State of New Hampshire

GENERAL COURT

CONCORD

MEMORANDUM

DATE: **November 1, 2017**

TO: **Honorable Christopher Sununu, Governor**
Honorable Shawn N. Jasper, Speaker of the House
Honorable Chuck W. Morse, President of the Senate
Honorable Paul C. Smith, House Clerk
Honorable Tammy L. Wright, Senate Clerk
Michael York, State Librarian

FROM: **Representative Neal Kurk, Chairman**

SUBJECT: **Final Report on HB 329, Chapter 20:1, Laws of 2017**

Pursuant to HB 329, Chapter 20:1, Laws of 2017, enclosed please find the Final Report of the Committee to Study Balance Billing by Health Care Providers.

If you have any questions or comments regarding this report, please do not hesitate to contact me.

Enclosure

cc. Committee members

FINAL REPORT

Committee to Study Balance Billing by Health Care Providers
HB 329, Chapter 20, Laws of 2017

November 1, 2017

MEMBERS:

Rep. Neal Kurk, Chairman
Rep. David Luneau, Clerk
Rep. Frank Byron
Rep. Charles McMahon
Sen. Harold French

CHARGE OF THE STUDY:

The Committee was directed to study the practice of balance billing by health care providers for services received by an insured person at an in-network health care facility.

ISSUE:

Balance billing (sometimes referred to as 'surprise billing'), that is in the scope of the charge of this committee, occurs when a person receives medical care from a professional provider in a health care facility who is not in his insurance carrier's network. The consumer assumes that since the health care facility, such as a hospital, is within the carrier's network, all of his care will involve providers that are also in the network and is surprised to receive a bill from an out-of-network provider. The providers in this situation are usually anesthesiologists, radiologists, pathologists or emergency room physicians.

New Hampshire specific data are difficult to obtain, but national estimates provided by the Kaiser Family Foundation suggest that about 40 percent of out-of-network care involves a surprise (involuntary) out-of-network bill. A Commonwealth Fund report indicates that 9 percent of hospital stays are likely to produce a surprise bill, with rates as high as 20 percent when the patient was admitted through the emergency department. Kaiser reports that, in a New York specific study, the average out-of-network radiologist bill was $5,406. The same study shows an average $7,006 billed for an emergency, and $13,914 for an assistant surgeon.

PROCESS:

The Committee met four times between September 13 and October 11, 2017.

Extensive testimony was presented orally and/or in writing by:

- Tyler Brannen, New Hampshire Insurance Department
- Insurance carrier representatives: Heidi Kroll, America's Health Insurance Plans, Paula Rogers, Anthem Blue Cross and Blue Shield, Adam Martignetti, Tufts Health Plan, and Matthew Veno, Harvard Pilgrim Health Care
- Health care provider representatives: Valerie Acres, NH Medical Society; Dr. Eric Loo, New Hampshire Society of Pathologists, Dr. Gary Friedman, NH Society of Physician Anesthesiologists
- Health care facility representatives: Paula Minnehan and Travis Boucher, NH Hospital Association
- Josh Kattef, a NH consumer who has had experience with balance bills.

FINDINGS:

On the basis of research provided to it and of written and oral testimony provided by interested parties, the Committee developed four possible strategies for addressing the issue of balance billing in New Hampshire.

1.) Prohibit balance billing by out-of-network hospital/facility-based providers for amounts beyond a "reasonable" fee for the service. The assumption is that the provider is out of network due to a disagreement about payment levels.

2.) Prohibit balance billing by out-of-network hospital/facility-based providers for amounts beyond the average amount paid for the service, determined by findings in the Comprehensive Health Information System (NH RSA 420-G:11-a). If the hospital-based provider is out of network, hospitals are required to pay the hospital-based provider the difference between the average amount due from the carrier and the hospital-based provider charge, or an amount negotiated between the hospital and the hospital-based provider.

3.) Prohibit an out-of-network hospital-based provider from balance billing the patient. No other requirements apply.

4.) Require notification by the hospital that the patient may receive a balance bill from an out-of-network hospital-based provider. No change to balance billing activities or new patient protections.

The Committee recognized that balance billing for health care procedures involves four distinct parties – the insured person, the insurance carrier, the out-of-network health care provider and the health care facility.

Because the insured consumer has a reasonable expectation that all services provided in an in-network health care facility would be covered under his or her health insurance plan, Committee members agreed that the consumer in this situation should be held harmless and not be required to pay for services provided by an out-of-network provider yet covered by his or her health plan in an in-network facility. A consumer would be required to adhere to any plan requirements such as prior authorization and any applicable deductibles and co-payments.

Testimony suggested that the existence of out-of-network hospital/facility-based providers is not common, but that the potential for surprise bills sent to the patient is substantial when the situation exists. The balance billing problem is the result of a breakdown in the negotiation between a carrier and a provider, leading to a surprise bill that the patient is not empowered to avoid. The carriers feel some constraint on the providers' ability to demand unreasonable payments is necessary, and the hospital/facility-based providers believe that network adequacy requirements need to be strengthened.

The out-of-network healthcare provider and the insurance carrier are in the best position to negotiate a "commercially reasonable" rate for the provider's services, with an appeal to the insurance commissioner if no agreement is reached. The Committee was informed that this procedure has worked well for workers' compensation cases where only one case has been appealed over the past two years, and it was resolved before the commissioner needed to make a determination. Whether or not an acceptable rate was negotiated, the healthcare facility could, if it wished, provide a supplemental payment to the out-of-network provider.

The Committee found that balance billing appears to involve primarily four types of medical providers: anesthesiologists, radiologists, emergency medicine providers and pathologists. The Committee believes their services should be incorporated in network adequacy standards established by the NH Insurance Department, as this would tend to even the negotiating leverage between providers and carriers and, potentially**,** increase the number of in-network providers, thus reducing the incidence of balance billing.

RECOMMENDATION:

The Committee recommends that balance billing by out-of-network hospital and ambulatory surgical center (ASC) based professional providers be prohibited when a commercially insured patient is covered by a managed care plan and the hospital or the ASC is an in-network provider. The assumption is that the hospital/facility-based provider is out-of-network due to a disagreement about payment levels, and any solution to the balance billing problem needs to address this underlying issue. In order to avoid tipping the balance of the negotiations unfairly in either party's favor, the legislation should address both reasonable payment levels and expectations for network adequacy. These recommendations have been incorporated into draft legislation, a copy of which is attached to this report.

To help determine whether the legislation, if enacted, is effective, the Committee recommends that the Insurance Department be required to assess its impact on premium rates and report relative to this impact, on or before July 1, 2020, to the Chairmen of the House and Senate Commerce Committees.

Respectfully submitted,

Rep. Neal M. Kurk

Chairman

Draft Legislation; Prohibiting Balance Billing

1 New Section; Prohibition on Balance Billing; Payment for Reasonable Value of Services. Amend RSA 329 by inserting after section 31-a the following new section:

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 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.

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.

III. In the event of a dispute between a provider and an insurance carrier relative to the reasonable value of a service 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.

2 New Section; Reasonable Value of Health Care Services. Amend RSA 420-J by inserting after section 8-d the following new section:

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, 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.

3 New Subparagraph; Network Adequacy; Rulemaking. Amend RSA 420-J:7, II by inserting after subparagraph (d) the following new subparagraph:

(e) Standards for addressing in-network access to hospital based providers, such as anesthesiologists, radiologists, pathologists, and emergency medicine physicians.

4 New Paragraph; Network Adequacy; Waiver. Amend RSA 420-J:7 by inserting after paragraph IV the following new paragraph:

V. The commissioner shall grant a waiver from the requirements under this section pertaining to a specific health care service if the health care provider will not accept commercially reasonable reimbursement rates, based on historical and existing payments made by insurance carriers to health care providers.

5 Report to Legislative Committees. The insurance commissioner shall assess the impact of RSA 420-J:8-e and RSA 329:31-b on health insurance premium rates and file a report describing the impact, on or before July 1, 2020, with the chairmen of the house and senate commerce committees.

6 Effective Date. This act shall take effect July 1, 2018.