LEGISLATIVE COMMITTEE MINUTES

SB97

Bill as Introduced

SB 97 - AS INTRODUCED

2021 SESSION

21-0407
08/06

SENATE BILL 97

AN ACT adopting omnibus legislation relative to health insurance.

SPONSORS: Sen. Hennessey, Dist 1

COMMITTEE: Health and Human Services

ANALYSIS

This bill adopts legislation:

I. Relative to direct primary care referral parity.

II. Relative to in-network retail pharmacies.

- -

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Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

21-0407
08/06

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Twenty One

AN ACT adopting omnibus legislation relative to health insurance.

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

1 Sponsorship. This act consists of the following proposed legislation:

Part I. LSR 21-0407, relative to direct primary care referral parity, sponsored by Sen. Hennessey, Prime/Dist 1; Sen. Sherman, Dist 24; Rep. Umberger, Carr 2; Rep. Marsh, Carr 8; and Rep. Woods, Merr 23.

Part II. LSR 21-1017, relative to in-network retail pharmacies, sponsored by Sen. Hennessey, Prime/Dist 1; Sen. Rosenwald, Dist 13; Sen. Soucy, Dist 18; and Rep. Merchant, Sull 4.

2 Legislation Enacted. The general court hereby enacts the following legislation:

PART I

Relative to direct primary care referral parity.

1 New Section; Primary Care Referral Parity. Amend RSA 420-J by inserting after section 6-e the following new section:

420-J:6-f Referrals and Orders from Direct Primary Care Providers. A health benefit plan under this chapter shall not deny or reduce payment for any health care service covered under an enrollee's health plan based solely on the basis that the enrollee's referral was made by a direct primary care provider fully compliant with the provisions of RSA 329:1-e who is not a member of the carrier's provider network, provided it would have covered the same services if ordered by an in-network provider, subject to the following limitations:

I. No payment shall be made to the direct primary care provider for primary care services covered by the direct primary care agreement pursuant to RSA 329:1-e, II(f).

II. An insurer shall not apply a deductible, coinsurance, or copayment greater than the applicable deductible, coinsurance, or copayment that would apply to the same health care service if the service was referred or ordered by an in-network participating primary care provider.

III. An insurer may require the direct primary care provider to file a written attestation or a copy of the direct primary care agreement to demonstrate that the provider is a direct primary care provider.

IV. Payments made may be subject to utilization review by the insurer, if they would have been subject to such review if ordered by an in-network provider.

V. The covered person shall retain the right to choose direct primary care on an elective, self-pay basis; no entity regulated under this chapter shall prohibit a direct primary care provider from continuing care on an elective, self-pay basis.

VI. Direct primary care providers shall not be required to contract as participating providers in any network.

2 Effective Date. Part I of this act shall take effect January 1, 2022.

PART II

Relative to in-network retail pharmacies.

1 New Section; Pharmacy Benefits Managers; Prohibited Acts. Amend RSA 402-N by inserting after section 4 the following new section:

402-N:4-a Prohibited Acts. A pharmacy benefit manager shall not, either directly or indirectly:

I. Prohibit an in-network retail pharmacy from:

(a) Mailing or delivering a prescription drug to an enrollee as a service of the in-network retail pharmacy.

(b) Charging a shipping or handling fee to an enrollee who requests that the in-network retail pharmacy mail or deliver a prescription drug to the enrollee.

(c) Offering the services described in subparagraph I(a) to an enrollee.

II. Charge an enrollee who uses an in-network retail pharmacy that offers to mail or deliver a prescription drug to an enrollee a fee or copayment that is higher than the fee or copayment the enrollee would pay if the enrollee used an in-network retail pharmacy that does not offer to mail or deliver a prescription drug to an enrollee.

2 Effective Date. Part II of this act shall take effect 60 days after its passage.

02/18/2021 0326s

2021 SESSION

21-0407
08/06

SENATE BILL ***97***

AN ACT adopting omnibus legislation relative to health insurance.

SPONSORS: Sen. Hennessey, Dist 1

COMMITTEE: Health and Human Services

ANALYSIS

This bill adopts legislation:

I. Relative to direct primary care referral parity.

II. Relative to in-network retail pharmacies.

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STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Twenty One

AN ACT adopting omnibus legislation relative to health insurance.

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

1 Sponsorship. This act consists of the following proposed legislation:

Part I. LSR 21-0407, relative to direct primary care referral parity, sponsored by Sen. Hennessey, Prime/Dist 1; Sen. Sherman, Dist 24; Rep. Umberger, Carr 2; Rep. Marsh, Carr 8; and Rep. Woods, Merr 23.

Part II. LSR 21-1017, relative to in-network retail pharmacies, sponsored by Sen. Hennessey, Prime/Dist 1; Sen. Rosenwald, Dist 13; Sen. Soucy, Dist 18; and Rep. Merchant, Sull 4.

2 Legislation Enacted. The general court hereby enacts the following legislation:

PART I

Relative to direct primary care referral parity.

1 New Section; Primary Care Referral Parity. Amend RSA 420-J by inserting after section 6-e the following new section:

420-J:6-f Referrals and Orders from Certified Direct Primary Care Providers. The department shall review direct primary care agreements submitted by direct primary care providers and shall certify the first 10 which it determines to be fully compliant with the provisions of RSA 329:1-e. A health benefit plan under this chapter shall not deny or reduce payment for any health care service covered under an enrollee's health plan based solely on the basis that the enrollee's referral was made by a certified direct primary care provider who is not a member of the carrier's provider network, provided it would have covered the same services if ordered by an in-network provider, subject to the following limitations:

I. No payment shall be made to the certified direct primary care provider for primary care services covered by the direct primary care agreement pursuant to RSA 329:1-e, II(f).

II. An insurer shall not apply a deductible, coinsurance, or copayment greater than the applicable deductible, coinsurance, or copayment that would apply to the same health care service if the service was referred or ordered by an in-network participating primary care provider.

III. An insurer may require the direct primary care provider to file a written attestation or a copy of the certified direct primary care agreement to demonstrate that the provider is a direct primary care provider.

IV. Health care services may be subject to utilization review by the insurer.

V. The covered person shall retain the right to choose direct primary care on an elective, self-pay basis; no entity regulated under this chapter shall prohibit a certified direct primary care provider from continuing care on an elective, self-pay basis.

VI. Direct primary care providers shall not be required to contract as participating providers in any network.

VII. On or before October 1, 2025, the insurance department shall report to the joint legislative oversight committee on health and human services, established in RSA 126-A:13, relative to any change in expenses to insurers and any resultant changes in insurance rates attributable to this section, as well as any other impacts of direct primary care on the insurance market or health care coverage.

2 Repeal. RSA 420-J:6-f, relative to referrals and orders from certified direct primary care providers, is repealed.

3 Effective Date.

I. Section 2 of this act shall take effect January 1, 2027.

II. The remainder of this act shall take effect January 1, 2022.

PART II

Relative to in-network retail pharmacies.

1 New Section; Pharmacy Benefits Managers; Prohibited Acts. Amend RSA 402-N by inserting after section 4 the following new section:

402-N:4-a Prohibited Acts. A pharmacy benefit manager shall not, either directly or indirectly:

I. Prohibit an in-network retail pharmacy from:

(a) Mailing or delivering a prescription drug to an enrollee as an ancillary service of the in-network retail pharmacy provided that confirmation of delivery is obtained.

(b) Charging a shipping or handling surcharge to an enrollee who requests that the in-network retail pharmacy mail or deliver a prescription drug to the enrollee as an ancillary service provided the enrollee receives a disclosure from the in-network retail pharmacy regarding any surcharge to be charged to the patient for the delivery of a prescription drug, including that the surcharge may not be reimbursable by the plan sponsor or pharmacy benefit manager.

(c) Offering the ancillary services described in subparagraph I(a) to an enrollee.

II. Charge an enrollee who uses an in-network retail pharmacy that offers to mail or deliver a prescription drug to an enrollee as an ancillary service a surcharge for the delivery of a prescription drug or copayment that is higher than the surcharge or copayment the enrollee would pay if the enrollee used an in-network retail pharmacy that does not offer to mail or deliver a prescription drug to an enrollee as an ancillary service.

III. For purposes of this section, a retail pharmacy shall not include a "mail-order pharmacy" as defined in RSA 318:1, VII-b.

2 Effective Date. Part II of this act shall take effect 60 days after its passage.

SB 97 - AS AMENDED BY THE HOUSE

02/18/2021 0326s
3Jun2021... 1606h

2021 SESSION

21-0407
08/06

SENATE BILL **97**

AN ACT relative to in-network retail pharmacies.

SPONSORS: Sen. Hennessey, Dist 1

COMMITTEE: Health and Human Services

AMENDED ANALYSIS

This bill prohibits certain acts relative to pharmacy benefits managers.

This bill also prohibits certain acts relative to health carriers and in-network retail pharmacies.

- -

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 One

AN ACT relative to in-network retail pharmacies.

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

1 New Section; Pharmacy Benefits Managers; Prohibited Acts. Amend RSA 402-N by inserting after section 4 the following new section:

402-N:4-a Prohibited Acts. A pharmacy benefit manager shall not, either directly or indirectly:

I. Prohibit an in-network retail pharmacy from:

(a) Mailing or delivering a prescription drug to an enrollee as an ancillary service of the in-network retail pharmacy provided that confirmation of delivery is obtained.

(b) Charging a shipping or handling surcharge to an enrollee who requests that the in-network retail pharmacy mail or deliver a prescription drug to the enrollee as an ancillary service provided the enrollee receives a disclosure from the in-network retail pharmacy regarding any surcharge to be charged to the patient for the delivery of a prescription drug, including that the surcharge may not be reimbursable by the plan sponsor or pharmacy benefit manager.

(c) Offering the ancillary services described in subparagraph I(a) to an enrollee.

II. Charge an enrollee who uses an in-network retail pharmacy that offers to mail or deliver a prescription drug to an enrollee as an ancillary service a surcharge for the delivery of a prescription drug or copayment that is higher than the surcharge or copayment the enrollee would pay if the enrollee used an in-network retail pharmacy that does not offer to mail or deliver a prescription drug to an enrollee as an ancillary service.

III. For purposes of this section, a retail pharmacy shall not include a "mail-order pharmacy" as defined in RSA 318:1, VII-b.

2 New Section; Health Carriers; Prohibited Acts. Amend RSA 420-J:7-b by inserting after paragraph XI the following new paragraph:

XII. A health carrier shall not, either directly or indirectly:

(a) Prohibit an in-network retail pharmacy from:

(1) Mailing or delivering a prescription drug to an enrollee as an ancillary service of the in-network retail pharmacy provided that confirmation of delivery is obtained.

(2) Charging a shipping or handling surcharge to an enrollee who requests that the in-network retail pharmacy mail or deliver a prescription drug to the enrollee as an ancillary service provided the enrollee receives a disclosure from the in-network retail pharmacy regarding any surcharge to be charged to the patient for the delivery of a prescription drug, including that the surcharge may not be reimbursable by the plan sponsor or health carrier.

(3) Offering the ancillary services described in subparagraph I(a) to an enrollee.

(b) Charge an enrollee who uses an in-network retail pharmacy that offers to mail or deliver a prescription drug to an enrollee as an ancillary service a surcharge for the delivery of a prescription drug or copayment that is higher than the surcharge or copayment the enrollee would pay if the enrollee used an in-network retail pharmacy that does not offer to mail or deliver a prescription drug to an enrollee as an ancillary service.

(c) For purposes of this section, a retail pharmacy shall not include a "mail-order pharmacy" as defined in RSA 318:1, VII-b.

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

CHAPTER 149
SB 97 - FINAL VERSION

02/18/2021 0326s
3Jun2021... 1606h

2021 SESSION

21-0407
08/06

SENATE BILL ***97***

AN ACT relative to in-network retail pharmacies.

SPONSORS: Sen. Hennessey, Dist 1

COMMITTEE: Health and Human Services

AMENDED ANALYSIS

This bill prohibits certain acts relative to pharmacy benefits managers.

This bill also prohibits certain acts relative to health carriers and in-network retail pharmacies.

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Explanation: Matter added to current law appears in ***bold italics.***
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CHAPTER 149
SB 97 - FINAL VERSION

02/18/2021 0326s
3Jun2021... 1606h

21-0407
08/06

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Twenty One

AN ACT relative to in-network retail pharmacies.

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

149:1 New Section; Pharmacy Benefits Managers; Prohibited Acts. Amend RSA 402-N by inserting after section 4 the following new section:

402-N:4-a Prohibited Acts. A pharmacy benefit manager shall not, either directly or indirectly:

I. Prohibit an in-network retail pharmacy from:

(a) Mailing or delivering a prescription drug to an enrollee as an ancillary service of the in-network retail pharmacy provided that confirmation of delivery is obtained.

(b) Charging a shipping or handling surcharge to an enrollee who requests that the in-network retail pharmacy mail or deliver a prescription drug to the enrollee as an ancillary service provided the enrollee receives a disclosure from the in-network retail pharmacy regarding any surcharge to be charged to the patient for the delivery of a prescription drug, including that the surcharge may not be reimbursable by the plan sponsor or pharmacy benefit manager.

(c) Offering the ancillary services described in subparagraph I(a) to an enrollee.

II. Charge an enrollee who uses an in-network retail pharmacy that offers to mail or deliver a prescription drug to an enrollee as an ancillary service a surcharge for the delivery of a prescription drug or copayment that is higher than the surcharge or copayment the enrollee would pay if the enrollee used an in-network retail pharmacy that does not offer to mail or deliver a prescription drug to an enrollee as an ancillary service.

III. For purposes of this section, a retail pharmacy shall not include a "mail-order pharmacy" as defined in RSA 318:1, VII-b.

149:2 New Section; Health Carriers; Prohibited Acts. Amend RSA 420-J:7-b by inserting after paragraph XI the following new paragraph:

XII. A health carrier shall not, either directly or indirectly:

(a) Prohibit an in-network retail pharmacy from:

(1) Mailing or delivering a prescription drug to an enrollee as an ancillary service of the in-network retail pharmacy provided that confirmation of delivery is obtained.

(2) Charging a shipping or handling surcharge to an enrollee who requests that the in-network retail pharmacy mail or deliver a prescription drug to the enrollee as an ancillary service provided the enrollee receives a disclosure from the in-network retail pharmacy regarding any

surcharge to be charged to the patient for the delivery of a prescription drug, including that the surcharge may not be reimbursable by the plan sponsor or health carrier.

(3) Offering the ancillary services described in subparagraph I(a) to an enrollee.

(b) Charge an enrollee who uses an in-network retail pharmacy that offers to mail or deliver a prescription drug to an enrollee as an ancillary service a surcharge for the delivery of a prescription drug or copayment that is higher than the surcharge or copayment the enrollee would pay if the enrollee used an in-network retail pharmacy that does not offer to mail or deliver a prescription drug to an enrollee as an ancillary service.

(c) For purposes of this section, a retail pharmacy shall not include a "mail-order pharmacy" as defined in RSA 318:1, VII-b.

149:3 Effective Date. This act shall take effect 60 days after its passage.

Approved: July 23, 2021
Effective Date: September 21, 2021

Amendments

Sen. Bradley, Dist 3
February 10, 2021
2021-0303s
08/06

Amendment to SB 97

Amend part I of the bill by replacing it with the following:

1 New Section; Primary Care Referral Parity. Amend RSA 420-J by inserting after section 6-e the following new section:

420-J:6-f Referrals and Orders from Certified Direct Primary Care Providers. The department shall review direct primary care agreements submitted by direct primary care providers and shall certify the first 10 which it determines to be fully compliant with the provisions of RSA 329:1-e. A health benefit plan under this chapter shall not deny or reduce payment for any health care service covered under an enrollee's health plan based solely on the basis that the enrollee's referral was made by a certified direct primary care provider who is not a member of the carrier's provider network, provided it would have covered the same services if ordered by an in-network provider, subject to the following limitations:

I. No payment shall be made to the certified direct primary care provider for primary care services covered by the direct primary care agreement pursuant to RSA 329:1-e, II(f).

II. An insurer shall not apply a deductible, coinsurance, or copayment greater than the applicable deductible, coinsurance, or copayment that would apply to the same health care service if the service was referred or ordered by an in-network participating primary care provider.

III. An insurer may require the direct primary care provider to file a written attestation or a copy of the certified direct primary care agreement to demonstrate that the provider is a direct primary care provider.

IV. Health care services may be subject to utilization review by the insurer.

V. The covered person shall retain the right to choose direct primary care on an elective, self-pay basis; no entity regulated under this chapter shall prohibit a certified direct primary care provider from continuing care on an elective, self-pay basis.

VI. Direct primary care providers shall not be required to contract as participating providers in any network.

VII. On or before October 1, 2025, the insurance department shall report to the joint legislative oversight committee on health and human services, established in RSA 126-A:13, relative to any change in expenses to insurers and any resultant changes in insurance rates attributable to this section, as well as any other impacts of direct primary care on the insurance market or health care coverage.

2 Repeal. RSA 420-J:6-f, relative to referrals and orders from certified direct primary care providers, is repealed.

3 Effective Date.

I. Section 2 of this act shall take effect January 1, 2027.

II. The remainder of this act shall take effect January 1, 2022.

Amend Part II of the bill by replacing section 1 with the following:

1 New Section; Pharmacy Benefits Managers; Prohibited Acts. Amend RSA 402-N by inserting after section 4 the following new section:

402-N:4-a Prohibited Acts. A pharmacy benefit manager shall not, either directly or indirectly:

I. Prohibit an in-network retail pharmacy from:

(a) Mailing or delivering a prescription drug to an enrollee as an ancillary service of the in-network retail pharmacy provided that confirmation of delivery is obtained.

(b) Charging a shipping or handling surcharge to an enrollee who requests that the in-network retail pharmacy mail or deliver a prescription drug to the enrollee as an ancillary service provided the enrollee receives a disclosure from the in-network retail pharmacy regarding any surcharge to be charged to the patient for the delivery of a prescription drug, including that the surcharge may not be reimbursable by the plan sponsor or pharmacy benefit manager.

(c) Offering the ancillary services described in subparagraph I(a) to an enrollee.

II. Charge an enrollee who uses an in-network retail pharmacy that offers to mail or deliver a prescription drug to an enrollee as an ancillary service a surcharge for the delivery of a prescription drug or copayment that is higher than the surcharge or copayment the enrollee would pay if the enrollee used an in-network retail pharmacy that does not offer to mail or deliver a prescription drug to an enrollee as an ancillary service.

III. For purposes of this section, a retail pharmacy shall not include a "mail-order pharmacy" as defined in RSA 318:1, VII-b.

Health and Human Services
February 11, 2021
2021-0326s
08/06

Amendment to SB 97

Amend part I of the bill by replacing it with the following:

1 New Section; Primary Care Referral Parity. Amend RSA 420-J by inserting after section 6-e the following new section:

420-J:6-f Referrals and Orders from Certified Direct Primary Care Providers. The department shall review direct primary care agreements submitted by direct primary care providers and shall certify the first 10 which it determines to be fully compliant with the provisions of RSA 329:1-e. A health benefit plan under this chapter shall not deny or reduce payment for any health care service covered under an enrollee's health plan based solely on the basis that the enrollee's referral was made by a certified direct primary care provider who is not a member of the carrier's provider network, provided it would have covered the same services if ordered by an in-network provider, subject to the following limitations:

I. No payment shall be made to the certified direct primary care provider for primary care services covered by the direct primary care agreement pursuant to RSA 329:1-e, II(f).

II. An insurer shall not apply a deductible, coinsurance, or copayment greater than the applicable deductible, coinsurance, or copayment that would apply to the same health care service if the service was referred or ordered by an in-network participating primary care provider.

III. An insurer may require the direct primary care provider to file a written attestation or a copy of the certified direct primary care agreement to demonstrate that the provider is a direct primary care provider.

IV. Health care services may be subject to utilization review by the insurer.

V. The covered person shall retain the right to choose direct primary care on an elective, self-pay basis; no entity regulated under this chapter shall prohibit a certified direct primary care provider from continuing care on an elective, self-pay basis.

VI. Direct primary care providers shall not be required to contract as participating providers in any network.

VII. On or before October 1, 2025, the insurance department shall report to the joint legislative oversight committee on health and human services, established in RSA 126-A:13, relative to any change in expenses to insurers and any resultant changes in insurance rates attributable to this section, as well as any other impacts of direct primary care on the insurance market or health care coverage.

2 Repeal. RSA 420-J:6-f, relative to referrals and orders from certified direct primary care providers, is repealed.

3 Effective Date.

I. Section 2 of this act shall take effect January 1, 2027.

II. The remainder of this act shall take effect January 1, 2022.

Amend Part II of the bill by replacing section 1 with the following:

1 New Section; Pharmacy Benefits Managers; Prohibited Acts. Amend RSA 402-N by inserting after section 4 the following new section:

402-N:4-a Prohibited Acts. A pharmacy benefit manager shall not, either directly or indirectly:

I. Prohibit an in-network retail pharmacy from:

(a) Mailing or delivering a prescription drug to an enrollee as an ancillary service of the in-network retail pharmacy provided that confirmation of delivery is obtained.

(b) Charging a shipping or handling surcharge to an enrollee who requests that the in-network retail pharmacy mail or deliver a prescription drug to the enrollee as an ancillary service provided the enrollee receives a disclosure from the in-network retail pharmacy regarding any surcharge to be charged to the patient for the delivery of a prescription drug, including that the surcharge may not be reimbursable by the plan sponsor or pharmacy benefit manager.

(c) Offering the ancillary services described in subparagraph I(a) to an enrollee.

II. Charge an enrollee who uses an in-network retail pharmacy that offers to mail or deliver a prescription drug to an enrollee as an ancillary service a surcharge for the delivery of a prescription drug or copayment that is higher than the surcharge or copayment the enrollee would pay if the enrollee used an in-network retail pharmacy that does not offer to mail or deliver a prescription drug to an enrollee as an ancillary service.

III. For purposes of this section, a retail pharmacy shall not include a "mail-order pharmacy" as defined in RSA 318:1, VII-b.

Committee Minutes

SENATE CALENDAR NOTICE
Health and Human Services

Sen Jeb Bradley, Chair
Sen James Gray, Vice Chair
Sen Kevin Avard, Member
Sen Tom Sherman, Member
Sen Rebecca Whitley, Member

Date: January 28, 2021

HEARINGS

Wednesday	02/03/2021
(Day)	(Date)

Health and Human Services	REMOTE 000	9:00 a.m.
(Name of Committee)	(Place)	(Time)

9:00 a.m.	**SB 98-FN**	relative to the SNAP incentive program.
9:15 a.m.	**SB 97**	adopting omnibus legislation relative to health insurance.

Committee members will receive secure Zoom invitations via email.

Members of the public may attend using the following links:

1. Link to Zoom Webinar: https://www.zoom.us/j/99175018421
2. To listen via telephone: Dial(for higher quality, dial a number based on your current location): 1-301-715-8592, or 1-312-626-6799 or 1-929-205-6099, or 1-253-215-8782, or 1-346-248-7799, or 1-669-900-6833
3. Or iPhone one-tap: US: +13126266799,,99175018421# or +16465588656,,99175018421#
4. Webinar ID: 991 7501 8421
5. To view/listen to this hearing on YouTube, use this link: https://www.youtube.com/channel/UCjBZdtrjRnQdmg-2MPMiWrA
6. To sign in to speak, register your position on a bill and/or submit testimony, use this link: http://gencourt.state.nh.us/remotecommittee/senate.aspx

The following email will be monitored throughout the meeting by someone who can assist with and alert the committee to any technical issues: remotesenate@leg.state.nh.us or call (603-271-6931).

EXECUTIVE SESSION MAY FOLLOW

Sponsors:

SB 98-FN

Sen. Whitley, Sen. Perkins Kwoka, Sen. Sherman, Sen. Rosenwald
Sen. Hennessey, Sen. Prentiss, Rep. Marsh, Rep. McWilliams
Rep. Walz

SB 97

Sen. Hennessey

Griffin Roberge 271-3042

Jeb Bradley
Chairman

Senate Health and Human Services Committee

Kirsten Koch 271-3266

SB 97, adopting omnibus legislation relative to health insurance.

Hearing Date: February 3, 2021

Time Opened: 9:55 a.m. **Time Closed:** 11:22 a.m.

Members of the Committee Present: Senators Bradley, Gray, Avard, Sherman and Whitley

Members of the Committee Absent : None

Bill Analysis: This bill adopts legislation:

I. Relative to direct primary care referral parity.

II. Relative to in-network retail pharmacies.

Sponsors:
Sen. Hennessey

Who supports the bill: Senator Hennessey, District 1; Rep. Marsh, Carr 8; Rep. Pederson, Hills 32; Rep. Mangipudi, Hills 32; Richard Cohen, NH Pharmacists Association; Eric Kropp, NH Medical Society; David Rochefort, NH Independent Pharmacy Association; Rick Newman, NH Independent Pharmacy Association; Kim Mohan, NH Nurse Practitioner Association; Samuel McCreedy, MD.

Who opposes the bill: Heidi Kroll, America's Health Insurance Plans (AHIP); Lindsay Nadeau, Cigna; Curtis Barry, Pharmaceutical Care Management Association; Andrew Hosmer, Harvard Pilgrim Healthcare.

Who is neutral on the bill: Tyler Brannen, NH Insurance Department; Sabrina Dunlap, Anthem.

Summary of testimony presented in support:

Senator Hennessey

NH Senate District 1

- Part I of this bill details that a health benefit plan under this chapter shall not deny or reduce payment for any health care service covered under an enrollee's health plan based solely on the basis that the enrollee's referral was made by a direct primary care provider, rather than an in-network primary care provider.
  - This change simplifies the system and removes costs.

- Part II of this bill details in-network retail pharmacies, specifically that pharmacy benefit managers (PBM) shall not prohibit in-network retail pharmacies from mailing or delivering prescription drugs to enrollees of the service.
    - COVID-19 has caused a need for individuals to shop in new ways, especially for those, such as the elderly or at-risk populations, who are not comfortable leaving their home and shopping at a store.

Representative William Marsh

Carrol 8

- Rep. Marsh will be speaking on Part I of SB 97.
- Direct primary care (DPC) is not insurance and people who utilize DPC should still utilize their insurance as DPC cannot address every medical need. The referrals made by direct primary care providers (DPCP) are not usually covered by insurance because the provider is out-of-network. For referrals the patient must then see a second doctor. This brings up health care costs.
- The state of Maine addressed this already in 2019 with SB 372 and in NH we want to use language similar to Maine. This way NH DPCPs are fully compliant with RSA 329(1)(e) and no longer at a competitive disadvantage.
- Rep. Marsh said he supports Part II, but he will not speak on it.
- Senator Sherman said, we have seen a practice of large hospital systems of requiring orders that have to come from one of their physicians. This issue is even broader than DPC. This clobbers independent practice care. Does this bill address that at all?
    - Rep. Marsh said, there are many barriers to independent practice. You are correct that one of the barriers is institutions that only allow for employees to utilize their resources. That will be an anti-competitive problem. On the other hand, this bill address insurers; it does not mandate that hospitals make use of other physicians. Please do not use this bill as a vehicle for that as there would be considerable push back.
- Senator Sherman said, I promise I will not do that. Will DPCP run into that same snafu even with this change?
    - Rep. Marsh said, certainly. Any physician ordering tests to another hospital will run into this issue. This is a very complex problem that will continue to happen.

Richard Cohen – submitted written testimony

NH Pharmacists Association

- Mr. Cohen is a retired NH pharmacist.
- Independent pharmacies in New Hampshire have long sought a level playing field when entering into agreements with Pharmacy Benefit Managers (PBM). The major PBM players all have a mail order segment to their operation and, according to their contracts, have prohibited pharmacies from mailing or delivering prescriptions to their clients. Why? Because by doing so they can then control, retain, or increase their patient market share.
- SB 97 will create a level playing field with respect to this matter. It will protect in-network pharmacies from being penalized by being charged additional or erroneous fees for the actions listed in the bill.

- Most importantly, it will protect the consumer who is enrolled in a network managed by a PBM from being penalized or assessed additional charges or co-payments for utilizing the local services of their neighborhood pharmacy.

Samuel McCreedy, MD – submitted written testimony

Gorham, NH

- Dr. McCreedy said he is a family physician in NH.
- Dr. McCreedy said, as things currently stand in New Hampshire, options for health insurance coverage are quite limited for many residents. For many, their choice depends upon whatever plan is offered by their employer. There are no Preferred Provider Organization ("PPO") plans or other types of plans listed for New Hampshire residents to choose from. For many residents who might wish to establish care with a Direct Primary Care ("DPC") doctor but find themselves receiving insurance coverage through an HMO plan, this situation presents a significant barrier to care creating unnecessary burdens in terms of time and expense.
- Typically, HMO plans require orders for items such as referrals to specialists, diagnostic testing, ancillary services, etc., to originate from an in-network provider to receive coverage. However, by definition, DPC doctors do not typically participate in insurance networks. As such, if a patient is enrolled in an HMO plan (frequently without any real choice in that matter, as discussed above), they are effectively penalized if they choose to receive their care from a DPC doctor.
- Dr. McCreedy shared an anecdote about launching his own, private Direct Primary Care practice. He then said, it seems ludicrous to me that, as a physician holding board certification with the American Board of Family Medicine, and entrusted by the State of New Hampshire with a full and unrestricted license to practice medicine, if and when I do make such an order, rather than simply scheduling an appointment for the care they need, my patient will first need to schedule an additional appointment with an in-network provider, (very possibly a provider who, until less than a year ago I was supervising), in the hopes of having my order re-issued.
- This effectively forces patients enrolled in HMOs who wish to have a DPC doctor as their Primary Care Provider ("PCP") to decide the following: either forgo their first choice of having a DPC doctor as their PCP or maintain a secondary in-network "pseudo-PCP" simply to re-issue orders already issued by their true PCP. This, clearly, is silly and wasteful.
- Taking inspiration from similar legislation passed recently by our neighbors in Maine, SB 97 seeks to improve upon this situation by simply requiring insurance companies to honor orders originating from DPC doctors in the same way they do from in-network providers. It allows NH residents to choose their care from the doctor they trust, without having to sacrifice insurance coverage (which they have paid for) for services ordered by their doctor if that doctor happens to be a DPC doctor. This bill does not in any way require the insurance companies to cover any services provided by DPC doctors nor any services provided by any other out-of-network provider. Nor does it require insurance companies to give any special treatment to DPC doctors, such as forgoing normal Utilization Review procedures or requiring copays and deductible from patients if those same requirements would otherwise apply to orders from an in-network doctor.

- Ultimately, this legislation will help remove an unnecessary burden on patients in New Hampshire, and frankly, it appears to me that it would serve to lower costs for the insurance companies as well by decreasing their need to pay for unnecessary extra appointments with in-network providers.
- Senator Avard asked, years ago when the HMOs were introduced, they were supposed to be a way for saving costs but one of the down sides to that appears as though the independent physicians have become "like a dinosaur;" how does this bill help you as an independent physician?
  - Mr. McCreedy said, it allows patients to have greater access to see me as their provider. I have been severed from all my patients because of insurance, this bill would correct that. It is inconvenient for patients to have to change providers and it is dangerous because their new providers do not know them well. HMOs require a referral, other insurances do not.
  - The only potential benefit to the current system accrues to those who might have a financial interest in controlling the system (e.g. hospitals only allowing referrals for services from their own employees).
  - This bill eliminates a redundant second appointment for the patient just to get a referral service covered by insurance. If anything, this bill has the potential to save insurance companies money.

Eric Kropp, MD – submitted written testimony

NH Medical Society

- Dr. Kropp said he is a family physician.
- This bill preserves a patient's freedom to choose their provider.
- DPCP should have the authority to treat patients as needed and patients should be covered by their insurance when they need it most.
- Dr. Kropp stated that the problem for the majority of new patients who are interested in his Direct Primary Care end up turning away because of the insurance issue.
- Insurance is saved for advanced consultation, surgeries, etc.
- Medicare, PPO, no referrals plans, and Medicaid have mechanisms where DPCPs can practice to the full extent of their license and make referrals, however, other plans (e.g. HMOs) do not. In those networks, such as HMOs, benefits can be denied, specialist will not get paid, and the patient can be stuck paying the bill.
- SB 97 creates equal opportunity for patients who want to choose their provider. There is currently discrimination against patients who cannot choose or afford these other types of insurance plans.
- These referrals are medically appropriate. This bill instructs plans that insurance carriers should apply the patient's benefits the same way, whether the referrals come from a contracted PCP or a DPCP.

David Rochefort

NH Independent Pharmacy Association

- Mr. Rochefort said he is the owner and chief pharmacist of Eastern States Pharmacy. He is here to comment on Part II of SB 97.

- PBMs are who independent pharmacies contract with to provide local services. PBMs often own their own mail-order pharmacies. It is common in PBM contracts to prohibit pharmacies from mail-orders. These contracts are self-veiling, but pharmacies accept them because they have to.
- COVID-19 brings about situational barriers for people coming into pharmacies to get their prescriptions. So, even now with COVID, if a pharmacy does mail out a prescription to a customer, there are in jeopardy of having audits or their contract canceled with the PBM.
- Mr. R. said he has heard Utah and Arizona have something similar to this bill.
- The point of this bill is not to turn retail pharmacies into mail-order pharmacies. It is to ensure that retail pharmacies do not get classified as mail-order pharmacies when they go out of their way to ship medications to customers who want to continue their care when they cannot come to the store.
- Senator Sherman referenced Mr. Brannen's testimony about statute definitions and then said, we may need to make a change in two areas of the statute, would you be open to allowing an amendment if appropriate?
    - Mr. R. said, our members are looking to eliminate the uncertainty that comes in the contracts with the PBMs and that they just want to serve their customers.
- Senator Bradley asked Mr. Brannen to cite the relevant statute here and send it to the committee later.

Summary of testimony presented in opposition:

Heidi Kroll

America's Health Insurance Plans (AHIP)

- AHIP is opposed to Part I of SB 97. This bill is trying to give out of network providers the same benefits as being in network.
- This type of legislation only exists in Maine and no other states.
- AHIP is concerned there would be unintended consequences for passing this bill. Part I undermines the insurance carriers' ability to build and maintain networks, specifically for primary care. Providers that join networks agree to price concessions with the carrier and referring to other in-network specialists. The concern is there would no longer be agreements regarding price concessions because there would no longer be any benefit to being an in-network provider. This may cause problems with patient care with both providers in and out of network. DPC is only a choice for consumers that can pay out of pocket directly to the physician. This choice for some could drive up the cost for everybody else.
- Senator Gray said, there must be an alternative. What if there was a review board? Or some other mechanism other than the patient going to have another appointment with another doctor, from what it sounds like drives up the cost. Whereas maybe a review board could look at the diagnostic evidence from the DPC. Are you guys willing to look at any alternative to find some middle ground?
    - Ms. Kroll answered, I will go back to the folks at AHIP. I have not heard that, but I do not have an answer at this time.

- Senator Avard asked, you mentioned it may erode networks? Is competition a bad thing in this prospective? It seems competition would lower prices.
    - Ms. Knoll said, there is a balance between a very narrow network, with a very limited number of providers, that really does lower costs. There are network adequacy requirements to ensure people do that adequate choice within the network, so there is competition in the network. If they cannot get the care they need in-network, they can go out of network.
- Senator Sherman said, that is an interesting dilemma you brought up. These people with private insurance and have chosen to go to a DPCP, of which there only six in the state, are saving you (the carrier) money because they are paying for their primary care themselves. And then you say they must see your practitioners, which would cost you. So, your objection to this is driving patients to have redundant care at more cost to you? Are we not actually saving dollars for people on your insurance panel by going to a DPCP? I would think patients would have to receive a remarkable number of unnecessary tests to drive up your costs.
    - Ms. Knoll said, the issue is not that unnecessary procedures being ordered to drive up the costs. The issue is of the value of networks. As a provider, if you can get all the benefits of being in-network, while being out-of-network, and not having to give any price concessions—that is where the concern comes.
- Senator Sherman said, he does not understand that answer.
- Senator Bradley asked, why can the carrier not reimburse the DPCP at the in-network provider rate? Wouldn't that be a reasonable compromise that allows for patient choice?
    - Ms. Knoll said, I think that is not what the bill is about. Ms. Knoll goes on to explain that the carrier wants to protect their in-network providers benefits that come from being in an agreement with the insurance carrier.
- Senator Bradley asked, if I as a patient am paying for my DPCP, and then I am referred to an in-network PCP, how is that driving up prices if the patient was the one who paid for the appointment with the DPCP?
    - Ms. Knoll said, I agree that there is savings because the DPCP visit is paid for out-of-pocket.
    - The issue is over time, if PCPs say there is no point in joining a network, then the network gets eroded because there are no longer providers in-network making price concessions with the carrier. Providers will choose to leave/avoid networks because, without price concessions, they can charge more for their services.
- Senator Avard asked, if this puts pressure on the price concessions, isn't that the whole concept of competition? If they want to do better, then they have to lower the prices, so people stay in network. Are you saying this will erode price concessions in-network?
    - Ms. Knoll said, the carrier and providers enter negotiations. There is also credentialing; providers in-network must pass high standards of care and quality measures. The benefit to the provider for coming into the network is the opportunity to serve all the insurance companies' members. We need to balance the choice of those who can pay out-of-pocket for a DPCP with those cannot afford that and who are still using in-network providers.
- Senator Gray asked, if a DPCP says you need a procedure, and sends you off, if this has to do with price concessions, why doesn't it have to go through some sort of review that says,

'yes, this is something the patient really needs' and then you charge that patient a little more for that procedure. Doesn't that take care of the problem?

  - Ms. Knoll said she is not following but we do need to be careful that the carrier does not know anything about the DPCP or their credentials. There does need to be integrity around whether that referral is for medically necessary services.

- Senator Gray said, there would be a panel, board, or specialist that would review the order from the DPCP. Then you would also have extra funds because you did not pay for the DPCP visit.
  - Ms. Knoll said, I made a note of that to take back to AHIP. This only exists in Maine; this field is still being sorted out. We need to be careful not to erode the benefits of networks and the choices of others is not to the detriment of everybody else sticking with networks.
- Senator Sherman said, I wonder if the question of quality is uniformly applied to providers in your panels, or just for physicians outside of your networks. Wouldn't it make sense that you're saving money? You wouldn't be paying for your customers' primary care. Wouldn't it make sense for the carriers to put in place a mechanism to put an order in through the HMO, by just confirming the credentials of the DPCP? I wonder about the quality question you bring up.
  - Ms. Knoll said, I mentioned quality to remind folks the benefit of networks.

Curtis Barry – provided written testimony

Pharmaceutical Care Management Association (PCMA)

- Mr. Barry stated that he will specifically discuss Part II of SB 97.
- PCMA is the national trade association for the PBM industry.
- The primary role of the PBM is to reduce the cost prescription drug benefits to reduce the costs of employers that pay the premium. Saving money for the people that pay the premium saves cost for the customers.
- The language in Part II of SB 97 is exactly what is on the books for Utah. Mr. Barry said he included the full text of the Arizona provisions in his written testimony.
- Mr. Barry made three points:
  - (1) PCMA is not aware of any members that are restricting pharmacies from delivering via mail. This provision, Part II (1)(a), would allow for a de facto mail order pharmacy being treated as a retail pharmacy for reimbursement rate purposes. This would allow for higher reimbursement rates and the costs would go up. Because of this, we would look for similar language to Arizona's provision.
  - (2) There are not any provisions around confirming whether the patient has received the prescription package. There should be some method for the patient to confirm they received the prescription.
  - (3) In Part II(B) the issue is the statute would allow for the retail pharmacy to charge the patient while sending by mail. Again, here we want similar language to Arizona.
- Senator Bradley said Mr. Barry's three points are reasonable and he requested for Mr. Barry to work with Senator Hennessey on Part II of SB 97.

Neutral Information Presented:

Sabrina Dunlap

Director of Government Relations, Anthem

- Ms. Dunlap said, Anthem is unaware of any issues with the DPCP referral and questions the necessity of this bill.
- Ms. Dunlap referenced HB 290 and said it would take direct primary care out from certain licensing requirements.
- DPCP functions in its own realm; this often gets confusing for patients on what they are signing up for and what is covered. This gets to the bigger picture and underlying concept of DPCP, which is not what this bill is about, but it worthy of discussion going forward.
- Ms. Dunlap said she has the same concerns that Ms. Knoll mentioned.

Tyler Brannen

NH Insurance Department

- This is a complicated bill; the implications and what it could mean downstream, the more things come up.
- Mr. Brannen said, the way we end up with DPCP network is the direct result of an insurance consumer protection law, the law says that every in-network provider is prohibited form balance billing for beyond anything that is not regular cost sharing, such as your deductible, your co-pay, etc. So, a monthly membership fee would be a clear violation of the additional amount being billed beyond cost-sharing, so the system works best when providers are out of network, which then lends to the problem we have here.
- When we clarified that DPC models are not insurance, we moved oversight the Board of Medicine, which is not routinely involved in administrative matters.
- This legislation is quite disruptive from an administrative view. I am not sure how it would function in the future. There is no relationship between providers outside of the network because there is no relationship with carrier. Outside of network providers can be some of the most expensive providers, who then can make referrals to other more expensive, outside of network providers. This change could create inflationary pressures.
- Mr. Brannen returned to Senator Sherman's questions earlier and said, hospitals might put-out providers by denying their referrals, we actually have an insurance law that requires a PCP to give a referral outside of the system the PCP works with so, if the hospital employs a PCP, and the patient wants to a specialist outside of that, then the PCP has to give that option. You could have a provider contract that has to satisfy some more options for patients.
- There are potential downstream implications. There are credentialing requirements for providers on the books for carriers.
- Mr. Brannen said, I am not sure how legislation would address this issue. I believe this legislation leads to more questions than answers.
- Mr. Brannen then began discussion Part II of the bill. He said, RSA 402(n) defines a PBM that services multiple insurance companies. We regulate PBMs. New requirements would need to apply to both parts of the statute, otherwise a double standard will be created.

- Traditionally independent pharmacies use mail-order to sell lower cost drugs. This legislation could lead to higher prices and premiums paid.
- Carrier control and reduce costs by the use of prior authorization from a primary care provider, without that carries could be forced to require prior authorization on a whole new range of services as the only way to keep down costs, or even some form of independent review. This would be very inconvenient.
- Senator Whitley asked, could this bill be amended to extend to make sure these consumers protections to make sure these providers are covered under that?
  - Mr. Brannen said, the only way to do that would be on the physician licensing side of statutes. Remember that we get to the provider's behavior through insurance law.
- Senator Sherman said, I think you are painting a doomsday position. Don't federal statutes already exist to prevent the shenanigans you are worried about occurring in inappropriate referrals?
  - Mr. Brannen, generally federal laws would apply, for example to Medicare. This is why hospitals have an interest in influencing or acquiring so many primary care practices.
- Senator Sherman said, he is referring to anti-kick back federal statutes that involve serious punishments for physicians that make bad referrals. Insurance carriers have the capacity to track referrals in-network. If the patient does not want to pay out-of-pocket for an out-of-network provider, then wouldn't the patient have to stay in-network?
  - Mr. Brannen said, it has more to do with if the patient's care is being managed in a cost-effective way
- Senator Bradley said, is Maine the only other state to allow this?
  - Mr. Brannen said he is unsure but trusts Ms. Knoll as a source when she stated this.
- Senator Bradley asked if Mr. Brannen knew if this system has been working well in Maine?
  - Mr. Brannen did not have an answer at the time.

KNK
Date Hearing Report completed: February 5, 2021

Speakers

Name	Title	Representing	Position	Testifing
Marsh William	An Elected Official	Carroll 8	Support	Yes
Cohen Richard	A Member of the Public	The New Hampshire Pharmacists Association	Support	Yes
McCreedy Samuel	A Member of the Public	Myself	Support	Yes
Kropp Eric	A Member of the Public	New Hampshire Medical Society	Support	Yes
Kroll Heidi	A Lobbyist	America's Health Insurance Plans (AHIP)	Oppose	Yes
Rochefort David	A Member of the Public	NH Independent Pharmacy Association	Support	Yes
Hennessey Erin	An Elected Official	SD1	Support	Yes
Brannen Tyler	State Agency Staff	Insurance Department	Neutral	Yes
Barry Curtis	A Lobbyist	Pharmaceutical Care Management Association	Oppose	Yes
Dunlap Sabrina	A Lobbyist	Anthem	Neutral	Yes
Nadeau Lindsay	A Lobbyist	Cigna	Oppose	No
Newman Rick	A Lobbyist	NH Independent Pharmacy Association	Support	No
Mangipudi Latha	An Elected Official	Hills 35	Support	No
Hosmer Andrew	A Lobbyist	Harvard Pilgrim Health Care	Oppose	No
Pedersen Michael	An Elected Official	Hillsborough 32	Support	No
Mohan Kim	A Member of the Public	New Hampshire Nurse Practitioner Association	Support	No

Testimony

PCMA

February 3, 2021

The Honorable Chair Jeb Bradley
Senate Health and Human Services Committee
New Hampshire State Capitol
Concord, NH 03301

RE: SB 97 – An act adopting omnibus legislation relative to health insurance.

Dear Health and Human Services Committee:

On behalf of the Pharmaceutical Care Management Association (PCMA), I am writing you to oppose SB 97, an act adopting omnibus legislation relative to health insurance. PCMA is the national trade association representing pharmacy benefit managers (PBMs), which administer prescription drug plans for millions of Americans with health coverage provided through large and small employers, health plans, labor unions, state and federal employee-benefit plans, and government programs.

PCMA is not aware of any activity that would fall under any of these prohibited acts outlined in the language of SB 97, thus we are unsure of the necessity and urgency of this proposal. PCMA member companies do not restrict nor are we opposed to in-network retail pharmacies offering limited mail or delivery, many have for years. PCMA's comments on specific provisions are as follows:

In Arizona, a law was passed that addresses similar issues that PCMA would instead like to see in this language. Part II, I (a) - The unrestricted nature of this language essentially allows a retail pharmacy to become a mail-order pharmacy while still receiving reimbursement at retail pharmacy rates. This, as an example, the Arizona language uses the term "limited" when referring to a retail pharmacy offering mail delivery, as follows (the full text of the Arizona statute is provided at the end of this testimony):

> *§ 44–1754.*
> *A. A plan sponsor or pharmacy benefit manager may not prohibit a retail pharmacy from offering as an ancillary service of a pharmacy within the terms of the contract either of the following:*
> *1. The limited delivery of prescription drugs by mail or common carrier to a patient.*

Additionally, there are no provisions around mail or delivery to confirm the patient has received the package. States are more lenient on those best practices under conditions driven by the current pandemic, but PCMA suggests policy makers should not establish those practices as permanent by referencing retail pharmacy mail and delivery without conditions.

Part II, I (b) would prevent a PBM from prohibiting an in-network retail pharmacy from charging a shipping or handling fee to an enrollee who requests that a in-network retail pharmacy mail or deliver a prescription drug to the enrollee. Like the previous section, we are not aware that this

Pharmaceutical Care Management Association
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Washington, DC 20004
www.pcmanet.org

PCMA

is happening. Without a full understanding of an existing problem this section corrects, we cannot comment further on this language in the context of unintended consequences.
For these reasons, we respectfully oppose SB 97. We are happy to work with stakeholders on the intent and text of this bill. Please contact me at 202-756-5727 if you have any questions.
Thank you.

Sincerely,

Sam Hallemeier
Director, State Affairs

Full Text of Arizona provision:

A.R.S. § 44–1754

§ 44–1754. Delivery of prescription drugs; disclosure; exception

A. A plan sponsor or pharmacy benefit manager may not prohibit a retail pharmacy from offering as an ancillary service of a pharmacy within the terms of the contract either of the following:

1. The limited delivery of prescription drugs by mail or common carrier to a patient.
2. The hand delivery of prescription drugs to a patient by an employee or contractor of the pharmacy.

B. A pharmacy may not charge the plan sponsor or pharmacy benefit manager for the delivery of a prescription to a patient pursuant to subsection A of this section unless specifically agreed on by the plan sponsor or pharmacy benefit manager.

C. A pharmacy shall disclose to the patient any fee that will be charged to the patient for the delivery of a prescription drug, including that the fee may not be reimbursable by the plan sponsor or pharmacy benefit manager.

D. This section does not apply to the Arizona health care cost containment system administration and its contractors as defined in § 36–2901 to the extent the services are provided pursuant to title 36, chapter 29 or 34.1

Pharmaceutical Care Management Association
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Washington, DC 20004
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Kirsten Koch

From:	Curtis Barry <curtis@barrygr.com>
Sent:	Tuesday, February 2, 2021 6:24 PM
To:	Jeb Bradley; James Gray; Tom Sherman; Becky Whitley; Kevin Avard; Kirsten Koch
Subject:	SB 97 - H&HS Committee Wednesday 2-3-21 - PCMA Testimony.
Attachments:	SB 97 PCMA Testimony _ Senate H&HS.pdf

Attached is testimony from the Pharmaceutical Care Management Association, the national trade association for the pharmacy benefit management (PBM) industry.

In addition I will present this testimony at the hearing.

For background on PCMA and PBM services, this web site has resources on a variety of related issues:
https://onyourrxside.org/

Thank you for your consideration, & I'll "see" you during tomorrow's hearing.

Curtis J. Barry
603-496-4564 (mobile)
www.linkedin.com/in/curtisjbarry
https://lobbylinx.com/profile.php?profileid=3111115

February 2, 2021

Re: Support for SB97

Dear Senator Bradley and members of the Senate Health and Human Services Committee,

I am writing in support of Part I of SB97 as a representative of the New Hampshire Medical Society, a Family Physician and direct primary care practitioner.

The New Hampshire Medical Society supports this bill which will help to preserve a patient's freedom to choose their healthcare provider and to ensure that they will receive the benefits they expect from their health insurance when they need it most. This bill applies narrowly to providers practicing in the direct primary care ("DPC") model as defined in HB 508, now RSA 329:1-e.

To review DPC briefly, it is an alternative to the usual fee for service model of care. It provides services in exchange only for a periodic fee paid directly by the patient. DPC is able to offer care at a low price point (national average <$100 per month) because the providers do not contract with insurance networks, or collect fee for service. This reduces the administrative burden tremendously, and most patients see a lower out of pocket cost in this model.

DPC itself is not insurance and patients are instructed to also carry a medical insurance plan whose premiums would guard against financial loss if they need to access other parts of the medical system. For patients on Medicare, PPO plans, POS or EPO plans and Medicaid, their DPC provider can order and refer for medical services. However, other plans penalize patients who choose a DPC provider, by denying to pay insurance benefits, solely on the basis that a referral was made by a DPC provider who is not "in-network" for the patient's insurance. Unfortunately, this practice is highly prevalent, and patients often have no alternative. Nearly all of the plans available on the marketplace and most lower price plans, (even those with very high deductibles) have this limitation and many patients with employer based insurance are only offered restrictive plans.

This bill will create parity for those who cannot afford or do not have access to the often more expensive open access plans, or who do not qualify for Medicare, or Medicaid. It will not do away with any requirement to obtain a referral, or the requirement that referrals be medically appropriate. The bill only instructs plans to apply the patient's benefits for medical services equally, whether the referral is from a network contracted provider, or Direct Primary Care provider who is otherwise licensed and fully eligible to be ordering or referring for those medically necessary services.

The NH Medical Society supports this bill which reinforces the patient's right to choose their provider without fear of non-covered services, whether they put their trust in an independant DPC provider, or one contracted to serve the health plan. Thank you for your kind attention. I will be present at the committee meeting by Zoom and will be happy to entertain questions at that time, or by phone or email any time.

Sincerely,

Eric Kropp, MD
Family Physician
President-elect, NH Medical Society

13 Chenell Drive, Suite 2 DrKropp@activechoicemd.com P: (603) 410-4644
Concord, NH 03301

Testimony

Senate Health and Human Services Committee

SB 97 - Adopting omnibus legislation relative to health insurance

February 3, 2021

Dear Chairman Bradley and Members of the Committee:

My name is Richard Cohen, and I am a retired pharmacist.

I practiced my profession in community pharmacy for more than 45 years, the past twelve of those years here in New Hampshire. Throughout my career I have served on many committees and boards which were committed to the promotion and advancement of the practice of pharmacy. I served as president of the Connecticut Pharmacists Association, and I currently serve on the executive board of the NH Pharmacists Association.

I am here today to testify in **support** of SB 97 for the Association, specifically the section on Pharmacy Benefit Managers (PBMs).

In 2018, I served on the committee to study the impact of pharmacy benefit manager operations on cost, administration, and distribution of prescription drugs. This committee discussed pharmacy relationships relative to pharmacy benefit manager business practices, licensure, and transparency. (SB 481).

Independent pharmacies in New Hampshire have long sought a level playing field when entering into agreements with Pharmacy Benefit Managers (PBM). The major PBM players all have a mail order segment to their operation and, according to their contracts, have prohibited pharmacies from mailing or delivering prescriptions to their clients. Why? Because by doing so they can then control, retain or increase their patient market share.

SB 97 will create a level playing field with respect to this matter. It will protect in-network pharmacies from being penalized by being charged additional or erroneous fees for the actions listed in the bill.

Most importantly, it will protect the consumer who is enrolled in a network managed by a PBM from being penalized or assessed additional charges or copayments for utilizing the local services of their neighborhood pharmacy.

In closing, I ask that you find SB 97 Ought to Pass.

Thank you for your consideration.

Richard A Cohen RPh.
racnhpa@gmail.com

Dear Chairman Bradley and members of the Senate Committee on Health and Human Services,

I am writing to express my support for Part I of the proposed Senate Bill 97, relative to direct primary care referral parity.

As things currently stand in New Hampshire, options for health insurance coverage are quite limited for many residents. For many, their choice depends upon whatever plan is offered by their employer. For the self-employed, and those for whom coverage is not offered by their employer, they are frequently left to choose a plan through the marketplace at Healthcare.gov. Unfortunately, the plans available there are limited. Currently, it appears that there are three insurance companies offering plans on the marketplace. Of these, two only offer Health Maintenance Organization ("HMO") plans and the remaining company only offers Exclusive Provider Organization ("EPO") plans. There are no Preferred Provider Organization ("PPO") plans or other types of plans listed for New Hampshire residents to choose from.

For many residents who might wish to establish care with a Direct Primary Care ("DPC") doctor but find themselves receiving insurance coverage through an HMO plan, this situation presents a significant barrier to care creating unnecessary burdens in terms of time and expense. Typically, HMO plans require orders for items such as referrals to specialists, diagnostic testing, ancillary services, etc., to originate from an in-network provider in order to receive coverage. However, by definition, DPC doctors do not typically participate in insurance networks. As such, if a patient is enrolled in an HMO plan (frequently without any real choice in that matter, as discussed above), they are effectively penalized if they choose to receive their care from a DPC doctor.

Until July of last year, I was an employed physician working for a large Federally Qualified Community Health Center in northern New Hampshire. As part of my duties in that position, I served as the supervising/collaborating physician for several non-physician "midlevel" providers. A few months ago, I made the decision to launch a private Direct Primary Care practice in Gorham, NH. As my practice is quite new, I have not yet run into the situation of ordering a referral to a specialist for a patient enrolled in an HMO, but it seems ludicrous to me that, as a physician holding board certification with the American Board of Family Medicine, and entrusted by the State of New Hampshire with a full and unrestricted license to practice medicine, if and when I do make such an order, rather than simply scheduling an appointment for the care they need, my patient will first need to schedule an additional appointment with an in-network provider, (very possibly a provider who, until less than a year ago I was supervising), in the hopes of having my order re-issued. This effectively forces patients enrolled in HMOs who wish to have a DPC doctor as their Primary Care Provider ("PCP") to decide the following: either forgo their first choice of having a DPC doctor as their PCP or maintain a secondary in-network "pseudo-PCP" simply to re-issue orders already issued by their true PCP. This, clearly, is silly and wasteful.

Taking inspiration from similar legislation passed recently by our neighbors in Maine, SB 97 seeks to improve upon this situation by simply requiring insurance companies to honor orders originating from DPC doctors in the same way they do from in-network providers. It allows NH residents to choose their care from the doctor they trust, without having to sacrifice insurance coverage (which they have paid for) for services ordered by their doctor if that doctor happens to be a DPC doctor. This bill does not in any way require the insurance companies to cover any services provided by DPC doctors nor any services provided by any other out-of-network provider. Nor does it require insurance companies to give any special treatment to DPC doctors, such as forgoing normal Utilization Review procedures or requiring copays and deductible from patients if those same requirements would otherwise apply to orders from an in-network doctor. Ultimately, this legislation will help remove an unnecessary burden on patients in New Hampshire, and frankly, it appears to me that it would serve to lower costs for the insurance companies as well by decreasing their need to pay for unnecessary extra appointments with in-network providers.

It is my sincere hope, Mr. Chairman, that SB 97 will be looked upon favorably by you and the members of the Committee as this appears to be a simple and common-sense solution to an unnecessary problem.

Thank you very much for your time and consideration in this matter.

Most Sincerely,

Samuel J. McCreedy, M.D.
Gorham, NH

Voting Sheets

Senate Health and Human Services Committee
EXECUTIVE SESSION RECORD
2021-2022 Session

Bill # SB 97

Hearing Date: 2/3/21

Executive Session Date: 2/10/21

Motion: Amendment # 2021-0303s **Vote:** 4-1

Committee Member	Present	Made by	Second	Yes	No
Sen. Bradley, Chair	X			X	
Sen. Gray, Vice Chair	X				X
Sen. Avard	X	X		X	
Sen. Sherman	X		X	X	
Sen. Whitley					

Motion: OTPA **Vote:** 4-1

Committee Member	Present	Made by	Second	Yes	No
Sen. Bradley, Chair	X			X	
Sen. Gray, Vice Chair	X				X
Sen. Avard	X			X	
Sen. Sherman	X	X		X	
Sen. Whitley	X		X	X	

Motion:__________ **Vote:**__________

Committee Member	Present	Made by	Second	Yes	No
Sen. Bradley, Chair					
Sen. Gray, Vice Chair					
Sen. Avard					
Sen. Sherman					
Sen. Whitley					

Motion:__________ **Vote:**__________

Committee Member	Present	Made by	Second	Yes	No
Sen. Bradley, Chair					
Sen. Gray, Vice Chair					
Sen. Avard					
Sen. Sherman					
Sen. Whitley					

Reported out by: Sen. Sherman

Notes:__________

Committee
Report

STATE OF NEW HAMPSHIRE

SENATE

REPORT OF THE COMMITTEE

Thursday, February 11, 2021

THE COMMITTEE ON Health and Human Services

to which was referred **SB 97**

AN ACT adopting omnibus legislation relative to health insurance.

Having considered the same, the committee recommends that the Bill

OUGHT TO PASS WITH AMENDMENT

BY A VOTE OF: 4-1

AMENDMENT # 0326s

Senator Tom Sherman
For the Committee

Kirsten Koch 271-3266

HEALTH AND HUMAN SERVICES

SB 97, adopting omnibus legislation relative to health insurance.
Ought to Pass with Amendment, Vote 4-1.
Senator Tom Sherman for the committee.

Docket of sb97		
01/26/2021	S	Introduced 01/06/2021 and Referred to Health and Human Services; SJ 3
01/28/2021	S	Remote Hearing: 02/03/2021, 09:15 am; Links to join the hearing can be found in the Senate Calendar; SC 9
02/11/2021	S	Committee Report: Ought to Pass with Amendment # 2021-0326s, 02/18/2021; SC 11
02/18/2021	S	Committee Amendment # 2021-0326s, RC 23Y-1N, AA; 02/18/2021; SJ 5
02/18/2021	S	Ought to Pass with Amendment 2021-0326s, RC 23Y-1N, MA; OT3rdg; 02/18/2021; SJ 5
03/10/2021	H	Introduced (in recess of) 02/25/2021 and referred to Health, Human Services and Elderly Affairs HJ 4 P. 48
03/10/2021	H	Vacated and Referred to Commerce and Consumer Affairs (Rep. Steven Smith): MA VV (in recess of) 02/25/2021 HJ 4 P. 49
03/17/2021	H	Public Hearing: 03/24/2021 11:00 am Members of the public may attend using the following link: To join the webinar: https://www.zoom.us/j/97709851457 / Executive session on pending legislation may be held throughout the day (time permitting) from the time the committee is initially convened.
05/05/2021	H	==RECESSED== Executive Session: 05/13/2021 10:00 am Members of the public may attend using the following link: To join the webinar: https://www.zoom.us/j/93883325643
05/18/2021	H	==CONTINUED== Executive Session: 05/25/2021 10:00 am Members of the public may attend using the following link: To join the webinar: https://www.zoom.us/j/94122935505
05/25/2021	H	Committee Report: Ought to Pass with Amendment # 2021-1606h (Vote 17-0; CC) HC 26 P. 5
06/03/2021	H	Amendment # 2021-1606h: AA VV 06/03/2021
06/03/2021	H	Ought to Pass with Amendment 2021-1606h: MA VV 06/03/2021
06/10/2021	S	Sen. Bradley Moved to Concur with the House Amendment, MA, VV; 06/10/2021; SJ 19
07/12/2021	H	Enrolled (in recess of) 06/24/2021
07/12/2021	S	Enrolled Adopted, VV, (In recess 06/24/2021); SJ 20

Other Referrals

Senate Inventory Checklist for Archives

Bill Number: SB 97 **Senate Committee:** HHS

Please include all documents in the order listed below and indicate the documents which have been included with an "X" beside

X Final docket found on Bill Status

Bill Hearing Documents: {Legislative Aides}

X Bill version as it came to the committee
X All Calendar Notices
X Hearing Sign-up sheet(s)
X Prepared testimony, presentations, & other submissions handed in at the public hearing
X Hearing Report
___ Revised/Amended Fiscal Notes provided by the Senate Clerk's Office

Committee Action Documents: {Legislative Aides}

All amendments considered in committee (including those not adopted):

___ - amendment # ____ X - amendment # 2021-0326s
___ - amendment # ____ X - amendment # 2021-0303s

X Executive Session Sheet
X Committee Report

Floor Action Documents: {Clerk's Office}

All floor amendments considered by the body during session (only if they are offered to the senate):

___ - amendment # ____ ___ - amendment # ~~[illegible]~~
___ - amendment # ____ ___ - amendment # ____

Post Floor Action: (if applicable) {Clerk's Office}

___ Committee of Conference Report (if signed off by all members. Include any new language proposed by the committee of conference):
___ Enrolled Bill Amendment(s)
___ Governor's Veto Message

All available versions of the bill: {Clerk's Office}

X as amended by the senate X as amended by the house
X final version

Completed Committee Report File Delivered to the Senate Clerk's Office By:

Kirsten Koch 7/26/21
Committee Aide Date

Senate Clerk's Office AK