HB 743-FN - AS INTRODUCED

2025 SESSION

25-0747
05/09

HOUSE BILL ***743-FN***

AN ACT relative to patient access to health care prices and billing practices.

SPONSORS: Rep. Soti, Rock. 35; Rep. Dunn, Rock. 16; Rep. McFarlane, Graf. 18; Rep. Perez, Rock. 16

COMMITTEE: Health, Human Services and Elderly Affairs

ANALYSIS

This bill requires health care entities to provide an estimate of the price of health care services to be provided. The bill also requires health care entities to post notice of a patient's right to request this information and requires health insurance carriers to provide an insured patient with an advanced explanation of benefits withing 3 business days of receiving a good faith estimate from a health care entity. The bill also requires hospitals to comply with federal price transparency requirements, directs the department of health and human services to adopt rules regarding the disclosure requirements, and provides for the assessment of fines for noncompliance.

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Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

25-0747
05/09

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Twenty Five

AN ACT relative to patient access to health care prices and billing practices.

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

1 1 New Chapter; Consumer Information Regarding Health Care Entity Prices. Amend RSA by
2 inserting after chapter 358-T the following new chapter:
3 CHAPTER 358-U
4 CONSUMER INFORMATION REGARDING HEALTH CARE ENTITY PRICES
5 358-U:1 Definitions. In this chapter:
6 I. "Frequently provided health care services and procedures" means those health care
7 services and procedures that were provided by the health care entity at least 50 times in the
8 preceding calendar year.
9 II. "Facility fee" means a fee charged or billed by a health care entity for outpatient services
10 provided in a hospital-based facility that is:
11 (a) Intended to compensate the hospital or health system for the operational expenses of
12 the hospital or health system; and
13 (b) Separate and distinct from a professional fee.
14 III. "Health care entity" means a health care provider; a group of health care providers; or a
15 health care facility that charges patients for health care services and procedures. A health care
16 entity does not include a pharmacy or a pharmacist.
17 IV. "Hospital" means a hospital licensed under RSA 151.
18 V. "Hospital-based facility" means a facility that is owned or operated, in whole or in part,
19 by a hospital or health system where hospital services or professional medical services are provided.
20 VI. "Professional fee" means a fee charged or billed by a health care entity for professional
21 medical services provided in a hospital-based facility.
22 358-U:2 Disclosure of Price for Health Care Services.
23 A health care entity shall inform patients about the availability of prices for the most frequently
24 provided health care services and procedures and the right of a patient to request information about
25 the price of health care services and procedures pursuant to RSA 358-U:4 and RSA 358-U:5 by
26 posting a notice on prominent display to patients.
27 358-U:3 Notice Required.
28 A health care entity shall include notice of a patient's right to request information about the
29 price of health care services and procedures pursuant to RSA 358-U:4 or 358-U:5 in any written
30 document provided to a patient prior to rendering health care treatment for the purpose of obtaining
31 informed consent to that treatment.

1 358-U:4 Patient Request for Good Faith Estimate or Other Information Related to Price of
2 Medical Services; Uninsured or Self-Pay Patient; Good Faith Estimate.
3 Upon the request of an uninsured or self-pay patient, a health care entity shall provide to the
4 patient a good faith estimate of the total price of health care services to be rendered directly by that
5 health care provider during a single medical encounter as follows:
6 I. The health care entity shall provide the good faith estimate within the following time
7 frames:
8 (a) When the medical encounter is scheduled at least 3 business days before the date the
9 medical encounter is scheduled to be furnished or when the patient is seeking urgent care, the
10 estimate shall be provided no later than one business day after the date of scheduling or the date of
11 the request if the patient is seeking urgent care;
12 (b) When the medical encounter is scheduled at least 10 business days before the
13 encounter is scheduled to be furnished, the estimate must be provided no later than 3 business days
14 after the date of scheduling; or
15 (c) In all other circumstances, the estimate shall be provided no later than 3 business
16 days after the date of the request.
17 II. If the health care entity is unable to provide an accurate estimate of the total price of a
18 specific health care service because the amount of the health care service to be rendered during the
19 medical encounter is unknown in advance, the health care entity shall provide a brief description of
20 the basis for determining the total price of that particular health care service.
21 III. If the single medical encounter will involve health care services to be rendered by one or
22 more third party health care entity, the health care entity shall identify each third party health care
23 provider to enable the uninsured patient to seek an estimate of the total price of health care services
24 to be rendered directly by each health care entity to that patient.
25 IV. A good faith estimate shall separately disclose the prices for each component of health
26 care services, including any facility fees or fees for professional services, and the current procedural
27 terminology codes used by the American Medical Association for those services.
28 V. When providing an estimate as required by this section, the health care entity shall also
29 notify the uninsured patient of any financial assistance policy adopted by the health care entity and
30 the availability of public or private health care coverage.
31 VI. Notwithstanding other provisions of this section, a health care entity does not violate
32 this section if it provides a good faith estimate to the patient in compliance with federal regulations.
33 358-U:5 Insured Patient; Description of Health Care Services and Current Procedural
34 Terminology Codes. Upon the request of an insured patient, a health care entity shall provide to the
35 patient a description of the health care services to be rendered directly by that health care entity
36 during a single medical encounter and the applicable standard medical codes or current procedural
37 terminology codes used by the American Medical Association for those services as follows:

I. The health care entity shall comply with the request within the following time frames:

(a) When the medical encounter is scheduled at least 3 business days before the date the medical encounter is scheduled to be furnished or when the patient is seeking urgent care, the health care entity shall respond no later than one business day after the date of scheduling or the date of the request if the patient is seeking urgent care;

(b) When the medical encounter is scheduled at least 10 business days before the encounter is scheduled to be furnished, the health care entity shall respond no later than 3 business days after the date of scheduling; or

(c) In all other circumstances, the health care entity shall respond no later than 3 business days after the date of the request.

II. If the single medical encounter will involve health care services to be rendered by one or more third party health care entities, the health care entity shall identify each third party health care entity to enable the patient to seek a description of the health care services to be rendered directly by that third party health care entity to that patient and the applicable standard medical codes or current procedural terminology codes used by the American Medical Association for those services.

III. The health care entity shall also notify the patient that the patient may use the information provided to request an estimate of the out-of-pocket costs expected to be paid by the patient from the patient's health insurance carrier.

IV. When providing the information required by this section, the health care entity shall also notify the insured patient of any financial assistance policy adopted by the health care entity and the availability of other public or private health insurance coverage.

V. Notwithstanding this section, if federal regulations are implemented that set forth requirements for health care entities to provide estimates to an insured patient, a health care entity that complies with such federal regulations does not commit a violation of this section.

358-U:6 Prohibition of Collection Actions for Noncompliance with Good Faith Estimate Requirements for Uninsured or Self-Pay Patients.

I. In this section, unless the context otherwise indicates, the following terms have the following meanings:

(a) "Collection action" means any of the following actions:

(1) Attempting to collect a debt from a patient or patient guarantor by referring the debt directly or indirectly to a debt collector, collection agency, or other third party retained by or on behalf of a health care entity;

(2) Suing the patient or patient guarantor or enforcing an arbitration or mediation clause in any health care entity documents, including contracts, agreements, statements, and bills; or

(3) Directly or indirectly causing a report to be made to a consumer reporting agency.

(b) "Collection agency" has the same meaning as "debt collector" has in RSA 358-C:1, VIII.

(c) "Consumer reporting agency" means any person that, for monetary fees or dues or on a cooperative nonprofit basis, regularly engages in whole or in part in the practice of assembling or evaluating consumer credit information or other information on consumers for the purpose of furnishing consumer reports to third parties. "Consumer reporting agency" includes any person defined in 15 United States Code section 1681a(f). "Consumer reporting agency" does not include any business entity that exclusively provides check verification or check guarantee services.

(d) "Items or services" means all items and services, including individual items and services and service packages, that are provided by a health care entity to a patient in connection with an inpatient admission or an outpatient visit for which the patient is charged.

(e) "Patient guarantor" means the individual held responsible for a patient's bill.

II. A health care entity that has not provided a good faith estimate in material compliance with RSA 358-U:4 on the date that items or services are purchased by a patient or provided to a patient may not initiate or pursue a collection action against the patient or patient guarantor for a debt owed for the items or services. Unless a health care entity can demonstrate that the health care entity provided a good faith estimate to the patient as requested, the health care entity or hospital may not further pursue a collection action against the patient or patient guarantor.

358-U:7 Health Care Price Transparency Tools.

Beginning January 1, 2026, a health carrier offering a health benefit plan in this state shall comply with the following requirements:

I. The health carrier shall develop and make available a website accessible to enrollees and a toll-free telephone number that enable enrollees to obtain information on the estimated costs for obtaining a comparable health care service, as defined in RSA 420-J:3, XXII, from network providers, as well as quality data for those providers, to the extent available. The health carrier may comply with the requirements of this paragraph by directing enrollees to the publicly accessible health care costs website of the department of insurance.

II. A health carrier shall make available to the enrollee through a toll-free telephone number the ability to obtain an estimated cost of a scheduled health care service or a comparable health care service that is based on a description of the service or the applicable standard medical codes or current procedural terminology codes used by the American Medical Association provided to the enrollee by the provider. Upon an enrollee's request, the health carrier shall request additional or clarifying code information, if needed, from the provider involved with the scheduled health care service or comparable health care service. If the health carrier obtains specific code information from the enrollee or the enrollee's provider, the health carrier shall provide the anticipated allowed

amount and the enrollee's anticipated out-of-pocket costs based on that code information, to the extent such information is made available to the carrier by the provider. Notwithstanding other provisions of this paragraph, a health carrier does not commit a violation of this paragraph if the carrier complies with federal regulations for price transparency relating to an estimate of an enrollee's cost-sharing responsibility.

III. A health carrier shall notify an enrollee that the amounts are estimates based on information available to the health carrier at the time the request is made and that the amount the enrollee will be responsible to pay may vary due to unforeseen circumstances that arise out of the proposed scheduled health care service or comparable health care service. This section does not prohibit a carrier from imposing cost-sharing requirements disclosed in the enrollee's certificate of coverage for unforeseen health care services that arise out of the proposed scheduled health care service or comparable health care service or for a procedure or service that was not included in the original estimate. This section does not preclude an enrollee from contacting the carrier to obtain more information about a particular admission, procedure or service with respect to a particular provider.

2 New Subdivision; Residential Care and Health Facility Licensing; Hospital Price Transparency. Amend RSA 151 by inserting after section 53 the following new subdivision:

Hospital Price Transparency

151:54 Compliance with Federal Regulations. A hospital licensed under this chapter shall comply with the price transparency requirements established in 45 Code of Federal Regulations, Part 180, Subparts A and B, as in effect on January 1, 2024.

151:55 Standard Format; Rules. A hospital shall provide price transparency data in a standardized format established in rules adopted under RSA 541-A by the department of health and human services. The department shall adopt by rule a standardized format for a hospital to disclose price transparency data that is the same or substantially similar to any format required by federal regulations.

151:56 Failure to Comply. A hospital that fails to comply with any provision of this subdivision or any rule adopted thereunder may be subject to a fine for failure to comply pursuant to RSA 151:16-a.

151:57 Determination of Material Compliance; Notice. Upon a determination that a hospital is not in material compliance with RSA 151:54 and RSA 151:55, the department of health and human services shall notify the hospital that the hospital is not in material compliance and require the hospital to take corrective action within 60 days to become materially compliant. The department shall adopt rules under RSA 541-A, establishing standards for material compliance that align with federal regulations.

3 Effective Date. This act shall take effect 60 days after its passage.

LBA
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Revised 2/4/25

HB 743-FN- FISCAL NOTE
AS INTRODUCED

AN ACT relative to patient access to health care prices and billing practices.

FISCAL IMPACT: This bill does not provide funding.

Estimated State Impact				
	FY 2025	**FY 2026**	**FY 2027**	**FY 2028**
Revenue	$0	Indeterminable	Indeterminable	Indeterminable
Revenue Fund(s)	General Fund			
Expenditures*	$0	Indeterminable	Indeterminable	Indeterminable
Funding Source(s)	General Fund, Highway Fund, and Various Agency Funds			
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 2025	**FY 2026**	**FY 2027**	**FY 2028**
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 health care entities to provide an estimate of the price of health care services to be provided. The bill also requires health care entities to post notice of a patient's right to request this information and requires health insurance carriers to provide an insured patient with an advanced explanation of benefits within 3 business days of receiving a good faith estimate from a health care entity. The bill also requires hospitals to comply with federal price transparency requirements, directs the Department of Health and Human Services to adopt rules regarding the disclosure requirements, and provides for the assessment of fines for noncompliance.

The Insurance Department states this bill could have an increase on the State's General Fund revenue primarily through its impact on Insurance Premium tax revenues. If health carriers face additional compliance costs beyond existing federal requirements, these expenses could

drive higher health insurance premiums, potentially increasing Insurance Premium Tax revenue for the State. However, greater pricing transparency might encourage competition, stabilizing or even lowering premiums over time.

The prohibition on collection actions against uninsured patients could reduce providers' bad debt but may prompt higher operational costs if providers raise prices to offset financial losses. Increased demand for services may temporarily raise public health program expenditures, though improved health outcomes could lead to long-term cost savings. Noncompliance fines might generate state revenue but also impose financial strain on healthcare providers.

Additionally, there could be a fiscal impact on county and local governments if they participate in insurance programs affected by the bill, as increased premiums or compliance costs could result in higher expenses for these entities.

Overall, the fiscal impact on state revenue and state, county, and local expenditures is indeterminable and will largely depend on how healthcare entities, consumers, and government programs adjust to the new requirements.

Department of Health and Human Services states this bill will not have an impact on their expenditures.

AGENCIES CONTACTED:

Insurance Department and Department of Health and Human Services