legal proceeding, unless a member of the team is involved in the investigation of the death or resulting prosecution and must participate in a legal proceeding in the course of performing his or her duties outside the team.

VII.(a) Proceedings, records, and opinions of the commission are confidential, not subject to RSA 91-A, and not subject to discovery, subpoena, or introduction into evidence in any civil or criminal proceeding. Nothing in this subparagraph shall be construed to limit or restrict the right to discover or use in any civil or criminal proceeding anything that is available from another source and entirely independent of the proceedings of the commission.

(b) Members of the commission shall not be questioned in any civil or criminal proceeding regarding information presented in or opinions formed as a result of a meeting of the team. Nothing in this subparagraph shall be construed to prevent a member of the commission from testifying to information obtained independently of the commission or which is public information.

VIII.(a) The commission shall maintain the confidentiality of all records pursuant to RSA 169-C:25, RSA 170-G:8-a, and all other related confidentiality laws.

(b) The information and records obtained and created in execution of the commission’s official functions shall be exempt from disclosure pursuant to RSA 91-A and shall be privileged and exempt from use or disclosure in any criminal or civil matter or administrative proceeding. No person who participates in the official functions of the commission shall be compelled to testify or produce evidence in any judicial or administrative proceeding with respect to any matter involving exercise of his or her official duties.

(c) Commission members, their agents and employees, shall not be subject to, and shall be immune from, claims, suits, liability, damages or any other recourse, civil or criminal, arising from any act, proceeding, decision or determination undertaken or performed or recommendation made, provided such persons acted in good faith and without malice in carrying out their responsibilities, authority, duties, powers and privileges of the offices conferred by this subdivision upon them.

(d) No organization, institution, or person furnishing information, data, reports, or records to the commission shall be liable in damages to any person or subject to any other recourse, civil or criminal.

(e) Any person who knowingly discloses case records or other information obtained from commission proceedings shall be guilty of a misdemeanor.

39:55 New Subdivision; Opioid Abatement Trust Fund. Amend RSA 126-A by inserting after section 82 the following new subdivision:

Opioid Abatement Trust Fund

126-A:83 Opioid Abatement Trust Fund Established.

I. There is hereby established in the state treasury the opioid abatement trust fund that shall be kept distinct and separate from all other funds. All proceeds received by the state from all consumer protection settlements or judgments against opioid manufacturers or distributors shall be deposited in accordance with RSA 7:6-f. Any amount that would have been deposited in the general fund under 7:6-f shall, instead, be placed in the trust fund. All other opioid-related settlement funds or judgments from New Hampshire counties and all political subdivisions shall, likewise, be placed in the trust fund. The state treasurer shall be the trustee of the trust fund, and shall invest the trust fund in accordance with RSA 6:8. Any earnings on trust fund moneys shall be added to the trust fund. All moneys in the trust fund shall be nonlapsing and shall be continually appropriated to the state treasury. The state treasurer shall disburse funds from the trust fund solely for the purposes and in the manner set forth in RSA 126-A:84.

II. The treasurer shall distribute 15 percent of all funds received prior to any deposit in the consumer escrow account or the opioid abatement trust fund to the counties and the political subdivisions that filed lawsuits, on or before September 1, 2019, against opioid manufacturers, distributors and other persons identified as defendants in the multidistrict opioid litigation pending in the federal district court for the northern district of Ohio. This distribution shall occur on an annual basis. The distribution of funds shall be based on the 2010 census population of each qualifying county and political subdivisions. The population of any political subdivision which receives funds under this section shall not be included in the population of the county for determining the distribution to that county.

126-A:84 Opioid Abatement Trust Fund; Management and Distribution of Funds.

I. The commissioner of the department of health and human services, in consultation with the opioid abatement advisory commission established in RSA 126-A:85, shall administer the opioid abatement trust fund established in RSA 126-A:83. The commissioner shall draw from the opioid abatement trust fund for qualifying opioid abatement projects under RSA 126-A:86, I(b).

II. Funds shall be distributed between the state, counties, cities and towns as follows:

(a) Fifteen percent of the funds each year shall be distributed to the counties and political subdivisions as identified in RSA 126-A:83, II.

(b) All remaining funds shall be deposited into the opioid abatement trust fund as established by RSA 126-A:83, I to be distributed by the commissioner of the department of health and human services, with approval of the opioid abatement advisory commission. Funds may be awarded to a qualifying governmental entity or program for an approved use under RSA 126-A:86, I(b).

III. The commissioner of the department of health and human services shall continue to make distributions from the trust fund under this section for as long as defendants in the opioid litigation make payments to the state or until such time that the funds in the opioid abatement trust fund are exhausted.

IV. On or before September 1, 2020, each county, city, town or program that receives funds under paragraph II shall annually provide to the department of health and human services and the opioid abatement advisory commission a detailed account of all monies spent on approved uses, including, but limited to, an analysis and evaluation of the projects and programs it has funded.

V. The department of health and human services shall adopt rules under RSA 541-A necessary to implement this subdivision. Such rules shall include funding qualifications, application procedures, time-lines for receiving, reviewing and acting upon application requests, and reporting requirements.

VI. On or before November 1, 2020, the commissioner of the department of health and human services shall submit an annual report to the governor and fiscal committee of the general court detailing the activities of the advisory commission, the administration of the opioid abatement trust fund, the amount distributed in the past year, the amount remaining in the trust fund, a summary of how funds were used in the past year, and any recommendations for future legislation.

126-A:85 New Hampshire Opioid Abatement Advisory Commission Established.

I. There is hereby established the New Hampshire opioid abatement advisory commission, which shall consult with and advise the commissioner of the department of health and human services relative to the proper administration and management of the opioid abatement trust fund, as established in RSA 126-A:83, and which shall approve all qualifying grants, loans, and matching funds from that fund under RSA 126-A:86, I(b).

II. The commission shall consist of the following members:

(a) The governor, or designee.

(b) The attorney general, or designee.

(c) The state treasurer, or designee.

(d) The commissioner of the department of corrections, or designee.

(e) The commissioner of the department of health and human services, or designee.

(f) One member of the house of representatives, appointed by the speaker of the house of representatives.

(g) One member of the senate, appointed by the president of the senate.

(h) The chairperson of the governor's commission on alcohol and drug abuse, prevention, treatment and recovery, or designee.

(i) A county attorney appointed by the governor.

(j) A county corrections superintendent, or designee, appointed by the governor.

(k) A county nursing home supervisor, or designee, appointed by the governor.

(l) A New Hampshire municipal fire chief, appointed by the governor.

(m) A New Hampshire municipal police chief, appointed by the governor.

(n) One designee from a county with a population of 100,000 or more, appointed by the governor.

(o) One designee from a county with a population of less than 100,000, appointed by the governor.

(p) One designee of a city with a population over 75,000, appointed by the governor.

(q) One designee of a city or town with a population under 75,000, appointed by the governor.

(r) One designee representing a town with a population under 20,000, appointed by the governor.

(s) One designee representing victims of the opioid crisis, appointed by the attorney general.

(t) One member representing prevention, appointed by the governor’s commission alcohol and drug abuse prevention, treatment, and recovery, or designee.

(u) One member representing treatment, appointed by the governor’s commission on alcohol and drug abuse prevention, treatment, and recovery, or designee.

(v) One member representing recovery, appointed by the governor’s commission on alcohol and drug abuse prevention, treatment, and recovery, or designee.

III. Members appointed under subparagraphs (n) through (v) shall be appointed for staggered 2-year terms. Members appointed under subparagraphs (a) through (m) shall serve a term coterminous with their term in office. The advisory commission shall elect a chairperson every year with no person serving as chairperson for more than 2 consecutive one-year terms.

IV. Each member of the advisory commission shall have one vote, with all actions being taken by an affirmative vote of the majority of present members. Eleven members shall constitute a quorum.

V. Members of the advisory commission shall receive no compensation except for legislative members who shall receive the legislative rate for mileage when attending to their duties on the commission.

VI. Meetings of the advisory commission shall be conducted in accordance with RSA 91-A and take place no less than twice per year.

VII. The department of health and human services shall provide administrative support to the advisory commission.

126-A:86 New Hampshire Opioid Abatement Advisory Commission; Duties.

I. The opioid abatement advisory commission shall:

(a) Consult with and advise the commissioner of the department of health and human services on the administration and management of the opioid abatement trust fund, and approve the selection of eligible fund recipients under RSA 126-A:83, II(b).

(b) Award grants, revolving loan funds, and matching funds to projects from the opioid abatement trust fund under RSA 126-A:83, I, in a manner consistent with the following criteria. All disbursements or grants shall require approval of the governor and executive council. Funds may be awarded if the project meets one of the following criteria:

(1) Reimburse the state and any political subdivision within the state for any portion of the cost related to outpatient and residential opioid use disorder (OUD) and any co-occurring substance use disorder or mental health (SUD/MH) treatment services, including, but

not limited to, services provided to incarcerated individuals, Medication assisted treatment (MAT); abstinence-based treatment; treatment, recovery or other services provided by states, subdivisions, community health centers, or not-for-profit providers;

(2) Reimburse the state and any political subdivision for emergency response services related to OUD and any co-occurring SUD/MH issues provided by law enforcement and first responders;

(3) Support mobile intervention, treatment, and recovery services, offered by qualified professionals, for persons with OUD and any co-occurring SUD/MH issues or persons who have experienced an opioid overdose;

(4) Support detoxification services for persons with OUD and any co-occurring SUD/MH issues, including medical detoxification, referral to treatment or connections to other services;

(5) Reimburse the state and any political subdivision within the state for any portion of the cost of administering naloxone;

(6) Provide access to housing for people with OUD and any co-occurring SUD/MH issues, including supportive housing, recovery housing, or housing assistance programs;

(7) Provide or support transportation to treatment or recovery programs or services for persons with OUD and any co-occurring SUD/MH issues;

(8) Provide employment training or educational services for persons in treatment for or in recovery from OUD and any co-occurring SUD/MH;

(9) Create or support centralizes call centers that provide information and connections to appropriate services and supports for persons with OUD and an co-occurring SUD/MH issues;

(10) Improve oversight of opioid treatment programs (OTPs) to assure evidence-based, evidence-informed practices;

(11) Provide scholarships and supports for certified addiction counselors and other mental and behavioral health providers involved in addressing OUD and any co-occurring SUD/MH issues, including, but not limited to, training, scholarships, fellowships, loan repayment programs, or other incentives for providers to work in rural or underserved areas of the state;

(12) Support efforts to prevent over-prescribing and ensure appropriate prescribing and dispensing of opioids through evidence-based, evidence-informed programs or strategies;

(13) Support enhancements or improvements consistent with state law to the prescription drug monitoring program; and

(14) Support the education of law enforcement or other first responders regarding appropriate practices and precautions when dealing with fentanyl or other drugs.

II. The commission or the commissioner of the department of health and human services may identify additional responsibilities including reporting on projects and programs related to addressing the opioid epidemic, developing priorities, goals and recommendations for spending on such projects and programs, working with state agencies or outside entities to develop measures for projects and programs that address substance use disorders, making recommendations for policy changes on a state and local level, including statutory law and administrative agency regulations.

III. The commission shall create and maintain a website on which it shall publish its minutes, attendance rolls and votes, including records of all votes on funding requests, funding awards, and reports of funding by recipients.

39:56 Disposition of Consumer Protection Settlement Funds. Amend RSA 7:6-f to read as follows:

7:6-f Disposition of Consumer Protection Settlement Funds. Any funds received by the attorney general on behalf of the state or its citizens as a result of any civil judgment or settlement of a claim, suit, petition, or other action under RSA 358-A or related consumer protection statutes shall be deposited in a consumer protection escrow account. The consumer protection escrow account shall at no time exceed $5 million, with any amount in excess of $5 million deposited into the general fund, except as otherwise provided in RSA 126-A:83. The attorney general shall not include language in any consumer protection settlement that restricts any payments to the state for attorneys' fees, investigation and litigation costs, consumer education, or consumer protection enforcement to the consumer protection escrow account or any other account or fund.

39:57 New Subparagraph; Dedicated Funds; Opioid Abatement Trust Fund. Amend RSA 6:12, I(b) by inserting after subparagraph (358) the following new subparagraph:

(359) Moneys deposited in the opioid abatement trust fund, established in RSA 126-A:83.

39:58 Pharmacist Administration of Vaccines. Amend RSA 318:16-b to read as follows:

318:16-b Pharmacist Administration of Vaccines. A pharmacist or pharmacy intern under the direct supervision of an immunizing pharmacist may administer influenza vaccines to the general public and a pharmacist or pharmacy intern may administer pneumococcal and varicella zoster vaccines to individuals 18 years of age or older, provided all of the criteria in this section have been met. A pharmacist or pharmacy intern under the direct supervision of an immunizing pharmacist may administer a COVID-19 vaccine, if available, provided that all applicable criteria in this section have been met. The pharmacist or pharmacy intern administering a COVID-19 vaccine shall notify the patient's primary care physician. The pharmacist and pharmacy intern shall:

I. Hold a current license to practice as a pharmacist or be registered as a pharmacy intern under RSA 318:15-b in New Hampshire.

II. Possess at least $1,000,000 of professional liability insurance coverage.

III. In order to administer influenza, pneumococcal, and varicella zoster vaccines, have completed training specific to the administering of the respective vaccines that includes programs approved by the Accreditation Council for Pharmacy Education (ACPE) or curriculum-based programs from an ACPE-accredited college of pharmacy or state or local health department programs or programs recognized by the board.

IV. Provide to the board evidence of compliance with paragraphs I-III.

V. Provide notice to the primary care provider, when designated by the patient, of the administration of the pneumococcal and varicella zoster vaccines.

VI. Maintain a record of administration of pneumococcal and varicella zoster vaccinations for each individual as required by state and federal law.

39:59 New Hampshire Granite Advantage Health Care Trust Fund. Amend RSA 126-AA:3, I(e)-(g) to read as follows:

(e) Funds received from the assessment under RSA 404-G; and

(f) Funds recovered or returnable to the fund that were originally spent on the cost of coverage of the granite advantage health care program~~; and~~

~~(g) Gifts, grants, and donations~~.

39:60 County Department of Corrections; Superintendent Duties. Amend RSA 30-B:4, V to read as follows:

V. The superintendent shall provide each prisoner in ~~his or her~~ the superintendent's custody with necessary sustenance, clothing, bedding, shelter, and medical care including screening for and provision of medication-assisted treatment for substance use disorders where medically appropriate and regardless of whether the prisoner was receiving medication-assisted treatment prior to incarceration. "Medication-assisted treatment" means treatment approved by the Food and Drug Administration for treatment of substance use disorders, which may include, but not be limited to, naltrexone, buprenorphine, methadone, or other compounds.

39:61 Health Facility Licensure; Patients' Bill of Rights. Amend RSA 151:21, XVI to read as follows:

XVI. The patient shall not be denied appropriate care on the basis of ~~race, religion, color, national origin, sex, age, disability, marital status, or source of payment, nor shall any such care be denied on account of the patient's sexual orientation~~ age, sex, gender identity, sexual orientation, race, color, marital status, familial status, disability, religion, national origin, source of income, source of payment, or profession.

39:62 Health Facility Licensure; Patients' Bill of Rights. Amend RSA 151:21, XVIII to read as follows:

XVIII. The patient shall be entitled to have the patient's parents, if a minor, or spouse, or next of kin, unmarried partner, or a personal representative chosen by the patient, if an adult, visit the facility, without restriction, if the patient is considered terminally ill by the physician responsible for the patient's care.

39:63 New Section; Physicians and Surgeons; Certain Examination Prohibited. Amend RSA 329 by inserting after section 1-e the following new section:

329:1-f Examination on Anesthetized or Unconscious Patient Prohibited. A physician, surgeon, physician assistant as defined in RSA 328-D:1, III, nurse as defined in RSA 326-B:2, VII-a, advanced practice registered nurse as defined in RSA 326-B:2, I, or student undertaking a course of professional instruction or a clinical training program, shall not perform a pelvic, prostate, rectal, or breast examination on an anesthetized or unconscious patient unless:

I. The patient gave informed consent to the examination;

II. The performance of the examination is within the scope of care for the patient;

III. The examination is reasonably required for diagnostic or treatment purposes; or

IV. The patient's consent cannot be obtained due to an emergency and the examination is reasonably required for diagnostic or treatment purposes.

39:64 New Section; Requirements for Licensure Near Critical Access Hospitals. Amend RSA 151 by inserting after section 4 the following new section:

151:4-a Requirements for Licensure Near Critical Access Hospitals.

I. In this section:

(a) “Health care services” means any of the following currently provided by the critical access hospital to the service area: inpatient care, inpatient or outpatient surgery, emergency services, labor and delivery services, addiction and recovery services, mental health services, or coordination with emergency response systems.

(b) “Material adverse impact” means that granting the application would more likely than not tangibly minimize the critical access hospital’s ability to continue providing the health care services.

(c) “Service area” means the area by which a majority of patients are served by the critical access hospital according to the hospital discharge data provided by the critical access hospital in accordance with RSA 126:25.

II.(a) Any person or entity proposing to establish an ambulatory surgical center, emergency medical care center, hospital, birthing center, drop-in or walk-in care center, dialysis center, or special health care service within a radius of 15 miles of the primary physical location of a New Hampshire hospital certified as a critical access hospital pursuant to 42 C.F.R 485.610(b) and (c), shall give written notice of the intent to establish a health care facility within a 15 mile radius with a description of the facility or special health care service to the chief executive officer of the hospital by certified mail.

(b) If, within 30 days of receipt of the notification under subparagraph (a), the critical access hospital notifies the department of health and human services that it objects to the establishment of the proposed health care facility and articulates a detailed basis for its objection, an expert report shall be completed by an independent contractor retained by the department and approved by the critical access hospital and proposed health care facility to determine whether or not the new facility will have a material adverse impact. If, after proposing 3 independent contractors in a period not to exceed 30 days, the critical access hospital and proposed health care facility cannot agree on an independent contractor selected by the commissioner of the department of health and human services, the commissioner shall independently designate the independent contractor to perform the assessment and create the expert report. The expert report shall be prepared as follows:

(1) The report shall include how the proposed project will impact the health care services in the service area in terms of utilization, patient charges, market share, physician referral patterns, personnel resources, and referral sources.

(2) The proposed health care facility and critical access hospital shall provide any information requested by the expert to complete its report. Information obtained at the request of the expert shall not be considered confidential under RSA 151:13, unless the department determines that it should be exempt from disclosure under RSA 91-A:5.

(3) Within 30 days of retention of the expert, the department shall publish a notice on the department’s Internet website to notify the public of the proposed health care facility and solicit public comment for a period of at least 7 calendar days. All public comments shall be provided to the expert for use in the analysis.

(4) The report shall be completed within 90 days of the retention of the expert unless an extension is granted by the department. Such an extension shall not exceed 30 days.

(5) If the report finds that the proposed health care facility will have a material adverse impact, then the proposed health care facility shall not be allowed to apply for licensure. If the proposed health care facility fails to provide the requested information to the expert, for which the expert is unable to complete its findings, the proposed health care facility shall not be allowed to apply for licensure. If the critical access hospital fails to provide the requested information to the expert, for which the expert is unable to complete its findings, no material adverse impact shall be found and the facility may apply for licensure.

(6) The cost of any fees associated with the retention and work completed by an independent contractor to comply with the provisions of this subparagraph shall be shared equally between the proposed health care facility and the critical access hospital. These costs shall be paid for in advance of any services performed.

(7) The department of health and human services shall provide a copy of the report within 10 days of receipt to the proposed health care facility and critical access hospital.

(c) The person or entity seeking to establish the proposed health care facility and the critical access hospital shall have the right to request a rehearing by the commissioner of the department of health and human services pursuant to RSA 541:3 and to appeal by petition to the supreme court pursuant to RSA 541:6 the expert’s findings. If the proposed health care facility chooses to move forward with the licensing process prior to all appeal rights being exhausted, the proposed health care facility shall do so at its own risk and shall not hold the critical access hospital or the department liable for any costs incurred. The appellant shall bear all costs of the state in connection with any rehearing or petition for appeal, including the state’s attorneys’ fees.

39:65 Health Facility Licensure; Application for License. Amend RSA 151:4, VI to read as follows:

VI. In addition to publication on the department's website, any initial application for ~~a special health care services license~~ licensure, under ~~RSA 151:2 e~~ this chapter, shall be available for inspection and copying by any person immediately upon it being filed and shall not be confidential under RSA 151:13.

39:66 New Paragraph; Health Facility Licensure; Rulemaking. Amend RSA 151:9 by inserting after paragraph II the following new paragraph:

II-a. The commissioner of the department of health and human services shall adopt rules relative to the requirements for licensing near a critical access hospital under RSA 151:4-a.

39:67 Health Facility Licensure; Information Confidential. Amend RSA 151:13 to read as follows:

151:13 Information Confidential. Information ~~other than reports relating to vital statistics~~ received or created by the department of health and human services, through inspection or otherwise, authorized hereunder shall be confidential and shall not be disclosed publicly except in a proceeding involving the question of licensure or revocation of license pursuant to RSA 541-A. The department may disclose such information after it denies, suspends or revokes a license pursuant to RSA 151:7, II. The department shall report any information relative to acts which appear contrary to accepted professional practices to the appropriate professional licensing board.

39:68 Repeal. RSA 151:4, III(a)(5)-(7) and VII, relative to certain requirements relative to application for licensure, are repealed.

39:69 Contingency; HB 1623; Renumbering. If HB 1623 of the regular 2020 legislative session becomes law, RSA 329:1-f as inserted by section 63 of this act shall be renumbered to read as RSA 329:1-g.

39:70 Contingency; HB 1582; Renumbering. If HB 1582 of the regular 2020 legislative session becomes law, RSA 126-A:81 and RSA 126-A:82 as inserted by section 16 of this act, and the subdivision heading preceding them, shall be renumbered to read as RSA 126-A:87 and RSA 126-A:88, respectively.

39:71 Authorization for Contingent Renumbering; Publication. If any of the provisions of HB 1166, HB 1264, and HB 1280-FN of the regular 2020 legislative session adding an RSA 415:6-y and RSA 415:18-cc, and amending RSA 420-A:2 and RSA 420-B:20, III, become law, the director of legislative services is authorized to make any technical changes to the numbering in such RSA sections inserted by those acts, and the corresponding provisions in section 6, 7, 8, and 20-25 of this act, as necessary to conform said sections to proper RSA numbering and format in order to reflect the intent of the legislature. The authority granted under this section shall not include the power to make any substantive changes to the law and shall expire upon publication of the 2020 session laws.

39:72 Effective Date.

I. Sections 1, 20-22, and 24 of this act shall take effect June 30, 2021.

II. Sections 7, 8, 23, and 25 of this act shall take effect January 1, 2021 at 12:04 a.m.

III. Sections 14, 26-47, 49, and 61-63 of this act shall take effect January 1, 2021.

IV. Sections 9-12, 50-54, and 59 of this act shall take effect 60 days after its passage.

V. Sections 55-57, 64-67, and 69 of this act shall take effect July 1, 2020.

VI. Sections 5, 60, and 68 of this act shall take effect July 1, 2021.

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

Approved: July 29, 2020

Effective Date:

I. Sections 1, 20-22, and 24 shall take effect June 30, 2021.

II. Sections 7, 8, 23, and 25 shall take effect January 1, 2021 at 12:04 a.m.

III. Sections 14, 26-47, 49 and 61-63 shall take effect January 1, 2021.

IV. Sections 9-12, 50-54 and 59 shall take effect September 27, 2020.

V. Sections 55-57, 64-67 and 69 shall take effect July 1, 2020.

VI. Sections 5, 60 and 68 shall take effect July 1, 2021.

VII. Remainder shall take effect July 29, 2020.

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