

Senate Health and Human Services Committee

Sophie Walsh 271-3469

SB 126-FN, relative to notice of changes to provider contracts.

Hearing Date: February 6, 2025

Time Opened: 12:09 p.m.

Time Closed: 12:47 p.m.

Members of the Committee Present: Senators Rochefort, Avard, Birdsell, Prentiss and Long

Members of the Committee Absent: None

Bill Analysis: This bill regulates the notice requirements regarding changes to contracts between health carriers and health care providers.

Sponsors:

Sen. Avard

Who supports the bill: Ben Bradley (NH Hospital Association), Brendan Williams (NH Health Care Association), Kathy Corey Fox (St. Joseph Hospital), and Kristine Stoddard (Bi-State Primary Care Association).

Who opposes the bill: Cam Lapine (Cigna), Andrew Hosmer (Harvard-Pilgrim), Nick Vailas (Bedford Ambulatory Surgical Center), Paula Rogers (AHIP), Chris Kennedy (Centene/Ambetter), and Sabrina Dunlap (Anthem).

Who is neutral on the bill: Keith Nyhan & Michelle Heaton (NH Insurance Department).

Summary of testimony presented:

Senator Kevin Avard, Senate District 12

- This bill regulates the notice requirements regarding changes to contracts between health carriers and health providers.
- Senator Avard said he is generally opposed to getting engaged with contract disputes, but this bill is a measured approach to provide predictability, transparency, and accountability for changes to provider agreements by health insurance companies.
- In past years, we have seen legislation prohibit unilateral policy changes in provider agreements.
- This bill does not prohibit unilateral changes to provider contracts. Instead, it: **(1)** sets a reasonable cadence for health insurance companies to make changes

to their provider manuals and other documents four times per year, **(2)** makes some exceptions to accommodate compliance with State and federal regulations and changes to American Medical Association procedural codes, **(3)** requires health insurance companies to make clear the redline changes in their provider manuals and other original documents when they make unilateral changes to ensure transparency and greater ability for providers to follow new policies, and **(4)** requires health insurance companies to submit good faith estimates for financial impacts of aggregate changes to the provider manual and other documentation and annually submit those estimates to the Department of Insurance and providers under their contracts.

- This bill is simply asking for health insurance companies to disclose those considerations with the Department of Insurance and the providers under their contracts.
- This bill resembles a bill passed in Maine last year.

Ben Bradley, New Hampshire Hospital Association

- Mr. Bradley stated that the New Hampshire Hospital Association (NHHA) is in strong support of this bill.
- Private and commercial health insurance payment systems are primarily based on HIPAA required coding sets, which are periodically updated.
- Thus, contracts between providers and health insurance companies allow for mid-contract policy changes to adjust coding in alignment with mid-year changes made by the American Medical Association and other governing bodies.
- In recent years, health insurance companies have begun implementing mid-contract policy changes to their agreements and supporting documentation, including their provider manuals. This has a material financial impact on the provider.
- The provider has little opportunity to dispute the change, other than the option to walk away from the contract. This would be a highly disruptive step.
- Hospitals and other stakeholders have tried to support legislative action in the past to prohibit this practice with no success. NHHA members have also attempted to privately negotiate protections against this unsuccessfully.
- This bill takes a measured approach without outright prohibiting health insurance companies from making changes.
- This proposes that health insurance carriers make changes with 60 days' notice, which is current law, only four times per year on the first of January, April, July and October.
- There are some exceptions for compliance with State and federal requirements or changes in procedural terminology codes used by the American Medical Association.
- This aims to reduce the administrative burden on providers created by these agreement changes. Mr. Bradley described the current way these changes are communicated via email to be difficult for providers to identify and navigate.
- This would also require health insurance companies to provide a good faith estimate of the financial impact of these changes to their contracts if the aggregate change in reimbursement is more than \$500,000 per year.

- The goal of this is to quantify the financial impact of these changes and be transparent about health insurance companies' management of health care costs.
- The administrative costs for health insurance companies to comply with these provisions is negligible or non-existent because they make the changes, and any cost would be accounted for by what they claim are the financial benefits from the change itself.
- The NHHA agrees that in many cases it is appropriate for insurers to privately negotiate terms in their contracts, but it is not uncommon for the legislature to enact statutory expectations for provider contracts as necessary.

Sabrina Dunlap, Anthem

- Ms. Dunlap stated that she appreciates the NHHA coming to them with this bill, but Anthem is in opposition with some major concerns.
- She explained that there is an underlying contract between the parties, and there are typically a number of attachments and ancillary documents included by reference in the underlying contract.
- On a number of these, both parties retain the right to make updates and changes with sufficient notice.
- The provider manual is one of the most important ancillary documents. These manuals are used to provide guidance to providers on a wide range of issues.
- Ms. Dunlap clarified that they are not making changes to the underlying agreement, as that would be a breach of contract.
- Instead, they are making necessary changes to the provider manual, which is intended to be updated periodically with advance notice. This is contemplated by both parties when they negotiate the contract.
- This bill limits making those periodic changes in an unworkable way.
- Ms. Dunlap explained that they are already highly regulated in this space. The notion that there is uneven negotiating power is not reflective of reality.
- She addressed the similar bill passed last year in Maine and noted that parts of it have been virtually unworkable. The most problematic section is the requiring of estimated cost.
- Ms. Dunlap said that if the committee chooses to move forward with the bill, they have thoughts on how it can be improved.
- Senator Avard asked if Ms. Dunlap sees any improvements that could be made, and Ms. Dunlap said she has a lot of thoughts. The first and third sections are the most problematic, but there are ways they can be improved. She believes the notion that they can anticipate changes on a quarterly basis is at odds with reality.
- Senator Avard asked how many times per year they make changes, and Ms. Dunlap said she does not have an exact number because it depends on what it is. For example, American Medical Association standards for coding changes can be more frequent. She said her guess is that while it does not happen frequently, it is throughout the year.
- Senator Long asked if the effective date of 60 days after passage is doable, and Ms. Dunlap said it would be very difficult because it is mid-plan year.

- Senator Birdsell asked if they provided any feedback to Senator Avard or the organizations who wanted this bill.
- Ms. Dunlap explained that they did not see the language early on, but they did have a robust discussion where they made it clear that they had issues with the bill.
- Senator Prentiss referenced Ms. Dunlap's example of the American Medical Association and asked if they post the changes that need to be made.
- Ms. Dunlap explained that she was just referencing that as an example, but her understanding is that the American Medical Association will update codes from time to time.
- Senator Prentiss confirmed that this is a continuous process. Ms. Dunlap confirmed and noted that it is dynamic as well.

Cam Lapine, Cigna

- Mr. Lapine submitted written testimony that speaks to the technical issues with this bill.
- He provided copies of hearing reports from SB 320 from 2022 and SB 131 from 2023, which are related to this issue. He emphasized that when such bills have come before the committee and the Senate in the past, they have been referred to interim study.
- Mr. Lapine emphasized that this is not a legislative matter. It is private contracting between two private companies.
- Senator Avard asked if this bill is identical to SB 320, and Mr. Lapine said it is not, but the spirit is the same.
- Senator Avard asked if he would consider this light, and Mr. Lapine said it would still be unworkable.

Andrew Hosmer, Harvard-Pilgrim

- Mr. Hosmer stated Harvard-Pilgrim is opposed to this legislation because it would put an unnecessary strain on these relationships.
- These provider contracts are between private parties. The Legislature should be cautious when intervening between private parties who choose to enter into a contract together.
- Mr. Hosmer noted that this is exclusively weighted in favor of providers.
- If enacted as proposed, there are concerns that this will result in significant challenges for carries both in the administration and implementation of these rules.
- Mr. Hosmer explained that there is a dynamic relationship when changes to coding or contracts need to be made.
- If limited to a quarterly basis, there could be a higher volume inundating those who have to implement those changes.
- Harvard-Pilgrim has found it extremely difficult to implement the administrative work required by the new bill passed in Maine.
- Mr. Hosmer said we should be cautious of the effect this could have on premiums.
- Senator Prentiss asked if there are administrative costs related to this.

- Mr. Hosmer explained that any administrative cost that the carrier is bearing goes into the overall business plan to ensure the carrier has long-term financial viability.
- The whole internal expense structure needs to be taken into consideration and balanced appropriately, so members will receive the benefits they have been promised and providers are paid reimbursement rates.
- Senator Prentiss asked what time frame they estimate they would be working with if a change needed to be made.
- Mr. Hosmer said he would have to refer to his client, but Harvard-Pilgrim feels strongly that the 60-day proposal is unmanageable at this point.
- He noted that the language is vague and questioned what a “proposed” change is.
- Senator Rochefort asked what Harvard-Pilgrim is doing to help alleviate some of these pressure points, as it is clear to him that one party feels like they are not being heard.
- Mr. Hosmer explained that Harvard-Pilgrim takes concerns from both providers and members very seriously. They work in good faith to ensure that voices are heard and policy reflects the parties’ desires. However, it is not always going to be perfect.
- Harvard-Pilgrim does their utmost to comply with all regulations fairly and are always open to conversations to adjust policies if necessary.

Nick Vailas, Bedford Ambulatory Surgical Center

- Mr. Vailas stated that he is the CEO of Bedford Ambulatory Surgical Center, Orchard Surgical Center, and Nashua Ambulatory Surgical Center.
- He works with many private practices and owns some primary care practices himself.
- His mission is to make healthcare more affordable and accessible.
- Price is the leading obstacle to healthcare, and healthcare is the leading cause of personal bankruptcy.
- Mr. Vailas said he has heard no complaints from those he works with in private practice about their relationship with their health plans from the standpoint of negotiating.
- He emphasized the importance of patients’ need to know, need to advocate, and need to be helped to navigate to lower cost providers.
- The cost difference between providers is enormous. Mr. Vailas said this can be blamed on all of the fee schedules that are released.
- People in private practice often pay five times less than higher cost hospital systems.
- This kind of legislation will prevent creative health plan design that allows patients to be steered and incentivized to go to lower cost providers.
- Mr. Vailas said while he is not all for free market everywhere, he does believe we need more free market forces in health care.

Keith Nyhan and Michelle Heaton, New Hampshire Insurance Department

- Mr. Nyhan introduced himself as the Deputy Commissioner of the Insurance Department, and Ms. Heaton introduced herself as the Director of the Life and Health Division.
- The Department is neutral on this bill.
- They are sensitive and appreciative of the challenges that the provider community faces in looking for predictability as changes are made to contracts and manuals.
- As they understand, this bill seeks to set up parameters for insurance carriers to follow in making these changes.
- This is ultimately a policy decision, but they recognize that there will be some cost shifting, as some administrative costs will be shifted to carriers. They do not know the extent of these administrative costs for carriers.
- There is always potential for those costs to be shifted into premiums for consumers.
- The Department finds Section 3 concerning because there is no enforcement mechanism for the Department.
- Ms. Heaton referenced a portion of Section 3, which requires the Department to post some of these reports on their website. This will be able to be absorbed into their budget as it currently stands.