SB 173-FN - AS AMENDED BY THE SENATE

01/03/2024 0049s

2023 SESSION

23-0858
05/04

SENATE BILL ***173-FN***

AN ACT relative to surprise medical bills.

SPONSORS: Sen. Carson, Dist 14; Sen. Bradley, Dist 3; Sen. Prentiss, Dist 5

COMMITTEE: Health and Human Services

AMENDED ANALYSIS

This bill enacts, at the state level, the same requirements and prohibitions as exist under the federal No Surprises Act (NSA) regarding payments to, and billing by, out-of-network providers of emergency medical services and out-of-network providers of any health care service rendered at an in-network facility. As under the NSA, this bill requires health carriers to cover out-of-network emergency services and services provided at an in-network facility by out-of-network providers in the same manner as if the services were provided by an in-network provider or facility. It requires the health carrier to pay the out-of-network provider or facility a rate that is determined either through open negotiation between the parties or through a fair value independent review process made available by the insurance commissioner using the same fair value standards as are established in the NSA and the same independent dispute resolution (IDR) entities as are certified under the federal IDR process. Under this bill, upon failure of open negotiation between the parties, the health care provider or facility will have the option to utilize either the state or the federal IDR process. This bill also incorporates in state law the same prohibitions as are included in the NSA regarding balance billing by out-of-network providers for covered services provided at an in-network facility and for covered emergency services.

The bill is a request of the insurance department.

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Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Twenty Three

AN ACT relative to surprise medical bills.

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

1 New Chapter; Prohibition on Balance Billing Covered Persons for Health Care Services. Amend RSA by inserting after chapter 358-S the following new chapter:

CHAPTER 358-T

PROHIBITION ON BALANCE BILLING COVERED PERSONS FOR HEALTH CARE SERVICES

358-T:1 Definitions. In this chapter:

I. “Covered benefits” means “covered benefits” as defined in RSA 420-J:3.

II. “Covered person” means “covered person” as defined in RSA 420-J:3.

III. “Emergency medical condition” means “emergency medical condition” as defined in RSA 420-J:3.

IV. "Emergency services" means “emergency services” as defined in RSA 420-J:3.

V. “Facility” means “facility” as defined in RSA 420-J:3.

VI. “Heath benefit plan” means a policy, contract certificate or agreement entered into, offered or issued by a health carrier or group health plan, as defined in 42 U.S.C. section 300gg-91(a), to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

VII. "Health care provider" or "provider" means “health care provider” or “provider” as defined in RSA 420-J:3.

VIII. "Health carrier" means “health carrier” as defined in RSA 420-J:3.

IX. "Nonparticipating emergency facility" means “nonparticipating emergency facility” as defined in RSA 420-J:3.

X. "Nonparticipating provider" means "nonparticipating provider" as defined in RSA 420-J:3.

XI. "Participating provider or facility" means "participating provider or facility" as defined in RSA 420-J:3.

358-T:2 Balance Billing in Cases of Emergency Services. If a covered person with benefits covering emergency services under a health benefit plan is furnished emergency services, then:

I. In the case that the hospital emergency department or independent freestanding emergency department is a nonparticipating emergency facility, the hospital emergency department or independent freestanding emergency department shall not bill, and shall not hold liable, the covered person for a payment amount for such emergency services that is more than the cost-sharing requirement for such services under the covered person’s health benefit plan; and

II. In the case that such emergency services are furnished by a nonparticipating provider, the health care provider shall not bill, and shall not hold liable, such covered person for a payment amount for such emergency services that is more than the cost-sharing requirement for such services under the covered person's health benefit plan.

358-T:3 Balance Billing in Cases of Non-emergency Services Performed by Nonparticipating Providers at Certain Participating Health Care Facilities.

I. Subject to paragraph II, if a covered person is furnished health care items or services, other than emergency services, by a nonparticipating provider at a participating facility for which benefits are provided under the covered person's health benefit plan, then such provider shall not bill, and shall not hold liable, such covered person for a payment amount for such item or service furnished by such provider with respect to a visit at such facility that is more than the cost-sharing requirement for such item or service under the covered person's health benefit plan.

II. Paragraph I shall not apply with respect to items or services, other than items or services that qualify as ancillary services under 42 U.S.C. section 300gg-132 (b)(2) and (3), furnished by a nonparticipating provider to a covered person if the provider satisfies the notice and consent criteria under 42 U.S.C. section 300gg-132 (c) and (d).

358-T:4 Dispute Resolution Regarding the Fair Value of Health Care Items or Services. In the event of a dispute between a nonparticipating provider or nonparticipating emergency facility and a health carrier relative to the fair value of emergency health care items or services with respect to which balance billing is prohibited under RSA 358-T:2 or in the event of a dispute between a nonparticipating provider and a health carrier relative to the fair value of health care items or services with respect to which balance billing is prohibited under RSA 358-T:3, the insurance commissioner shall make available, as provided in RSA 420-J:8-e, an independent dispute resolution process to determine the fair value payment amount.

2 New Paragraph; Consumer Protection Act; Acts Unlawful; Balance Billing. Amend RSA 358-A:2 by inserting after paragraph XVIII the following new paragraph:

XIX. Balance billing a covered person in violation of RSA 358-T.

3 Managed Care Law; Definitions. RSA 420-J:3, XV and XVI are repealed and reenacted to read as follows:

XV. "Emergency medical condition" means "emergency medical condition" as defined in 42 U.S.C. section 300gg-111(a)(3)(B).

XVI. "Emergency services" means health care services, including mental health and substance use disorder treatment services, that meet the definition of "emergency services" in 42 U.S.C. section 300gg-111(a)(3)(C).

4 New Paragraph; Managed Care Law. RSA 420-J:3 by inserting after paragraph XVI the following new paragraph:

XVI-a. “Episode of care” means the period of time during which all of the health care services that are needed to care for a patient’s clinical condition or to complete a procedure are delivered.

5 New Paragraphs; Managed Care Law; Definitions. Amend RSA 420-J:3 by inserting after paragraph XXVI the following new paragraphs:

XXVI-a. "Nonparticipating emergency facility" means an emergency department of a hospital or an independent freestanding emergency department as defined in 42 U.S.C. section 300gg-111(a)(3)(D) that does not have a contractual relationship directly or indirectly with a health carrier.

XXVI-b. "Nonparticipating provider" means any health care provider, excluding ground and air ambulance service providers, who is acting within the scope of practice of that provider's license or certification under applicable state law and who does not have a contractual relationship directly or indirectly with a health carrier.

6 Managed Care Law; Definition of Participating Provider or Facility. Amend RSA 420-J:3, XXVII to read as follows:

XXVII. "Participating provider ***or facility***" means a provider [~~who~~] ***or facility that***, under a contract with the health carrier or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, directly or indirectly from the health carrier.

7 New Paragraph; Managed Care Law; Definitions; Qualifying Payment Amount. Amend RSA 420-J:3 by inserting after paragraph XXIX the following new paragraph:

XXIX-a. "Qualifying payment amount" means “qualifying payment amount” as defined in 42 U.S.C. section 300gg-111(3)(E).

8 Coverage for Emergency Services; Definitions. RSA 417-F:1 is repealed and reenacted to read as follows:

417-F:1 Definitions. In this chapter:

I. “Emergency medical condition” means “emergency medical condition” as defined in RSA 420-J:3, XV.

II. "Emergency services" means “emergency services” as defined in RSA 420-J:3, XVI.

III. "Insurer" means any entity providing managed care coverage or accident or health insurance or accident and health insurance policies, contracts, certificates, or other evidence of coverage to enrollees, insureds, or subscribers pursuant to RSA 415, 415-A, 420-A, 420-B, or 420-J.

9 Managed Care Law; Determining the Fair Value of Certain Health Care Items or Services Provided by Nonparticipating Providers. RSA 420-J:8-e is repealed and reenacted to read as follows:

420-J:8-e Determining the Fair Value of Certain Health Care Items or Services Provided by Nonparticipating Providers. Nonparticipating providers or emergency facilities and health carriers

shall have access to a state-based independent dispute resolution (IDR) process for determining the fair value of certain health care items or services as follows:

I. Determination through open negotiation.

(a) With respect to an item or service furnished by a nonparticipating provider or nonparticipating emergency facility to which the prohibition on balance billing in RSA 358-T applies and for which a payment is required to be made by the health carrier under RSA 420-J:8-g or under RSA 420-J:8-h, the provider, facility or health carrier may, during the 30-day period beginning on the day the provider or facility receives an initial payment or a notice of denial of payment from the health carrier regarding a claim for payment for such item or service, initiate open negotiations under this paragraph between such provider or facility and health carrier for purposes of determining, during the open negotiation period, a fair value amount agreed on by the parties for payment, including any cost-sharing, for such item or service. For purposes of this paragraph, the state-based open negotiation period relating to an item or service is the 20-day period beginning on the date of initiation of the negotiations with respect to such item or service.

(b) Each health carrier shall provide to the commissioner a designated point of contact, including his or her email address, for open negotiations, and the commissioner shall publish and update a directory of such designated point of contacts. A provider or facility properly initiates open negotiations by emailing such designated point of contact and providing information sufficient to identify the initial payment or notice of denial of payment at issue.

II. Accessing the state-based IDR process in case of failed negotiations. If open negotiations with respect to an item or service under paragraph I do not result in a determination of an amount of payment for such item or service by the last day of the state-based open negotiation period, the provider or facility may initiate the state-based IDR process by delivering, simultaneously to the commissioner and to the health carrier during the 4-day period beginning on the day after the open negotiation period, a review request notification form containing such information as specified by the commissioner. The date of submission of the review request notification form shall be the date of receipt of a qualifying form by the commissioner.

III. Submission of offers. Not less than 10 days after the date of submission of the review request notification, the provider or facility and health carrier party to such IDR process regarding the fair value of an item or service shall each submit to the IDR entity appointed pursuant to this section:

(a) An offer for a payment amount for such item or service furnished by such provider or facility;

(b) Such information as is requested by the independent review entity relating to such offer; and

(c) Any information relating to the offer deemed by the provider, facility, or health carrier to be relevant to the fair value determination.

IV. Authority to continue negotiations. Under the state IDR process provided for in this section, in the case that the disputing parties agree on a payment amount for the item or service in dispute during the period in which the dispute is under review by the selected IDR entity and before the date on which the selected IDR entity makes its fair value determination, then such agreed amount shall qualify as the fair value amount without the necessity of a fair value determination by the IDR entity. This agreement during the period in which the dispute is before the IDR entity shall not affect the fee that the IDR entity is entitled to collect.

V. Considerations in the fair value determination.

(a) In general, in determining which offer is the payment amount to be applied pursuant to this section as the fair value of items or services rendered, the IDR entity shall consider:

(1) The qualifying payment amount for the item or service furnished; and

(2) Subject to subparagraph (c), information regarding any circumstance described in subparagraph (b), such information as is requested and received by the IDR entity, and any additional relevant information provided by the parties.

(b) In addition to the considerations listed in RSA 420-J:8-e, V(a), the IDR entity shall consider, if such information is provided by either of the parties:

(1) The level of training, experience, and quality and outcomes measurements of the provider or facility that furnished such item or service, such as those endorsed by the consensus-based entity authorized in 42 U.S.C. section 1395aaa.

(2) The market share held by the nonparticipating provider or facility or that of the plan or issuer in the geographic region in which the item or service was provided.

(3) The acuity of the individual receiving such item or service or the complexity of furnishing such item or service to such individual.

(4) The teaching status, case mix, and scope of services of the nonparticipating facility that furnished such item or service.

(5) Demonstrations of good faith efforts, or lack of good faith efforts, made by the nonparticipating provider or nonparticipating facility or the health carrier to enter into network agreements and, if applicable, contracted rates between the provider or facility, as applicable, and the health carrier, as applicable, during the previous 4 plan years.

(c) In determining which offer is the payment to be applied pursuant to this sub-section as the fair value of items or services rendered, the IDR entity shall not consider usual and customary charges, the amount that would have been billed by such provider or facility with respect to such items and services had the provisions of 42 U.S.C. section 300gg– 131 or 300gg–132, as applicable, not applied, or the payment or reimbursement rate for such items and services furnished by such provider or facility payable by a public payor, including under the Medicare program under 42 U.S.C. 1395 et seq., under the Medicaid program under 42

U.S.C. 1396 et seq., under the Children's Health Insurance Program under 42 U.S.C. 1397aa et seq., and under the federal TRICARE program.

VI. Batching of items and services.

(a) The provider or facility initiating the IDR process described in this section may batch items and services from more than one episode of care for consideration jointly as part of a single determination by a single independent dispute resolution entity provided that the following requirements are met:

(1) Such items and services to be included in such determination are furnished by the same provider or facility;

(2) Payment for such items and services is required to be made by the same health carrier;

(3) Such items and services are related to the treatment of a similar condition; and

(4) Such items and services were furnished during the 30-day period following the date on which the first item or service included with respect to such determination was furnished or an alternative period as determined by the commissioner, for use in limited situations, such as by the consent of the parties or in the case of low-volume items and services, to encourage procedural efficiency and minimize health carrier and provider administrative costs.

(b) In carrying out subparagraph (a), the commissioner shall provide that, in the case of items and services which are included by a provider or facility as part of a single episode of care, the items and services furnished in that single episode of care may be part of a single fair value determination under this section.

VII. Fair value determination based on written record. In making the fair value determination, the IDR entity shall consider only such written material as is submitted by the parties and shall not engage in ex parte contact with either party.

VIII. Timing of the fair value determination. Not later than 30 days after the submission of offers under paragraph III with respect to a fair value determination for an item or service, the IDR entity shall:

(a) Taking into account the considerations specified in paragraph V, select one of the offers submitted under paragraph III to be the amount of payment for such item or service determined under this section; and

(b) Provide written notification to the provider or facility and the health carrier party to such determination of the offer selected under subparagraph (a).

IX. Effects of determination. The fair value decision of the IDR entity shall be binding on the parties and shall not be subject to re-review except in the case of fraud. The decision shall be enforceable against the health carrier by the commissioner pursuant to the penalty provisions of RSA 420-J:14 and under the enforcement provisions of RSA 417. The fair value dispute resolution process shall not be considered an adjudicative proceeding within the meaning of RSA 541-A, and

the decision of the independent dispute resolution entity shall not be subject to rehearing and appeal pursuant to RSA 541 or RSA 400-A:17.

X. Timing of payment of fair value amount.

(a) The health carrier shall make payment to the nonparticipating provider or facility within 30 days after the date on which:

(1) A fair value amount is agreed on by the parties in open negotiations under paragraph I or while the dispute is before the IDR entity as provided in paragraph IV; or

(2) A fair value determination is made by the IDR entity under paragraph VIII.

(b) If the fair value amount is not paid in full within the 30-day period under subparagraph (a), the health carrier shall also be liable to the nonparticipating provider or facility for an interest payment of 5 percent per month, in addition to all other remedies otherwise provided by law. In addition, the nonparticipating provider or facility may recover from the health carrier, upon a judicial finding that the out-of-network rate was not timely paid, reasonable attorney's fees for advising and representing the nonparticipating provider or facility in an action against a carrier for prompt payment of the fair value amount.

XI. Certification and selection of independent dispute resolution entities.

(a) The commissioner shall certify independent dispute resolution entities that:

(1) Make application to the commissioner for certification on a form requiring such information as specified by the commissioner through an insurance department bulletin; and

(2) Demonstrate that they are certified as IDR entities under the federal process set out in 42 U.S.C. section 300gg-111(c)(4) or otherwise meet these federal standards for certification; and

(3) Satisfy such additional requirements established by the commissioner.

(b) The commissioner shall utilize the process set out in 42 U.S.C. section 300gg-111(c)(4)(F) for the selection of an independent dispute resolution entity to adjudicate fair value disputes under this section.

XII. Costs of the independent dispute resolution process.

(a) There shall be no administrative fee charged by the commissioner for administering the independent dispute resolution process.

(b) The commissioner shall establish by rulemaking a fee schedule, which may vary by complexity of the matter in dispute, that independent dispute resolution entities may charge for the review and resolution of disputes with respect to the fair value of unbatched and batched services. To the extent practicable, the fee schedule shall be sufficient to ensure that an adequate number of entities are certified as required for the timely and efficient adjudication of fair value disputes and sufficiently limited to produce a cost-effective option for disputing parties to reach a fair value amount.

(c) Each party participating in a fair value dispute resolution process under this section shall submit, together with or no later than 10 days after its submission of an offer for a payment amount as provided under paragraph III, one half of the fee charged by the certified IDR entity. If any party does not timely submit its half of the IDR entity's fee together with its offer for a payment amount, then the IDR entity shall, without further consideration, select the offer of the party that has paid its half of the fee as the winning offer and notify the parties of the determination as provided in paragraph VIII.

XIII. The commissioner shall make the IDR process set out in this section available, on a case-by-case basis, to providers or facilities that are party to a fair value dispute about items or services to which the prohibition on balance billing in RSA 358-T applies. This option shall include fair value disputes in which one of the parties is a self-funded health plan not otherwise subject to regulation under this chapter only if the self-funded plan has opted into the state IDR program generally, with respect to all subsequent fair value disputes, and consented to be bound by the terms of the process as set out in this section through the submission to the commissioner of a program opt-in form which shall be made available by the commissioner.

XIV. The authority of the commissioner to administer the IDR process set out in this section shall arise on a case-by-case basis with respect to specific items or services as providers or facilities choose to invoke the state IDR process to determine the fair value of that item or service. This section shall constitute a "specified state law" under 42 U.S.C. section 300gg-111 (a)(3)(I) contextually with respect to an item or service and only when a provider or facility has invoked the state IDR process with respect to that item or service. This section is not intended to preempt or displace the authority or obligation of the secretary of the federal department of health and human services to administer the federal IDR process as provided under 42 U.S.C. section 300gg-111 whenever the provider or facility to which the prohibition on balance billing in RSA 358-T applies does not choose to invoke the state IDR process.

XV. If a provider or facility that is party to a fair value dispute about items or services to which the prohibition on balance billing in RSA 358-T applies invokes the state IDR process set out in this chapter by submission of a review request notification under paragraph II, then both parties shall be precluded from accessing the federal IDR process under 42 U.S.C. section 300gg-111. If no party to a fair value dispute about items or services to which the prohibition on balance billing in RSA 358-T applies invokes the state IDR process set out in this chapter by submitting a review request notification under paragraph II within the 4-day period following the 20 day state-based open negotiation period, then the federal IDR process under 42 U.S.C. section 300gg-111 shall be available to both parties after the expiration of the federal 30-day open negotiation period as provided in 42 U.S.C. section 300gg-111(c)(1)(B).

XVI. If a party to a fair value dispute about items or services to which the prohibition on balance billing in RSA 358-T applies initiates the state IDR process set out in this chapter by

submission of a review request notification under paragraph II, then the disputing parties shall be limited to the state IDR process for determining the fair value of all other items and services that are part of the same episode of care, and both parties shall be precluded from accessing the federal IDR process under 42 U.S.C. section 300gg-111 with respect to all such items or services.

XVII. The commissioner shall enter into a collaborative enforcement agreement with the Centers for Medicare and Medicaid Services (CMS) in order to set up processes and systems in coordination with CMS to resolve potential federal IDR eligibility questions arising from the case-specific applicability of the specified state law created in this chapter.

10 New Sections; Managed Care Law; Coverage and Payment for Emergency Services Provided by Nonparticipating Providers or Nonparticipating Emergency Facilities and for Services Provided at Participating Facilities by Nonparticipating Providers. Amend RSA 420-J by inserting after section 8-f the following new sections:

420-J:8-g Coverage and Payment for Emergency Services Provided by Nonparticipating Providers or Nonparticipating Emergency Facilities.

I. Each insurer that issues or renews any policy of health insurance providing benefits for emergency services shall cover emergency services provided by a nonparticipating provider or nonparticipating emergency facility in the same manner and without imposing any additional requirements as if the services were provided by a participating provider or participating emergency facility.

II. The patient's cost-sharing for items or emergency services provided by a nonparticipating provider or nonparticipating emergency facility shall be calculated by the health carrier based on the qualifying payment amount.

III. The insurer shall pay the nonparticipating provider of emergency services or nonparticipating emergency facility an amount based on the fair value considerations set out in RSA 420-J:8-e, IV, less any cost-sharing for the services provided.

IV. In the event of a dispute between a nonparticipating provider or facility and an insurer relative to the fair value of an item or service under this section, the commissioner shall make available, as provided in RSA 420-J:8-e, an independent dispute resolution process to determine the fair value payment amount.

420-J:8-h Coverage and Payment for Services Provided at Participating Facilities by Nonparticipating Providers.

I. Each health carrier that issues or renews any policy of health insurance shall cover services provided by nonparticipating providers at a participating facility in the same manner and without imposing any additional requirements as if the services were provided by a participating provider.

II. The patient's cost-sharing for items or services provided by a nonparticipating provider at a participating facility shall be calculated using the qualified payment amount for the item or service.

III. The health carrier shall pay the nonparticipating provider an amount based on the fair value considerations set out in RSA 420-J:8-e, IV, less any cost-sharing for the services provided.

IV. In the event of a dispute between a nonparticipating provider and a health carrier relative to the fair value of an item or service under this section, the commissioner shall make available, as provided in RSA 420-J:8-e, an independent dispute resolution process to determine the fair value payment amount.

11 New Subparagraph; Unfair Insurance Trade Practices; Unfair Claim Settlement Practices by Insurers. Amend RSA 417:4 XV(a) by inserting after subparagraph (14) the following new subparagraph:

(15) Failing to make payment to the nonparticipating provider or facility within the 30-day period specified in RSA 420-J:8-e, IX.

12 Repeal. RSA 329:31-b, regarding a prohibition on balance billing and payment for reasonable value of services, is repealed.

13 Effective Date. This act shall take effect January 1, 2025.

LBA
23-0858
Amended 1/22/24

SB 173-FN- FISCAL NOTE
AS AMENDED BY THE SENATE (AMENDMENT #2024-0049s)

AN ACT relative to surprise medical bills.

FISCAL IMPACT: [X] State [ ] County [ ] Local [ ] None

Estimated State Impact - Increase / (Decrease)				
	FY 2024	**FY 2025**	**FY 2026**	**FY 2027**
Revenue	$0	$0	$0	$0
Revenue Fund(s)	None			
Expenditures	$0	Indeterminable	Indeterminable	Indeterminable
Funding Source(s)	Insurance Department Assessment (RSA 400-A:39)			
Appropriations	$0	$0	$0	$0
Funding Source(s)	None			

- Does this bill provide sufficient funding to cover estimated expenditures? [X] N/A
- Does this bill authorize new positions to implement this bill? [X] No

METHODOLOGY:

The Insurance Department assumes this bill is intended to harmonize New Hampshire's Balance Billing laws (RSA 420-J: 8-e and RSA 329:31-b) with the federal No Surprises Act (NSA) (42 U.S.C. §300gg-111) by enacting, at the state level, the same requirements and prohibitions as exist under the NSA regarding payments to, and billing by, out-of-network providers of emergency medical services and out-of-network providers of any health care service rendered at an in-network facility. The Department assumes the bill would lead to an increase in the number of review requests under RSA 420-J:8-e concerning the reasonable value of health care services. Under current law, the Insurance Department has received no review requests. Under the federal independent dispute resolution (IDR) process, the federal Centers for Medicare and Medicaid Services (CMS) reports that 20 IDR requests were made in New Hampshire between April 15 and September 30, 2022, and 26 IDR requests were made between October 1 and December 31, 2022. Based on these frequencies, the Department estimates that approximately 100 IDR requests will be made in New Hampshire per year. The Department expects approximately one half of those requests will come to the Insurance Department under the provisions of this bill. The Department assumes that the cost of administering an IDR process for this number of cases is indeterminable but likely to be within its existing operating budget.

AGENCIES CONTACTED:

Insurance Department