HB 1554-FN - AS INTRODUCED

2026 SESSION

26-2818
05/06

HOUSE BILL ***1554-FN***

AN ACT requiring insurance carriers to provide peer-to-peer review at any stage of prior authorization and mandating disclosure of reviewer credentials.

SPONSORS: Rep. Miles, Hills. 12; Rep. Nagel, Belk. 6; Rep. Kuttab, Rock. 17; Rep. Mary Murphy, Hills. 27; Rep. Kofalt, Hills. 32; Sen. McGough, Dist 11; Sen. Prentiss, Dist 5; Sen. Gannon, Dist 23

COMMITTEE: Commerce and Consumer Affairs

ANALYSIS

This bill requires insurance carriers to provide peer-to-peer review at any stage of prior authorization, establishes qualifications for reviewing providers, and requires disclosure of such information to the treating provider.

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Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

26-2818
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STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Twenty-Six

AN ACT requiring insurance carriers to provide peer-to-peer review at any stage of prior authorization and mandating disclosure of reviewer credentials.

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

1 Prior Authorization Standards for Managed Care Plans. Amend RSA 420-E:4-b, VII to read as follows:

VII. Option to request a peer-to-peer review. When a utilization review entity requires prior authorization for an item or service, the utilization review entity shall offer the provider the opportunity to request a peer-to-peer review of a prior authorization request in which the provider is able to have a direct conversational exchange with a medical director or a designated provider who is a clinical peer about the basis for the prior authorization request. A "clinical peer" in this context shall [~~be a health care professional who has demonstrable expertise to review a case, whether or not the reviewing professional is in the same or a similar specialty as the provider~~] ***meet the criteria established in subparagraph VII-a(a)***. The peer-to-peer review may be requested before the utilization review entity's prior authorization determination or after a prior authorization denial [~~and before a formal grievance request has been made~~]. ***A claimant retains the right to a peer-to-peer review regardless of whether an appeal has been requested by or on behalf of the claimant.*** The peer-to-peer review shall be made available by the utilization review entity within 2 business days of the request. If the peer-to-peer review is requested after a prior authorization denial, the utilization review entity shall treat the review request as a request for reconsideration that is external to the grievance process and shall provide the provider and the covered person a written determination containing a statement of the specific reasons for the reconsideration determination with reference to the information provided in the peer-to-peer review. The written reconsideration determination shall be provided within 7 business days of the peer-to-peer review.

2 New Paragraph; Prior Authorization Standards for Managed Care Plans; Peer-to-Peer Review. Amend RSA 420-E:4-b by inserting after paragraph VII the following new paragraph:

VII-a. Upon issuance of an adverse prior authorization determination, an insured or their provider may at any time request and receive a peer-to-peer review, including after an appeal has been initiated. The insurer shall honor such a request regardless of appeal status and schedule the peer-to-peer conversation within 5 business days of the request.

(a) The peer-to-peer review shall be conducted by a physician reviewer who:

(1) Holds an active license in the same or a similar specialty as the treating provider;

(2) Is actively practicing in the same or similar field of medicine; and

(3) Has expertise to assess the medical necessity of the specific procedure or service under review.

(b) In any peer-to-peer review conducted by an insurer, the insurer shall disclose to the requesting provider, at or before the start of the peer-to-peer conversation:

(1) The reviewer's full name;

(2) The reviewer's licensure type and issuing state; and

(3) The reviewer's National Provider Identifier (NPI). This disclosure requirement applies regardless of whether the call is initiated by the provider or the insurer.

(c) Failure of the insurer to comply with this section shall constitute an unfair insurance practice under RSA 417 and may be subject to administrative penalties by the insurance commissioner.

3 Utilization Review. Amend RSA 420-J:6, X to read as follows:

X. Option to request a peer-to-peer review. When a health carrier requires prior authorization for an item or service, the carrier shall offer the provider the opportunity to request a peer-to-peer review of a prior authorization request in which the provider is able to have a direct conversational exchange with a medical director or a designated provider who is a clinical peer about the basis for the prior authorization request. A "clinical peer" in this context shall [~~be a health care professional who has demonstrable expertise to review a case, whether or not the reviewing professional is in the same or a similar specialty as the provider~~] ***meet the criteria established in subparagraph X-a(a)***. The peer-to-peer review may be requested before the carrier's prior authorization determination or after a prior authorization denial [~~and before a formal grievance request has been made~~]. ***A claimant retains the right to a peer-to-peer review regardless of whether an appeal has been requested by or on behalf of the claimant.*** The peer-to-peer review shall be made available by the health carrier within 2 business days of the request. If the peer-to-peer review is requested after a prior authorization denial, the [~~heath~~] ***health*** carrier shall treat the review request as a request for reconsideration that is external to the grievance process and shall provide the provider and the covered person a written determination containing a statement of the specific reasons for the reconsideration determination with reference to the information provided in the peer-to-peer review. The written reconsideration determination shall be provided within 7 business days of the peer-to-peer review.

4 New Paragraph; Utilization Review; Peer-to-Peer Review Requirements. Amend RSA 420-J:6 by inserting after paragraph X the following new paragraph:

X-a. Upon issuance of an adverse prior authorization determination, an insured or their provider may at any time request and receive a peer-to-peer review, including after an appeal has been initiated. The insurer shall honor such a request regardless of appeal status and schedule the peer-to-peer conversation within 5 business days of the request.

(a) The peer-to-peer review shall be conducted by a physician reviewer who:

(1) Holds an active license in the same or a similar specialty as the treating provider;

(2) Is actively practicing in the same or similar field of medicine; and

(3) Has expertise to assess the medical necessity of the specific procedure or service under review.

(b) In any peer-to-peer review conducted by an insurer, the insurer shall disclose to the requesting provider, at or before the start of the peer-to-peer conversation:

(1) The reviewer's full name;

(2) The reviewer's licensure type and issuing state; and

(3) The reviewer's National Provider Identifier (NPI). This disclosure requirement applies regardless of whether the call is initiated by the provider or the insurer.

(c) Failure of the insurer to comply with this section shall constitute an unfair insurance practice under RSA 417 and may be subject to administrative penalties by the insurance commissioner.

5 Effective Date. This act shall take effect January 1. 2027.

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HB 1554-FN- FISCAL NOTE
AS INTRODUCED

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FISCAL IMPACT:

Estimated State Impact				
	FY 2026	**FY 2027**	**FY 2028**	**FY 2029**
Revenue	$0	Indeterminable Increase (not provided by agency)	Indeterminable Increase (not provided by agency)	Indeterminable Increase (not provided by agency)
Revenue Fund(s)	General Funds			
Expenditures*	$0	$0	$0	$0
Funding Source(s)	None			
Appropriations*	$0	$0	$0	$0
Funding Source(s)	None			

***Expenditure = Cost of bill** ***Appropriation = Authorized funding to cover cost of bill**

Estimated Political Subdivision Impact				
	FY 2026	**FY 2027**	**FY 2028**	**FY 2029**
County Revenue	$0	$0	$0	$0
County Expenditures	$0	Indeterminable	Indeterminable	Indeterminable
Local Revenue	$0	$0	$0	$0
Local Expenditures	$0	Indeterminable	Indeterminable	Indeterminable

METHODOLOGY:

This bill requires insurance carriers to provide peer-to-peer review at any stage of prior authorization, establishes qualifications for reviewing providers, and requires disclosure of such information to the treating provider.

The Insurance Department states this bill will result in an indeterminable impact on state revenues and no impact on state expenditures. The Department explains that utilization review is a structured process with multiple levels of due process, and allowing peer-to-peer review at any stage would create additional inefficiencies and increase administrative costs for health carriers. These increased administrative costs would have to be absorbed within carriers' medical loss ratio requirements, potentially affecting carrier profitability and their continued

participation in the New Hampshire insurance market. Any shifts in market participation or pricing strategies could affect premium levels and therefore premium tax revenue, but the direction and size of this impact cannot be estimated.

The Department is unable to estimate the potential administrative costs carriers may incur or how each carrier may adjust its business strategy in response. As a result, the impact on Insurance Premium Tax revenue is indeterminable.

To the extent counties and municipalities purchase health insurance, they could see an impact to their health insurance premiums.

AGENCIES CONTACTED:

Insurance Department