SB 173-FN - AS INTRODUCED

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

ANALYSIS

This bill requires insurers to cover emergency services provided by nonparticipating providers in the same manner as if the services were provided by a participating provider and requires the insurer to pay the nonparticipating provider the out-of-network rate less any cost-sharing for the services provided. The bill prohibits surprise medical bills and balance billing.

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Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

23-0858
05/04

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 Section; Third Party Administrators; Preventing Surprise Medical Bills. Amend RSA 402-H by inserting after section 7 the following new section:

402-H:7-a Preventing Surprise Medical Bills. Administrators shall process claims in accordance with RSA 417-F:5, RSA 420-J:8-e, and RSA 420-J:8-g.

2 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 RSA 417-F:1 is repealed and reenacted to read as follows: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 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 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-I.

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 to be commercially reasonable pursuant to RSA 420-J:8-e.

VII. "Qualifying payment amount" means qualifying payment amount as defined in 42 U.S.C. section 300gg-111(3)(E) and 45 C.F.R. section 149.140.

3 New Section; Coverage 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 qualified 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.

4 Managed Care Law; Definitions. 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.

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 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 to be commercially reasonable pursuant to RSA 420-J:8-e.

6 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) and 45 C.F.R. section 149.140.

7 Managed Care; 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 covered person receives notice*** 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.

8 Out-of-Network Rate and Reasonable Value of Health Care Services. Amend RSA 420-J:8-e to read as follows:

420-J:8-e Reasonable Value of Health Care Services. [~~In the event of a dispute between a health care provider and an insurance carrier relative to the reasonable value of a service under RSA 329:31-b or RSA 415-J:3,~~] The commissioner shall have exclusive jurisdiction to determine [~~if the fee is commercially reasonable~~. ~~Either the provider or the insurance carrier may petition for a hearing under RSA 400-A:17. The petition shall include the appealing party's evidence and methodology for asserting that the fee is reasonable, and shall detail the efforts made by the parties to resolve the dispute prior to petitioning the commissioner for review. The department may require the parties to engage in mediation prior to rendering a decision.~~] ***the out-of-network rate and commercially reasonable compensation under RSA 415-J:3. The commissioner may require the parties to mediate prior to requesting a hearing. The commissioner shall take into consideration the factors set forth in 42 U.S.C. section 300gg-111(c)(5)(C), and 45 C.F.R. section 149.510, including any federal guidance, when determining the out-of-network rate, but shall not be prohibited from deviating from those factors or from considering other factors if the commissioner finds such deviation to be in the public interest. The commissioner may adopt rules under RSA 541-A, further defining qualified payment amount, out-of-network rate, and the dispute resolution process for determining such rates or compensation.***

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

II. 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 shall cover services provided by nonparticipating provider at a participating facility in the same manner and without imposing any additional requirements as if the services were provided by a participating provider.

III. The patient's cost-sharing for emergency services or 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.

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

10 Rulemaking Authority. Amend RSA 420-J:12 to read as follows:

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

11 Prohibition on Balance Billing. Amend RSA 329:31-b to read as follows:

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

I. [~~When a commercially insured patient is covered by a managed care plan as defined under RSA 420-J:3, XXV,~~] A health care provider [~~performing anesthesiology, radiology, emergency medicine, or pathology services~~] shall not balance bill the patient for fees or amounts other than copayments, deductibles, or coinsurance[~~, if the service is performed in a hospital or ambulatory surgical center~~] ***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, [~~fees for health care services submitted to an insurance carrier for payment shall be limited to a commercially reasonable value, based on payments for similar services from New Hampshire insurance carriers to New Hampshire health care providers~~] ***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.

III. In the event of a dispute between a provider and an insurance carrier relative to the [~~reasonable value of a service~~] ***out-of-network rate*** under this section, the insurance commissioner shall have exclusive jurisdiction under RSA 420-J:8-e to determine [~~if the fee is commercially reasonable. The provider and the insurance carrier shall each make best efforts to resolve any dispute prior to applying to the insurance commissioner for resolution, which shall include presenting to the other party evidence supporting its contention that the fee level it is proposing is commercially reasonable. The department of insurance may require the parties to engage in mediation prior to rendering a decision.~~] ***the out-of-network rate.***

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

CHAPTER 332-M

PROHIBITION ON BALANCE BILLING

332-M:1 Definitions. In this chapter:

I. "Emergency services" means health care services that are provided to a patient in a licensed health facility by a health care provider after the 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" or "provider" means a physician or other health care practitioner licensed, accredited, or certified to perform specified health services consistent with state law.

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

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 to be commercially reasonable pursuant to RSA 420-J:8-e.

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

332-M:2 Prohibition on Balance Billing.

I. No health care provider shall balance bill the patient 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 or emergency 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.

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.

13 New Paragraphs; Patients' Bill of Rights. Amend RSA 151:21 by inserting after paragraph XXIII the following new paragraphs:

XXIV. The patient shall be fully informed, in writing in language that the patient can understand, about requirements and prohibitions relating to balance billing.

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

14 Emergency Medical and Trauma Services; Definition of Air Ambulance Service. 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 C.F.R. section 414.605, or a fixed wing air ambulance, as defined in 42 C.F.R. section 414.605, for patients.***

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

15 New Subdivision; Emergency Medical and Trauma Services; 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 qualified 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 qualified 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.

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

LBA
23-0858
Revised 1/20/23

SB 173-FN- FISCAL NOTE
AS INTRODUCED

AN ACT relative to surprise medical bills.

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

	Estimated Increase / (Decrease)			
STATE:	**FY 2023**	**FY 2024**	**FY 2025**	**FY 2026**
Appropriation	$0	$0	$0	$0
Revenue	$0	$0	$0	$0
Expenditures	$0	Indeterminable Increase	Indeterminable Increase	Indeterminable Increase
Funding Source:	[ ] General [ ] Education [ ] Highway [X] Other - Insurance Department Restricted Funds			

METHODOLOGY:

This bill requires insurers to cover emergency services provided by nonparticipating providers in the same manner as if the services were provided by a participating provider and requires the insurer to pay the nonparticipating provider the out-of-network rate less any cost-sharing for the services provided. The bill prohibits surprise medical bills and balance billing.

The Insurance Department indicates this bill would lead to an increase in the number of hearing requests under RSA 420-J:8-e. The Department assumes that the cost of administering additional fair value hearings under this bill is indeterminable but it is likely that they could be provided within its existing operational budget. The Department expects there would be no fiscal impact to insurance premiums or premium tax revenue.

AGENCIES CONTACTED:

Insurance Department