

HB 705 - AS AMENDED BY THE HOUSE

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2025 SESSION

25-0576

05/08

HOUSE BILL **705**

AN ACT relative to health care cost transparency.

SPONSORS: Rep. Ammon, Hills. 42; Rep. Burroughs, Carr. 2; Rep. Hunt, Ches. 14; Rep. Soti,
Rock. 35

COMMITTEE: Commerce and Consumer Affairs

AMENDED ANALYSIS

This bill requires health plans to disclose specific pricing information regarding covered items and services. The bill is contingent upon finalization of federal guidance under Presidential Executive Order 14221.

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Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.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

AN ACT relative to health care cost transparency.

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

1 1 New Subdivision; Managed Care Law; Transparency in Coverage. Amend RSA 420-J by
2 inserting after section 19 the following new subdivision:

3 Transparency in Coverage

4 420-J:20 Definitions. In this subdivision:

5 I. "Billed charge" means the total charges for an item or service billed to a health carrier by
6 a provider.

7 II. "Billing code" means the code used by a health carrier or provider to identify health care
8 items or services for purposes of billing, adjudicating, and paying claims for a covered item or
9 service, including the current procedural terminology (CPT) code, health care common procedure
10 coding system (HCPCS) code, diagnosis-related group (DRG) code, national drug code (NDC), or
11 other common payer identifier.

12 III. "Bundled payment arrangement" means a payment model under which a provider is
13 paid a single payment for all covered items and services provided to a covered person for a specific
14 treatment or procedure.

15 IV. "Derived amount" means the price that a health carrier assigns to an item or service for
16 the purpose of internal accounting, reconciliation with providers or submitting data in accordance
17 with state or federal regulations.

18 V. "Health plan" means health carriers, third party administrators, and any other entity
19 that is subject to claims data submission requirements under RSA 420-G:11 IV.

20 VI. "Historical net price" means the retrospective average amount a health carrier paid for a
21 prescription drug, inclusive of any reasonably allocated rebates, discounts, chargebacks, fees, and
22 any additional price concessions received by the carrier with respect to the prescription drug. The
23 allocation shall be determined by dollar value for nonproduct-specific and product-specific rebates,
24 discounts, chargebacks, fees, and other price concessions to the extent that the total amount of any
25 such price concession is known to the health carrier at the time of publication of the historical net
26 price in a machine-readable file in accordance with this subdivision. However, to the extent that the
27 total amount of any nonproduct-specific and product-specific rebates, discounts, chargebacks, fees, or
28 other price concessions is not known to the health carrier at the time of file publication, then the
29 carrier shall allocate such rebates, discounts, chargebacks, fees, and other price concessions by using
30 a good faith, reasonable estimate of the average price concessions based on the rebates, discounts,

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1 chargebacks, fees, and other price concessions received over a time period prior to the current
2 reporting period and of equal duration to the current reporting period.

3 VII. "Items or services" means all encounters, procedures, medical tests, supplies,
4 prescription drugs, durable medical equipment, and fees, including facility fees, provided or assessed
5 in connection with the provision of health care.

6 VIII. "Machine-readable file" means a digital representation of data or information in a file
7 that can be imported or read by a computer system for further processing without human
8 intervention, while ensuring no semantic meaning is lost.

9 IX. "National drug code" means the unique 10- or 11-digit 3-segment number assigned by
10 the United States Food and Drug Administration (FDA), which provides a universal product
11 identifier for drugs in the United States.

12 X. "Negotiated rate" means the amount a health carrier has contractually agreed to pay an
13 in-network provider, including an in-network pharmacy or other prescription drug dispenser, for
14 covered items and services, whether directly or indirectly, including through a third-party
15 administrator or pharmacy benefit manager.

16 XI. "Out-of-network allowed amount" means the maximum amount a health carrier will pay
17 for a covered item or service furnished by an out-of-network provider.

18 XII. "Underlying fee schedule rate" means the rate for a covered item or service from a
19 particular in-network provider, or providers that a health carrier uses to determine a participant's,
20 beneficiary's, or enrollee's cost-sharing liability for the item or service, when that rate is different
21 from the negotiated rate or derived amount.

22 420-J:21 Scope.

23 I. This subdivision establishes price transparency requirements for the timely disclosure of
24 information about costs related to covered items and services under a health benefit plan. These
25 disclosure requirements shall apply to all health plans.

26 II. Requirements for public disclosure in this subdivision apply to in-network provider rates
27 for covered items and services, out-of-network allowed amounts and billed charges for covered items
28 and services, and negotiated rates and historical net prices for covered prescription drugs.

29 III. A health plan shall make available on an Internet website the information required
30 under RSA 420-J:22 in 3 machine-readable files, in accordance with the method and format
31 requirements described in RSA 420-J:23, and updated as required under RSA 420-J:23, III.

32 420-J:22 Required Information. The machine-readable files made available to the public by a
33 health plan shall include:

34 I. An in-network rate machine-readable file that includes the required information under
35 this paragraph for all covered items and services, except for prescription drugs that are subject to a
36 fee-for-service reimbursement arrangement, which shall be reported in the prescription drug

1 machine-readable file pursuant to paragraph III. The in-network rate machine-readable file shall
2 include:

3 (a) For each coverage option offered by a health plan, the name and the 14-digit health
4 insurance oversight system (HIOS) identifier, or, if the 14-digit HIOS identifier is not available, the
5 5- digit HIOS identifier, or if no HIOS identifier is available, the employer identification number
6 (EIN).

7 (b) A billing code, which in the case of prescription drugs must be an NDC, and a plain
8 language description for each billing code for each covered item or service under each coverage
9 option offered by a carrier.

10 (c) All applicable rates, which may include one or more of the following: negotiated rates,
11 underlying fee schedule rates, or derived amounts. If a health plan does not use negotiated rates for
12 provider reimbursement, then the carrier shall disclose derived amounts to the extent these amounts
13 are already calculated in the normal course of business. If the health plan uses underlying fee
14 schedule rates for calculating cost sharing, then the carrier shall include the underlying fee schedule
15 rates in addition to the negotiated rate or derived amount. Applicable rates, including for both
16 individual items and services and items and services in a bundled payment arrangement, shall be:

17 (1) Reflected as dollar amounts, with respect to each covered item or service that is
18 furnished by an in-network provider. If the negotiated rate is subject to change based upon
19 participant, beneficiary, or enrollee-specific characteristics, these dollar amounts shall be reflected
20 as the base negotiated rate applicable to the item or service prior to adjustments for participant,
21 beneficiary, or enrollee-specific characteristics.

22 (2) Associated with the national provider identifier (NPI), tax identification number
23 (TIN), and place of service code for each in-network provider.

24 (3) Associated with the last date of the contract term or expiration date for each
25 provider-specific applicable rate that applies to each covered item or service.

26 (4) Indicated with a notation where a reimbursement arrangement other than a
27 standard fee-for-service model, such as capitation or a bundled payment arrangement, applies.

28 II. An out-of-network allowed amount machine-readable file, including:

29 (a) For each coverage option offered by a health plan, the name and the 14-digit HIOS
30 identifier, or, if the 14-digit HIOS identifier is not available, the 5-digit HIOS identifier, or, if no
31 HIOS identifier is available, the EIN.

32 (b) A billing code, which in the case of prescription drugs shall be an NDC, and a plain
33 language description for each billing code for each covered item or service under each coverage
34 option offered by a carrier.

35 (c) Unique out-of-network allowed amounts and billed charges with respect to covered
36 items or services furnished by out-of-network providers during the 90-day time period that begins
37 180 days prior to the publication date of the machine-readable file, except that a health plan shall

1 omit such data in relation to a particular item or service and provider when compliance with this
2 paragraph would require the carrier to report payment of out-of-network allowed amounts in
3 connection with fewer than 20 different claims for payments under a single plan or coverage.
4 Consistent with RSA 420-J:25 II, nothing in this paragraph requires the disclosure of information
5 that would violate any applicable health information privacy law. Each unique out-of-network
6 allowed amount shall be:

7 (1) Reflected as a dollar amount, with respect to each covered item or service that is
8 furnished by an out-of-network provider.

9 (2) Associated with the NPI, TIN, and Place of Service Code for each out-of-network
10 provider.

11 III. A prescription drug machine-readable file, including:

12 (a) For each coverage option offered by a health plan, the name and the 14-digit HIOS
13 identifier, or, if the 14-digit HIOS identifier is not available, the 5-digit HIOS identifier, or, if no
14 HIOS identifier is available, the EIN.

15 (b) The NDC, and the proprietary and nonproprietary name assigned to the NDC by the
16 FDA, for each covered item or service that is a prescription drug under each coverage option offered
17 by a carrier.

18 (c) The negotiated rates, which shall be:

19 (1) Reflected as a dollar amount, with respect to each NDC that is furnished by an
20 in-network provider, including an in-network pharmacy or other prescription drug dispenser.

21 (2) Associated with the NPI, TIN, and place of service code for each in-network
22 provider, including each in-network pharmacy or other prescription drug dispenser.

23 (3) Associated with the last date of the contract term for each provider-specific
24 negotiated rate that applies to each NDC.

25 (d) Historical net prices that are:

26 (1) Reflected as a dollar amount, with respect to each NDC that is furnished by an
27 in-network provider, including an in-network pharmacy or other prescription drug dispenser.

28 (2) Associated with the NPI, TIN, and place of service code for each in-network
29 provider, including each in-network pharmacy or other prescription drug dispenser.

30 (3) Associated with the 90-day time period that begins 180 days prior to the
31 publication date of the machine-readable file for each provider-specific historical net price that
32 applies to each NDC, except that a health plan shall omit such data in relation to a particular NDC
33 and provider when compliance with this paragraph would require the carrier to report payment of
34 historical net prices calculated using fewer than 20 different claims for payment. Consistent with
35 RSA 420-J:25, II, nothing in this paragraph requires the disclosure of information that would violate
36 any applicable health information privacy law.

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1 420-J:23 Required Reporting of Information to the Commissioner in a Standardized Format;
2 Rulemaking; Commissioner's Responsibility to Make Comparative Price Information Publicly
3 Available.

4 I. Pricing information from the machine-readable files described in RSA 420-J:22 shall be
5 electronically provided to the commissioner in a form and manner as specified in rule adopted by the
6 commissioner under RSA 541-A. The commissioner shall ensure that the required form and manner
7 for providing pricing information from the machine-readable files:

8 (a) Is consistent with the updated federal guidance or rulemaking ensuring that pricing
9 information is standardized and easily comparable across health plans and hospitals required under
10 United States Presidential Executive Order 14221 of February 25, 2025, "Making America Healthy
11 Again by Empowering Patients with Clear, Accurate, and Actionable Healthcare Pricing
12 Information"; and

13 (b) Results in standardization of format and terminology from one health plan to
14 another sufficient to facilitate the compilation by the commissioner of market wide data and market
15 wide cost comparisons between health plans and health care providers.

16 II. The machine-readable files shall be publicly available and accessible to any person free of
17 charge and without conditions, such as establishment of a user account, password, or other
18 credentials, or submission of personally identifiable information to access the file.

19 III. A health plan shall update the machine-readable files and information required in RSA
20 420-J:22 and the information submitted to the commissioner described in this subdivision on a
21 monthly basis. The health plan shall clearly indicate in the files the date that the files were most
22 recently updated.

23 IV. The commissioner shall compile the pricing information submitted by health plans under
24 this subsection and make it available to the public through an online tool that facilitates market
25 wide price comparison for health care items or services between health plans and health care
26 providers and empowers patients, researchers, policy makers, and other stakeholders with clear,
27 accurate, and actionable health care pricing information.

28 420-J:24 Contractual Delegation Agreements.

29 I. A health plan may satisfy the requirements of this subdivision by entering into a written
30 agreement under which another person, including a third-party administrator or health care claims
31 clearinghouse, provides the disclosures required under this subdivision.

32 II. If a health plan and another person enter into an agreement under paragraph I, the
33 health plan shall be subject to any enforcement action for failure to provide a required disclosures in
34 accordance with this subdivision.

35 420-J:25 Applicability.

36 I. The provisions of this subdivision apply for plan years beginning on or after January 1,
37 2026.

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1 II. Nothing in this subdivision alters or otherwise affects a health plan's duty to comply with
2 requirements under other applicable state or federal laws, including those governing the
3 accessibility, privacy, or security of information required to be disclosed under this section, or those
4 governing the ability of properly authorized representatives to access participant, or beneficiary
5 information held by health plans.

6 420-J:26 Compliance With Subdivision.

7 I. A health plan that, acting in good faith and with reasonable diligence, makes an error or
8 omission in a disclosure required under this subdivision does not fail to comply with this subdivision
9 solely because of the error or omission if the issuer or administrator corrects the error or omission as
10 soon as practicable.

11 II. A health plan, acting in good faith and with reasonable diligence, does not fail to comply
12 with this subdivision solely because the carrier's Internet website is temporarily inaccessible if the
13 carrier makes the information available as soon as practicable.

14 III. To the extent compliance with this subdivision requires a health plan to obtain
15 information from another person, the carrier does not fail to comply with the subdivision because the
16 carrier relies in good faith on information from the other person unless the carrier knows or
17 reasonably should have known that the information is incomplete or inaccurate.

18 2 Contingency. Section 1 of this act shall take effect 6 months after finalization of federal
19 guidance under United States Presidential Executive Order 14221. The commissioner of the
20 insurance department shall notify the secretary of state and director of the office of legislative
21 services of the date on which federal guidance under Executive Order 14221 has been finalized.

22 3 Effective Date.

23 I. Section 1 of this act shall take effect as provided in section 2 of this act.

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