

SB 287 - AS INTRODUCED

2022 SESSION

22-2945

12/10

SENATE BILL **287**

AN ACT relative to balance billing for certain health care services.

SPONSORS: Sen. Bradley, Dist 3; Sen. Sherman, Dist 24; Rep. Bartlett, Merr. 19

COMMITTEE: Health and Human Services

ANALYSIS

This bill modifies insurance coverage to reflect changes in federal law and clarifies coverage related to emergency services.

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 Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.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 Two

AN ACT relative to balance billing for certain health care services.

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

1 1 Residential Care and Health Facility Licensing; Emergency Services. RSA 151:2-g is repealed
2 and reenacted to read as follows:

3 151:2-g Residential Care and Health Facility Licensing; Emergency Services.

4 I. In this section, "emergency services" means health care services that are provided to a
5 patient in a licensed health facility by a health care provider after the onset of a medical condition,
6 including a mental health condition or substance use disorder, that manifests itself by symptoms of
7 sufficient severity that a prudent layperson with average knowledge of health and medicine could
8 reasonably expect that the absence of immediate medical attention could be expected to result in any
9 of the following:

10 (a) Serious jeopardy to the patient's health.

11 (b) Serious impairment to bodily functions.

12 (c) Serious dysfunction of any bodily organ or part.

13 II. Every facility licensed as a hospital under RSA 151:2, I(a) shall operate an emergency
14 department offering emergency services to all individuals regardless of ability to pay 24 hours every
15 day, 7 days a week. This requirement shall not apply to any hospital licensed and operating prior to
16 July 1, 2016, which does not operate an emergency department or to any new psychiatric or
17 substance abuse treatment hospital.

18 III. No emergency department of a hospital or an independent freestanding emergency
19 department that provides emergency services shall balance bill the patient for fees or amounts other
20 than copayments, deductibles, or coinsurance for emergency services performed in the facility. This
21 prohibition shall apply whether or not the health care provider is contracted with the patient's
22 insurance carrier or group health plan as defined in 42 U.S.C. section 300gg-91.

23 IV. In the event of a dispute between an emergency facility and an insurer or group health
24 plan relative to the out-of-network rate for an item or service under this section, the insurance
25 commissioner shall have exclusive jurisdiction under RSA 420-J:8-e to determine the out-of-network
26 rate.

27 2 New Paragraphs; Patients' Bill of Rights. Amend RSA 151:21 by inserting after paragraph
28 XXI the following new paragraphs:

29 XXII. The patient shall be fully informed, in writing in language that the patient can
30 understand, of requirements and prohibitions relating to balance billing.

XXIII. The patient shall be fully informed, in writing in language that the patient can understand, of the patients' rights when receiving care or services from a provider or facility that is outside the patient's insurance or group health plan network.

3 Emergency Medical and Trauma Services; Definitions. Amend RSA 153-A:2, I to read as follows:

I. ***"Air ambulance service" means medical transport by a rotary wing air ambulance as defined in 42 CFR 414.605, or a fixed wing air ambulance, as defined in 42 CFR 414.605, for patients.***

I-a. "Coordinating board" means the emergency medical and trauma services coordinating board established in RSA 153-A:3.

4 New Subdivision; Prohibition on Balance Billing. Amend RSA 153-A by inserting after section 36 the following new subdivision:

Prohibition on Balance Billing

153-A:37 Prohibition on Balance Billing.

I. Providers of air ambulance services shall not balance bill the patient for fees or amounts other than copayments, deductibles, or coinsurance for emergency services performed in the facility. This prohibition shall apply whether or not the air ambulance service provider is contracted with the patient's insurance carrier.

II. The patient's cost-sharing for items or services shall be calculated using the qualifying payment amount, as defined in RSA 417-F:1, VII, for the item or service.

III. Accepted payment for air ambulance services shall be calculated using the qualifying payment amount, as defined in RSA 417-F:1, VII, for the item or service.

IV. In the event of a dispute between an air ambulance service provider and an insurance carrier or group health plan as defined in 42 U.S.C. section 300gg-91 relative to the out-of-network rate for an item or service under this section, the insurance commissioner shall have exclusive jurisdiction under RSA 420-J:8-e to determine the out-of-network rate.

5 Physicians and Surgeons; Payment for Reasonable Value of Service RSA 329:31-b is repealed and reenacted to read as follows:

329:31-b Prohibition on Balance Billing; Payment for Reasonable Value of Services.

I. A health care provider shall not balance bill the patient for fees or amounts other than copayments, deductibles, or coinsurance for emergency services as defined under RSA 417-F:1, I or services performed in a facility that is in-network under the patient's health insurance plan. This prohibition shall apply whether or not the health care provider is contracted with the patient's insurance carrier or group health plan as defined in 42 U.S.C. section 300gg-91.

II. Pursuant to paragraph I, the accepted payment for health care services shall be limited to the out-of-network rate as defined in RSA 420-J:3, XXVI-c.

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1 III. In the event of a dispute between a provider and an insurance carrier relative to the out-
2 of-network rate under this section, the insurance commissioner shall have exclusive jurisdiction
3 under RSA 420-J:8-e to determine the out-of-network rate.

4 6 New Chapter; Prohibition on Balance Billing. Amend RSA by inserting after chapter 332-L
5 the following new chapter:

6 CHAPTER 332-M
7 PROHIBITION ON BALANCE BILLING

8 332-M:1 Definitions. In this chapter:

9 I. "Emergency services" means health care services that are provided to a patient in a
10 licensed health facility by a health care provider after the onset of a medical condition, including a
11 mental health condition or substance use disorder, that manifests itself by symptoms of sufficient
12 severity that a prudent layperson with average knowledge of health and medicine could reasonably
13 expect that the absence of immediate medical attention could be expected to result in any of the
14 following:

- 15 (a) Serious jeopardy to the patient's health.
- 16 (b) Serious impairment to bodily functions.
- 17 (c) Serious dysfunction of any bodily organ or part.

18 II. "Health care provider" or "provider" means a physician or other health care practitioner
19 licensed, accredited, or certified to perform specified health services consistent with state law.

20 III. "Insurer" means a group health plan as defined in 42 U.S.C. section 300gg-91 or an
21 entity subject to the insurance laws and rules of this state offering group or individual health
22 insurance coverage.

23 IV. "Nonparticipating emergency facility" means an emergency department of a hospital or
24 an independent freestanding emergency department that does not have a contractual relationship
25 directly or indirectly with an insurer as defined in this chapter.

26 V. "Nonparticipating provider" means any health care provider who is acting within the
27 scope of practice of that provider's license or certification under applicable State law and who does
28 not have a contractual relationship directly or indirectly with an insurer as defined in this chapter.

29 VI. "Out-of-network rate" means, with respect to an item or service furnished by a
30 nonparticipating provider or nonparticipating emergency facility, the amount agreed to through open
31 negotiations or the amount determined by the commissioner pursuant to RSA 420-J:8-e.

32 VII. "Participating facility" means a health care facility that has a contractual relationship
33 with the insurer, as defined in this chapter, for furnishing such item or service under the plan or
34 coverage, respectively.

35 332-M:2 Prohibition on Balance Billing. No health care provider shall balance bill the patient
36 for fees or amounts other than copayments, deductibles, or coinsurance for emergency services

performed at an emergency facility or services performed in a participating facility. This prohibition shall apply whether or not the health care provider is a participating provider.

332-M:3 Dispute Resolution for Out-of-network Rate. In the event of a dispute between a nonparticipating provider and an insurer relative to the out-of-network rate for an item or service under this section, the insurance commissioner shall have exclusive jurisdiction under RSA 420-J:8-e to determine the out-of-network rate.

332-M:4 Provision of Information for Scheduled Appointments. Each health care provider shall comply with the requirements of 42 U.S.C. section 300gg-136.

332-M:5 Violations. The state entity that licenses, accredits, certifies, or credentials the health care provider shall take regulatory action against the health care provider for any violations of this chapter.

7 Insurance Coverage for Emergency Services; Definitions. Amend RSA 417-F:1 to read as follows:

417-F:1 Definitions. In this chapter:

I. "Emergency services" means health care services that are provided to an enrollee, insured, or subscriber in a licensed hospital emergency facility by a provider after the ~~sudden~~ onset of a medical condition, ***including a mental health condition or substance use disorder***, that manifests itself by symptoms of sufficient severity that a prudent layperson with average knowledge of health and medicine could reasonably expect that the absence of immediate medical attention could be expected to result in any of the following:

- (a) Serious jeopardy to the patient's health.
- (b) Serious impairment to bodily functions.
- (c) Serious dysfunction of any bodily organ or part.

II. ***"Health care provider" means a health care provider as defined in RSA 420-J:3, XXI.***

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, 419, 420, 420-A, 420-B, or 420-J.

IV. ***"Nonparticipating emergency facility" means an emergency department of a hospital or an independent freestanding emergency department that does not have a contractual relationship directly or indirectly with an insurer as defined in this chapter.***

V. ***"Nonparticipating provider" means any health care provider 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 an insurer as defined in this chapter.***

VI. *“Out-of-network rate” means, with respect to an item or service furnished by a nonparticipating provider or nonparticipating emergency facility, the amount agreed to through open negotiations or the amount determined by the commissioner pursuant to RSA 420-J:8-e.*

VII. *“Qualifying payment amount” means qualifying payment amount as defined in 42 U.S.C.S. section 300gg-111 (3)(E) and 45 CFR sec. 149.140.*

8 New Section; Payment for Emergency Services. Amend RSA 417-F by inserting after section 4 the following new section:

417-F:5 Payment for Emergency Services

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 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 or nonparticipating emergency facility shall be calculated using the qualifying payment amount for the item or service.

III. The insurer shall pay the nonparticipating provider or nonparticipating emergency facility the out-of-network rate less any cost-sharing for the services provided.

IV. In the event of a dispute between a provider or facility and an insurer relative to the out-of-network rate for an item or service under this section, the insurance commissioner shall have exclusive jurisdiction under RSA 420-J:8-e to determine the out-of-network rate.

9 Managed Care Law; Definitions; Emergency Services. Amend RSA 420-J:3, XVI to read as follows:

XVI. "Emergency services" means health care services that are provided to an enrollee, insured, or subscriber in a licensed hospital emergency facility by a provider after the ~~[sudden]~~ onset of a medical condition, ***including a mental health condition or substance use disorder***, that manifests itself by symptoms of sufficient severity that a prudent layperson with average knowledge of health and medicine could reasonably expect that the absence of immediate medical attention could result in any of the following:

(a) Serious jeopardy to the patient's health.

(b) Serious impairment to bodily functions.

(c) Serious dysfunction of any bodily organ or part.

10 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 that does not have a contractual

relationship directly or indirectly with a health carrier or a group health plan as defined in 42 U.S.C. section 300gg-91.

XXVI-b. "Nonparticipating provider" means any health care provider 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 or a group health plan as defined in 42 U.S.C. section 300gg-91.

XXVI-c. "Out-of-network rate" means, with respect to an item or service furnished by a nonparticipating provider or nonparticipating emergency facility, the amount agreed to through open negotiations or the amount determined by the commissioner pursuant to RSA 420-J:8-e.

11 New Paragraph; Managed Care Law; Definition. 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.S. section 300gg-111 (3)(E) and 45 CFR sec. 149.140.

12 Managed Care Law; Provider Contract Standards. Amend RSA 420-J:8, XI to read as follows:

XI. Every contract ~~[entered into after July 1, 2003]~~ between a health carrier and any ~~[physician]~~ **health care provider** or facility shall contain a provision that ensures that covered persons will have continued access to the provider in the event that the contract is terminated for any reason other than unprofessional behavior. The continued access to providers shall be made available for ~~[60]~~ **90** days from the date **the health carrier provides notice to the covered person** of termination of the contract and shall be provided and paid for in accordance with the terms and conditions of the covered person's health benefit plan and the prior contract between a health carrier and a health care provider. Within 5 business days of the contract termination, the health carrier shall provide written notice to affected covered persons explaining their continued access rights.

13 Out-Of-Network Rate and Reasonable Value of Health Care Services RSA 420-J:8-e is repealed and reenacted to read as follows:

420-J:8-e. Out-of-Network Rate and Reasonable Value of Health Care Services. The commissioner shall have exclusive jurisdiction to determine the out-of-network rate and commercially reasonable compensation under RSA 415-J:3. The commissioner may adopt rules further defining qualifying payment amount, out-of-network rate, and the dispute resolution process for determining such rates or compensation.

14 New Section; Managed Care Law; Preventing Surprise Medical Bills. Amend RSA 420-J by inserting after section 8-f the following new section:

420-J:8-g Preventing Surprise Medical Bills.

I. Each health carrier or a group health plan as defined in 42 U.S.C. section 300gg-91 that issues or renews any policy of health insurance providing benefits for emergency services shall cover emergency services provided at a nonparticipating emergency facility or by a nonparticipating

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1 provider in the same manner and without imposing any additional requirements as if the services
2 were provided at a participating facility or by a participating provider.

3 II. Each health carrier or a group health plan as defined in 42 U.S.C. section 300gg-91 that
4 issues or renews any policy of health insurance shall cover services provided by nonparticipating
5 providers at a participating facility, in the same manner and without imposing any additional
6 requirements, as if the services were provided by a participating provider.

7 III. The patient's cost-sharing for emergency services or items or services provided by a
8 nonparticipating provider at a participating facility shall be calculated using the qualifying payment
9 amount for the item or service.

10 IV. The health carrier or a group health plan as defined in 42 U.S.C. section 300gg-91 shall
11 pay the nonparticipating provider or nonparticipating emergency facility the out-of-network rate less
12 any cost-sharing for the services provided.

13 15 Managed Care Law; Rulemaking Authority. Amend RSA 420-J:12 to read as follows:

14 420-J:12 Rulemaking Authority. The commissioner may adopt such rules, under RSA 541-A,
15 and issue such orders as may be necessary to carry out the purposes and provisions of this chapter.
16 ***The commissioner may adopt rules relating to price transparency for health care services.***

17 16 Federal Health Care Reform 2010; Purpose and Scope. Amend RSA 420-N:1 to read as
18 follows:

19 420-N:1 Purpose and Scope. The intent of this chapter is to preserve the state's status as the
20 primary regulator of the business of insurance within New Hampshire and the constitutional
21 integrity and sovereignty of the state of New Hampshire under the Tenth Amendment to the United
22 States Constitution and part I, article 7 of the New Hampshire constitution and to create a
23 legislative oversight committee to supervise the insurance commissioner's administration of the
24 insurance reforms required under the Patient Protection and Affordable Care Act of 2009, Public
25 Law 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Public Law
26 111-152, including any ***amendments thereto, and related provisions of the Public Health***
27 ***Service Act (42 U.S.C. section 300gg et seq.),*** federal regulations, interpretations, standards, or
28 guidance issued thereunder (hereinafter "the Act").

29 17 Federal Health Care Reform 2010; Definitions. Amend RSA 420-N:2, I to read as follows:

30 I. "Act" means the Patient Protection and Affordable Care Act of 2009, Public Law 111-148,
31 as amended by the Health Care and Education Reconciliation Act of 2010, Public Law 111-152,
32 including any ***amendments thereto, and related provisions of the Public Health Service Act***
33 ***(42 U.S.C. section 300gg et seq.),*** federal regulations, interpretations, standards, or guidance
34 issued thereunder.

35 18 Effective Date. This act shall take effect 60 days after its passage.