Rep. Hunt, Ches. 14
March 18, 2025
2025-1090h
05/08

Amendment to HB 705

Amend the bill by replacing all after the enacting clause with the following:

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

Transparency in Coverage

420-J:20 Definitions. In this subdivision:

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

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

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

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

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

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

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

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

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

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

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

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

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

420-J:21 Scope.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) The negotiated rates, which shall be:

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

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

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

(d) Historical net prices that are:

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

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

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

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

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

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

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

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

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

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

420-J:24 Contractual Delegation Agreements.

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

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

420-J:25 Applicability.

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

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

420-J:26 Compliance With Subdivision.

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

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

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

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

3 Effective Date.

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

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

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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.