LEGISLATIVE COMMITTEE MINUTES

SB320

Bill as Introduced

SB 320 - AS INTRODUCED

2022 SESSION

22-3051
11/10

SENATE BILL ***320***

AN ACT relative to health care provider contract standards.

SPONSORS: Sen. Soucy, Dist 18; Sen. Whitley, Dist 15; Sen. Watters, Dist 4; Sen. Cavanaugh, Dist 16; Sen. Rosenwald, Dist 13; Sen. Prentiss, Dist 5; Sen. Sherman, Dist 24; Sen. Bradley, Dist 3; Sen. Perkins Kwoka, Dist 21; Sen. Gannon, Dist 23; Sen. Hennessey, Dist 1; Sen. Kahn, Dist 10; Sen. D'Allesandro, Dist 20; Sen. Gray, Dist 6; Rep. Knirk, Carr. 3; Rep. Marsh, Carr. 8; Rep. Weston, Graf. 8; Rep. Bartlett, Merr. 19

COMMITTEE: Health and Human Services

ANALYSIS

This bill modifies provider contract standards for purposes of the managed care law.

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Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

SB 320 - AS INTRODUCED

22-3051
11/10

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Twenty Two

AN ACT relative to health care provider contract standards.

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

1 New Paragraph; Managed Care Law; Provider Contract Standards. Amend RSA 420-J:8 by inserting after paragraph XVII the following new paragraph:

XVIII.(a) Each health care provider contract with a health carrier shall refer to the provider manual only as an administrative tool and use such provider manual only for administrative purposes. The provider manual shall not contain, nor shall it be used to effectuate changes that conflict with, health benefit plan member certificates that impact consumer health care coverage or the economic arrangement between a health care provider and health carrier. Further, a health carrier is prohibited from engaging in any practice, either through notice to consumers or health care providers or by amending a provider manual, which results in any of the following:

(1) Disruption of coverage or site of care chosen by the policy holder for health care services during a health benefit plan year; or

(2) Uniliteral changes to the terms, including economic terms, of a health care provider contract for health care services contemplated pursuant to a current agreement for which a payment rate has already been established in the health care provider contract.

(b) A health carrier seeking to make such changes must enter into good faith negotiations with the health care provider; provided, however, that such carrier is prohibited from removing a health care provider from its network for covered services already agreed upon in an existing health care provider contract until the termination or renewal of such health care provider contract occurs.

(c) Failure to adhere to the standards of this paragraph shall result in the following, as applicable:

(1) An assessment of damages to either the policy holder or to the health care provider;

(2) Policy holders harmed shall be able to access covered health care services at the highest level of benefit offered under their respective health benefit plan;

(3) Health care providers harmed by a health carriers' failure to meet the standards outlined in this section shall be entitled to reimbursement for health care services at the rates contemplated in the existing health care provider contract until such contract expires or is terminated in accordance with the termination provisions of such contract and within the constraints of RSA 420-J; and

(4) Any other remedy deemed appropriate by the commissioner.

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

Committee Minutes

AMENDED
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: February 1, 2022

HEARINGS

Wednesday	02/09/2022
(Day)	(Date)

Health and Human Services	State House 100	9:00 a.m.
(Name of Committee)	(Place)	(Time)

9:00 a.m.	**SB 285**	relative to discount medical plan organizations.
9:15 a.m.	**SB 320**	relative to health care provider contract standards.
9:30 a.m.	**SB 457**	establishing a committee to study nonprofit organizations contracting with the department of health and human services for children's services.
9:45 a.m.	**SB 390**	relative to telemedicine and telehealth.
10:00 a.m.	**SB 323**	permitting state trade associations to purchase health insurance offered by their peer national trade associations.
10:30 a.m.	**SB 374-FN**	relative to the SARS-CoV-2 vaccinations.

EXECUTIVE SESSION MAY FOLLOW

Sponsors:

SB 285

Sen. Cavanaugh	Rep. Potucek	Rep. Bartlett	

SB 320

Sen. Soucy	Sen. Whitley	Sen. Watters	Sen. Cavanaugh
Sen. Rosenwald	Sen. Prentiss	Sen. Sherman	Sen. Bradley
Sen. Perkins Kwoka	Sen. Gannon	Sen. Hennessey	Sen. Kahn
Sen. D'Allesandro	Sen. Gray	Rep. Knirk	Rep. Marsh
Rep. Weston	Rep. Bartlett		

SB 457

Sen. Carson

SB 390

Sen. Avard	Sen. Reagan	Sen. Hennessey	Sen. Carson
Rep. P. Schmidt	Rep. Rice	Rep. Knirk	Rep. M. Pearson
Rep. S. Pearson			

SB 323

Sen. French	Sen. Hennessey	Sen. Carson	Sen. Bradley
Sen. Giuda	Sen. Avard	Sen. Gannon	Rep. Hunt
Rep. Potucek			

SB 374-FN

Sen. French	Sen. Avard	Rep. Hill	Rep. Hough
Rep. Silber			

Cameron Lapine 271-2104

Jeb Bradley
Chairman

Senate Health and Human Services Committee

Cameron Lapine 271-2104

SB 320, relative to health care provider contract standards.

Hearing Date: February 9, 2022

Time Opened: 9:15 a.m. **Time Closed:** 10:39 a.m.

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

Members of the Committee Absent: None

Bill Analysis: This bill modifies provider contract standards for purposes of the managed care law.

Sponsors:

Sen. Soucy	Sen. Whitley	Sen. Watters
Sen. Cavanaugh	Sen. Rosenwald	Sen. Prentiss
Sen. Sherman	Sen. Bradley	Sen. Perkins Kwoka
Sen. Gannon	Sen. Hennessey	Sen. Kahn
Sen. D'Allesandro	Sen. Gray	Rep. Knirk
Rep. Marsh	Rep. Weston	Rep. Bartlett

Who supports the bill: Senator Kevin Cavanaugh (Senate District 16), Senator David Watters (Senate District 4), Senator Rebecca Perkins Kwoka (Senate District 21), Senator Jay Kahn (Senate District 10), Senator Cindy Rosenwald (Senate District 13), Senator James Gray (Senate District 6), Senator Jeb Bradley (Senate District 3), Senator Tom Sherman (Senate District 24), Senator Donna Soucy (Senate District 18), Jackson Bouley (Physical Therapist Association), Paula Minnehan (NH Hospital Association), and Matthew Houde (Dartmouth-Hitchcock).

Who opposes the bill: Maura Weston (Derry Medical Center), Representative Raymond Howard (Belknap County District 8), Nick Vailas, Jodi Grimbilas (CVS Health), Sabrina Dunlap (Anthem), Peter Bragdon (HPHC), Heidi Kroll (AHIP), and Mark Pundt (President/CMO Convenient MD).

Who is neutral on the bill: Tyler Brannen (NHID).

Summary of testimony presented in support:

Senator Donna Soucy

Senate District 18

- Senator Soucy said that SB 320 modifies the health care provider contract standards for the purposes of the managed care law.
- Senator Soucy said that contract negotiations should be done in good faith and the terms of those negotiations should be honored. She said that the question SB 320 seeks to address is whether or not there should be changes outside of what has been negotiated. She said that this is a complicated issue.
- Senator Soucy said that when a provider negotiates a contract, volume is a major consideration. She said that, especially for larger providers, the volume of care anticipated has a direct and significant impact on the economic terms of the negotiation.
- Senator Soucy said that the payment system is complicated.
- Senator Soucy said that if a carrier has concerns about prices, they should engage the provider in a negotiation and not use unilateral adjustments which, she said, jeopardizes the system of care.
- Senator Soucy said that a carrier's provider manual is a guidebook for all aspects of the contract and can be 800 pages long. She said that provider manuals are cumbersome and difficult to keep up with. She said that there is a concern that the provider manual should not be used by the carrier to refuse payment for a medically necessary procedure. Senator Soucy said that if a hospital has contracts with 12 different carriers, each carrier has a different provider manual with different rules and terms, which is challenging for the hospital.
- Senator Soucy said that pre-existing complexities have been made more complex due to the COVID-19 pandemic.
- Senator Soucy said that hospitals believe that there is a potential for disruption of care when there is a disruption in the care plan. She said that if a carrier program changes and redirects a member outside of the provider network, there are concerns about the continuity of care being disrupted.
- Senator Soucy said that there is a concern that community-based health care will be in jeopardy if unilateral changes through the provider manual continue.
- Senator Soucy said that SB 320 is about patients and providing care for patients.
- Senator Avard asked if SB 320 lowers costs for consumers.
    - Senator Soucy said that she could not say that it would lower costs in a specific area but said that it aims to make a difficult system more manageable, promote greater continuity, and lead towards better outcomes as a minimum.
- Senator Sherman said that he is confused about the relationship between carriers and providers. He asked if there was one bucket of agreements in a contract and another bucket of agreements in the provider manual. Senator Sherman said he understands provider-carrier contracts but said that he doesn't understand if the terms of the provider manual are agreed to by both parties or if there needs to be an agreement if changes are made to the provider manual.
    - Senator Soucy deferred the question to the carriers and the hospitals. She said that, in short, providers and carriers negotiate their contracts. She said that in

order to effectuate the terms of that contact, they use the provider manual. She said that there is language in the contract to allow for changes to the provider manual during the course of the contract. Senator Soucy said that SB 320 attempts to address the extent of changes allowed in the provider manual and whether or not the contract terms limit the changes to the provider manual. She said that the crux of the issue is to what extent the changes in the provider manual conflict with the terms of the negotiated contract.

- Senator Soucy said that she and the stakeholders had expected that SB 320 would be heard later than February 9th in order to have some attempts to better understand where the issue is. She said that she hoped the Committee would allow those discussions to occur.
- Senator Bradley said that it sounded like this was a situation where a non-legislative solution was possible. He said that he agreed to cosponsor SB 320 on the belief that the main content of the bill was the language on Lines 12 – 14, relating to unilateral changes. He said that, based on Senator Soucy's testimony, it seems to be broader in scope than he originally understood it to be. He asked if Senator Soucy was concerned about that.
    - Senator Soucy said that SB 320 was attempting to define, and refine, the changes that can be made, post-negotiation, to the contract through the provider manual. She said that the hospitals and carriers can dig in to that deeper. She said that in some cases changes to the provider manual have caught providers off guard and have impacted their ability to care for patients.
- Senator Avard asked if SB 320 was discussing breaches of contract and asked, in the spirit on non-legislative solutions, why not go to court.
    - Senator Soucy said that she did not want to use that phrase. She said that the parties want to avoid litigation. She said everything is happening against the backdrop of an extraordinary time in health care and it is important to be mindful of that.

Former Senator Matthew Houde

Vice President, Government Relations, Dartmouth-Hitchcock

- Mr. Houde said that Ms. Minnehan would lay out the larger situation for the New Hampshire Hospital Association (NHHA) in her testimony.
- Mr. Houde said that he saw SB 320 the night prior from the Vice President of Contracting at Dartmouth-Hitchcock.
- Mr. Houde said that changes to the provider manual have changed the material terms of how the provider operates. He gave four examples:
    - First, he said that a carrier designated specialty pharmacy networks with non-negotiated fees. He said that if a provider refused to accept the new fee schedule they would be declared out of network.
    - Second, he said that a carrier declared that a hospital is unable to use their internal lab services and was forced to use freestanding lab services at a lower-than-usual rate.
    - Third, he said that a carrier established a diagnostic imaging network with a new, non-negotiated fee schedule.

    - Fourth, he said that a carrier established a designated ambulatory hospital network and declared a provider out of network if they did not accept the new, non-negotiated fee schedule.
- Mr. Houde said that a provider could open negotiations over a change in the provider manual or could take the nuclear option and withdraw from the network. He said that doing so would be extremely significant for Dartmouth-Hitchcock, given its many relationships across the state. He said that he is happy to sit at a table and discuss this issue but said that it takes coming to the General Court to make those conversations take place.
- Senator Sherman said that he understands how to negotiate a contract. He asked if it was correct that providers do not negotiate the provider manuals but the provider manuals do change the terms of the services.
    - Mr. Houde said that that was his understanding.

Paula Minnehan

Senior Vice President, State Government Relations, NHHA

- Ms. Minnehan said that the system overall is complex, but SB 320 is a straightforward bill. She said that it will ensure that no substantive contract changes can be made outside the terms of the contract through the provider manual.
- Ms. Minnehan said that hospitals have had these changes occur many times. She said that the consequences of changes imposed by carriers are disruptions to service, loss of revenue, and uncertainty in patient volume.
- Ms. Minnehan said that SB 320 is focused primarily on unilateral contract changes. She said that the provider manual should only be used for administrative provisions. She said that SB 320 is asking that the provider manual should not be used to make changes that impact consumer health care contracts.
- Ms. Minnehan said that SB 320 is about not allowing for unilateral changes in the contract terms, when a carrier has negotiated in good faith, that would result in disruptions in the site of care during a benefit year and the economic terms of the contract for services considered under the contract.
- Ms. Minnehan said that although there is a breach of contract option available through the courts, it is not ideal. She said that it is the hospitals' position that the contracts were negotiated in good faith, as those negotiations are extensive, time consuming, and painful. She asked what the point of a contract is if one party can unilaterally make changes to the terms.
- Senator Avard asked, if the situation is complex, if the General Court would be siding with one party over the other. He asked if that would not be better handled in the court system, where the contracts and both sides can be considered. He said that the issue seems like a breach of contract issue to him.
    - Ms. Minnehan said that, historically, when a provider needs to challenge a contract with a carrier, the patient gets caught in the middle. She said New Hampshire hospitals are everywhere and to have one not in a network, with members everywhere, would be a concern. She said that going to court is very expensive. She said that she is happy to continue having discussions and hash it

out to get towards a solution. She said that she believes a legislative solution would be appropriate but perhaps not with the exact language in SB 320.

- Senator Sherman said that he has a contract with a hospital to do his job, where he agrees to the reimbursement and where he will be practicing, among other issues. He said that he has no provider manual other than his professional standards of conduct and if he or the hospital want to change the terms then they amend the contract. He asked if the hospitals are saying that there is an agreed-to site of service and agreed-to rates that the provider manual is then being used to change.
    - Ms. Minnehan said that she is not part of the negotiations and is not sure of the specifics. She said that she has heard that, for example, a contract was negotiated in February and then the carrier made changes with 60 days' notice that had a dramatic, material effect on the economic terms of the contract with the hospital. She said that the provider manual is being used as the vehicle for making these changes. She said that the point is that the provider manual should only be used for administrative purposes – prompt payment expectations, prior authorization rules, formulary rules, etc. – rather than completely changing the substantive and economic factors of the contract.
- Senator Sherman said that he did not understand how a carrier could act in the way Ms. Minnehan described if the fee schedules and such were negotiated in the contract. He asked if there was something in the contract that said that the provider could do so.
    - Ms. Minnehan said that the carriers are not changing the reimbursement terms negotiated but they are effectuating the change through a benefit change. She said that they can impose a site of service change and a benefit change, redirecting people away from the hospital, affecting the volume. She said that the contracts are negotiated in buckets, looking at in-patient care, out-patient care, etc. She said that to then make changes to the provider manual impacts the negotiated topics. Ms. Minnehan said that the entire process is very complicated.
- Senator Sherman asked what gave the carriers that power to make those changes. He asked why a hospital would agree to terms that allow a carrier to use the provider manual to make such changes.
    - Ms. Minnehan said that that is the state of the situation at the moment. She said that the provider manuals are 800 pages long and parties do not sit and negotiate the terms of the provider manual, they negotiate the terms of the contract.
- Senator Bradley said that he thought that SB 320 was more narrow when he had spoken to Ms. Minnehan about it. He said that he though SB 320 was focused on Lines 12 – 14 and the unilateral changes to the terms of a contract. He said that there are a range of actions carriers have always done to minimize that costs of insurance by directing care to alternate sites.
    - Ms. Minnehan said that nothing in SB 320 is intended to affect any programs that a carrier may institute for lower-cost alternatives and transparency. She said that she would argue that it is still narrow in focus. She said that if contract negotiations are taking place and then three months later terms are changed in the provider manual that were not discussed then the negotiations were not in good faith. She said that a carrier should disclose their intentions during that

negotiation so that a provider can comment and be prepared. Ms. Minnehan said that she understands both sides and can discuss it further.

Jim Monahan

NH Community Behavioral Health Association

- Mr. Monahan submitted a letter.
- Mr. Monahan said that the issue is not narrowly about hospitals and payers and other organizations do get involved. He said that he would be happy to try to work towards a non-legislative solution.

Summary of testimony presented in opposition:

Nick Vailas

- Mr. Vailas said that SB 30 is disruptive and limits competition. He said that health care already has limited competition and needs more competition and more free markets.
- Mr. Vailas described the extreme price differences available in the cost of receiving some procedures, including colonoscopies, infusion therapy, etc. He said that patients are drawn towards lower cost sites of service.
- Mr. Vailas said the leading cause of bankruptcy is health care costs. He said that that is awful to think about.
- Mr. Vailas said that health care is complicated but there needs to be disruption. He said that what is going on cannot continue to be accepted.
- Mr. Vailas said that SB 320 hurts private practice providers because they are lower-cost providers.
- Mr. Vailas said that he agrees with comments made towards why hospitals can't renegotiate if they are unhappy. He said that he negotiates terms all the time as a provider. He said that if there is a serious problem, the New Hampshire Insurance Department (NHID) can get involved.
- Mr. Vailas said that continuity of care can happen easily thanks to technology. He said that being caught in one system of care is not in the best interests of the patient if it is five times more expensive than other options.

Former Senator Peter Bragdon

Harvard Pilgrim Health Care (HPHC)

- Mr. Bragdon said that HPHC opposed SB 320 on five points:
  - First, he said that SB 320 is overly broad.
  - Second, he said that SB 320 is a solution in search of a problem.
  - Third, he said that SB 320 would be a nightmare to implement.
  - Fourth, he said that SB 320 undermines consumer choice.
  - Fifth, he said that SB 320 would lead to increased costs and premiums.

- Mr. Bragdon said that SB 320 is overly broad in that it applies to any practice and bans changes that impact the economic arrangement of the contract or engaging in any such practice. He asked what these phrases mean. He said that the process would get bogged down in NHID if SB 320 passes.
- Mr. Bragdon said that SB 320 is a solution in search of a problem and the phrase "breach of contract" is used often. He submitted for testimony the first page of the HPHC provider contract and read provisions that indicate that if a provision of the provider manual is inconsistent with a provision of the contract, the contract shall control. He said that it is not a gray area. He said that if there is a conflict, the contract shall control. Mr. Bragdon said that the provider contract for Anthem had similar language in it. He said that the HPHC provider manual is available online.
- Mr. Bragdon said that SB 320 refers to unilateral breaches of contract. He said that a carrier cannot unilaterally change the contract.
- Mr. Bragdon said that he has not heard definitive examples of the practices SB 320 alleges to solve until this hearing, from Mr. Houde. He said that the problems alleged are not clear, but he would be happy to work with providers to understand their problems.
- Mr. Bragdon said that, hypothetically, a situation could emerge where a provider and a carrier have a contract that allows for in-house lab services and then a Quest Diagnostic facility opens down the road where a carrier would want to inform and educate their members about their options.
- Mr. Bragdon said that SB 320 would be a nightmare to implement, as contracts do not expire at the same time. He said that they expire on a rotating basis and, under SB 320, HPHC would be required to have 36 separate provider manuals – one for each month of their contract period. He said that if people find it hard to find information in provider manuals now, it would be even harder with 36 different provider manuals.
- Mr. Bragdon said that SB 320 would also require 36 different copies of each prior authorization policy.
- Mr. Bragdon said that carriers update their provider manuals to maintain compliance with changes in law. He asked if they would be required to negotiate, and be held hostage over, each change in law.
- Mr. Bragdon said that carriers educate members, who see their deductibles rising, about cost-saving options. He said that in come cases they provide incentives to choose lower-cost options. He said that sometimes those incentives are worth it to help make those choices, as they impact their ability to manage costs. Mr. Bragdon said that SB 320 erodes the managed care model.
- Mr. Bragdon said that SB 320 interferes with private contracts between providers and carriers. He said that SB 320, on Lines 17 – 19, prohibits a carrier from removing a provider for fraud, waste, and abuse.
- Mr. Bragdon said that SB 320 would increase costs for the state, as there are not separate provider plans for the state and for private companies. He said that if statue says that providers cannot steer and incentive towards lower-cost options, the cost for the state to insure its employees will skyrocket.
- Mr. Bragdon encouraged an inexpedient to legislate (ITL) recommendation.
- Senator Sherman said that he read Lines 16 – 19 differently. He said that he read it as saying that a carrier cannot remove a provider for covered services already agreed to in

the contract. He asked if a carrier is able to breach the contract or if the provider manual is subservient to the contract.

- Mr. Bragdon said that SB 323 is overly broad and does not apply just to the provider manual.
- Senator Sherman said that he was specifically referencing Lines 16 – 19.
- Mr. Bragdon said SB 320 references "any action". He said that carriers are able to remove providers if there are issues of fraud and abuse. He said that Lines 16 – 19 changes that within the contract period. Mr. Bragdon said that he may be wrong, but that is how he read the language.

Sabrina Dunlap

Senior Director of Government Relations, Anthem

- Ms. Dunlap said that she echoes Mr. Bragdon's comments and opposes SB 320.
- Ms. Dunlap said that there are no unilateral changes to a contract, as that would be a breach of contract for which there are existing remedies.
- Ms. Dunlap said that carriers provide 60 days' notice for making changes. She said that Anthem makes changes a few times per year and rarely hears any feedback on those changes.
- Ms. Dunlap said that although there is a notion that member benefits are changed in the provider manual, a carrier cannot change member benefits through the provider manual. Ms. Dunlap said that if a patient is already receiving care at a hospital, they would continue to receive that care at a hospital.
- Ms. Dunlap said that the Anthem provider manual is 120 pages and is online.
- Ms. Dunlap said that a goal of utilization management is to have members receive the appropriate quantity and quality of care in an appropriate setting based on their medical necessity. She said that "medically necessary" is defined in statute and includes the appropriateness of the site of care.
- Ms. Dunlap said that she was not aware of any other state that has the type of restrictions found in SB 320.
- Ms. Dunlap said that the language of SB 320 is too broad and would lead to unintended consequences with a lack of definitions.
- Ms. Dunlap said that CPT codes are mandated by the American Medical Association and a change in those codes could, under SB 320, be considered a change in the economic arrangements of a contract. She said that that would be absurd.
- Ms. Dunlap said that a Congressional Budget Office report from January of 2022 found that commercial insurers are paying significantly higher rates at hospitals than Medicare. She said that that leads to an increase in spending on claims and, in turn, greater cost sharing. She said that there has been a greater consolidation in independent providers into hospital networks.
- Ms. Dunlap said that she has spoken to NHHA and has not received any clear examples of the unilateral changes they are alleging. She said that she is open to discussing how to improve communications and she believes that there is a path forward, although it is not SB 320.

- Ms. Dunlap said that, as the mother of a child with a chronic illness who needs specialty drugs, the increase in costs is not because of insurance carriers, it is because of hospitals.
- Senator Whitley asked what the notification of a change looks like. She asked what the communication is.
    - Ms. Dunlap said that she understands that there is a notice on a special website for providers, there are regular provider communications that go out, she believes that there are emails that go out, and she believes that it is posted on a specialized Anthem website. She also said that Anthem gives webinars in advance of certain changes as well. She said that she would be glad to discuss the logistics to find ways to improve communication.
- Senator Whitley said that notification could be an area of fertile ground and said that transparency and communication could resolve the pain points. She asked if they had looked at the notice requirements.
    - Ms. Dunlap said that they had and she has mentioned it to NHHA.
- Senator Sherman asked if the 60 days' notice is for a change in the provider manual, not a change in the contract.
    - Ms. Dunlap said that that was correct.
- Senator Sherman asked if there was time or room for negotiation after the 60 days' notice is given. He asked if a provider could challenge the change or if there was a back and forth.
    - Ms. Dunlap said that the reimbursement issues and the fee schedules are not in the provider manual. She said that she is not sure if there is an exchange after the 60 days' notice is given but she could check with her team. She said that the changes are mostly practical, technical changes and she is not sure why there would need to be a back-and-forth.
- Senator Sherman said he would like to know if there is an exchange. He asked what gives the carrier the ability to make changes to the provider manual and asked if the contract says, "the carrier can do whatever they want to the provider manual".
    - Ms. Dunlap said that it is not written like that. She said that there is an underlying contract, which has gone through a long and drawn-out negotiating process, as well as ancillary policy documents. She said that there is a need to be nimble and provide updates on clinical guidance and medical best practices. She said that appropriate notice is spelled out in the contract. She said that she has never heard of that language being an issue during negotiations.
- Senator Sherman asked Ms. Dunlap to provide a template of the wording from a contract that allows changes to the provider agreement.
    - Ms. Dunlap said that she believed she could get that language.

Heidi Kroll and Donald Fundstein

America's Health Insurance Providers (AHIP)

- Ms. Kroll said that AHIP opposes SB 320 and encourages an ITL recommendation.
- Ms. Kroll said that it is clear that carriers in New Hampshire are not breaching their provider contracts or changing their member benefits. She said that those plans are filed and approved with NHID each year.

- Ms. Kroll said that provider contracts guarantee the reimbursement rates for hospitals, but do not guarantee volume or usage or revenue for hospitals.
- Ms. Kroll said that the provider manuals are meant to provide flexibility and agility to provide safe, high quality, affordable care in a patient-centric model.
- Ms. Kroll said that legislation is not necessary and legal remedies are in place.
- Ms. Kroll said that SB 320's broad language would not prohibit contractual breaches but would impede consumer choice and competition and prohibit the use of utilization management tools.
- Ms. Kroll said that SB 320 would lock out competition and lock in high revenues for providers at the expense of citizens. She said that no other state has this kind of law and she does not believe the New Hampshire should adopt it.
- Ms. Kroll said that the "economic terms" language is not about the contracted reimbursement rates but is about revenue for hospitals. She said that SB 320 would deny patients access to innovation. She said that attempts by hospitals to limit lower cost care could be an anti-trust issue.
- Ms. Kroll said that SB 320 aims to prevent pointing consumers towards embracing lower cost sites of care.
- Ms. Kroll said that a study found that, nationally, hospitals are marking up the cost of specialty drugs 479% compared to acquisition costs.
- Ms. Kroll said that it is clear that the site of care issue is within the carrier's purview. She said that SB 320 was unworkable, raises anti-trust issues, prevents consumer choice, and guarantees higher costs.
- Senator Whitley asked if a change in the site of care was permitted under the contract or if it was said that that change would happen in the provider manual.
    - Ms. Kroll said that, as part of a carrier's ability to look at medical necessity, the site of care is part of the clinical decision of medically appropriate. Ms. Kroll said that carriers are not yanking patients out of where they are receiving care but are, instead, informing them that lower cost sites of care exist.
- Senator Sherman asked if the site of care was covered in the contract or if free reign was given to direct consumers to lower cost options. He asked if there were any restrictions in the contract on the site of care.
    - Ms. Kroll said that, generally, there is probably a provision to reserve the right to exercise a change in the site of service.
    - Mr. Fundstein said that consumers are embracing lower cost sites of care. He said that the contracts clearly allow that pursuant to the procedures. He said that this has nothing to do with a breach of contract. He said, referring to Senator Sherman's concerns, that there could be some dialogue around changing the manual. Mr. Fundstein read a letter submitted by Cigna. He said that Cigna has 175 million customers across the globe and SB 320 would be asking Cigna to dialogue with each of the millions of providers who serve those 175 million customers. He said that that is not advisable from a delivery of care perspective and would be impossible to deliver.

Neutral Information Presented:

Tyler Brannen

Life and Health Director, NHID

- Director Brannen said that many of his points had already been made.
- Director Brannen said that SB 320 seemed to be more about benefits rather than provider contracts or provider manuals.
- Director Brannen said that the provider manual is the same provider manual that all providers receive. He said that if there is a problem with a change, an individual provider likely would not be alone.
- Director Brannen said that a provider could go to a carrier and raise specific concerns during a contract negotiation.
- Director Brannen said that NHID has been involved in disputes in the past. He said that SB 320 is about something different than disputes. He said that it is about managed care practices and would prohibit seeking out lower cost options for both the individual and the employer.
- Director Brannen said that if the General Court is prohibiting specific actions by carriers, the language needs to be very specific. He said that NHID does not want to be drawn into every contract negotiation with each carrier. He said that NHID does not even review a contract unless there is a complaint and being directly involved is very unusual.
- Director Brannen said that carriers are competing with each other to come up with an innovate design with lower costs to the benefit of the market overall.
- Senator Bradley said that since SB 320 does not have a fiscal note, there is an opportunity for the parties to work together on a non-legislative solution. He said that NHID and himself can be part of the conversation. He said that his sense was that, if SB 320 was going to pass, it would need to be a much more narrow.

cml
Date Hearing Report completed: February 11, 2022

Speakers

Senate Health & Human Services Committee
SIGN-IN SHEET

Date: Wednesday, February 9, 2022 **Time:** 9:15 a.m.

SB 320 AN ACT relative to health care provider contract standards.

Name/Representing *(please print neatly)*	Support	Neutral	Oppose	Speaking?	Yes	No
Senator Donna Soucy D-18 (Introducing Bill)	☑	☐	☐		☑	☐
Nick Varilas	☐	☐	☑		☑	☐
Jodi Grimbilas CVS Health	☐	☐	☑		☐	☑
Jackson Bouley Physical Therapist Assoc.	☒	☐	☐		☐	☐
Paula Minehan NH Hospital Association	☐	☐	☐		☒	☐
Tyler Brannen NHID	☐	☑	☐		☑	☐
Sabrina Dunlap Anthem	☐	☐	☑		☑	☐
Peter Bragdon HPHC	☐	☐	☑		☑	☐
Heidi Kroll - (AHIP) America's Health Insurance Plans	☐	☐	☒		☒	☐
Mark Pundt - President/CMO Convenient MD	☐	☐	☒		☐	☒
Matthew Hondo Dartmouth-Hitchcock	☑	☐	☐		☑	☐
	☐	☐	☐		☐	☐
	☐	☐	☐		☐	☐

Senate Remote Testify

Health and Human Services Committee Testify List for Bill SB320 on 2022-02-

Support: 8 Oppose: 2

Name	Title	Representing	Position
Cavanaugh, Senator Kevin	An Elected Official	Myself	Support
Watters, Senator David	An Elected Official	Myself	Support
Perkins Kwoka, Senator Rebecca	An Elected Official	Myself	Support
Kahn, Jay	An Elected Official	Senate District 10	Support
Rosenwald, Cindy	An Elected Official	SD 13	Support
Gray, James	An Elected Official	Sen. James Gray SD 6	Support
Bradley, Senator Jeb	An Elected Official	SD3	Support
Sherman, Senator	An Elected Official	SD24	Support
Weston, Maura	A Lobbyist	Derry Medical Center	Oppose
Howard, Raymond	An Elected Official	Belknap 8	Oppose

Testimony

Christine Cooney
State Government Affairs Manager, New England

Routing B6LPA
900 Cottage Grove Road
Bloomfield, CT 06002
Christine.Cooney@Cigna.com

February 9, 2022

Senate Health and Human Services Committee
Attn: Chairman Jeb Bradley
LOB Room 101
Concord, NH 03301

Re: SB 320 An Act Relative to Health Care Provider Contracts

Dear Senator Bradley and Members of the Committee,

Thank you for the opportunity to provide comments in opposition to Senate Bill 320, An Act Relative to Health Care Provider Contracts. Cigna is concerned that this proposal could have unintended negative consequences for health plan customers if it were enacted, and that it would interfere with long-standing contracts between Cigna and its providers.

Cigna Corporation is a global health service company dedicated to improving the health, well-being and peace of mind of those we serve. Cigna delivers choice, predictability, affordability and access to quality care through integrated capabilities and connected, personalized solutions that advance whole person health. Such solutions include an integrated suite of health services, such as medical, dental, behavioral health, pharmacy, vision, supplemental benefits, and other related products. Cigna maintains sales capability in over 30 countries and jurisdictions, and has more than 175 million customer relationships throughout the world.

SB 320 would restrict health plans from a wide range of conduct including:

- Engaging in any practice resulting in "[d]isruption of coverage or site of care chosen by the policy holder for health care services during a health benefit plan year;" and
- Making "unilateral changes to the terms, including economic terms, of a health care provider contract for health care services contemplated pursuant to a current agreement for which a payment rate has already been established in the health care provider contract."

If interpreted broadly, such restrictions would interfere with Cigna's provider and client contracts and profoundly disrupt well-established mechanisms for communicating evolving coverage and reimbursement standards without renegotiating hundreds – if not thousands – of contracts every year.

Contracts between Cigna and network providers specifically state that the provider agrees to abide by Cigna's administrative guidelines (including coverage and reimbursement policies) as a condition of participating in our network. Administrative guidelines are used, in part, to adopt emerging industry standards, and to administer our client benefits more accurately with the advent of new technology and processes. Cigna agrees to provide advance notice of material changes to Administrative Guidelines, and the provider has the right to terminate the agreement if they object to a change in the Administrative Guidelines. This allows the parties' relationship to evolve with changing coverage and reimbursement policies without having to continually amend contracts. If contract amendments were required every time a guideline changed, Cigna's ability to administer client accounts in step with emerging industry practices would be severely compromised.

Administrative guidelines are often used to communicate new reimbursement policies, such as billing protocols for new services. They are also used to inform providers of new coverage policies that align with customer certificates and benefit plans. Administrative guidelines are not, and cannot, be used to make changes to customer insurance certificates or negotiated reimbursement rates with providers. It is important to recognize that in the event of an inconsistency between the provider contract and the administrative guidelines, the provider contract controls.

SB 320 appears at least to be partially motivated by some high-cost providers' desire to be protected against changes in customer volume and associated revenue based on changes in coverage policies that influence customers to use other, lower cost providers. Cigna does not guarantee any particular volume of services to a provider, and reserves the right to influence customer choice through vehicles such as cost-transparency initiatives that give customers the freedom to choose providers based on cost. Accordingly, there is no reasonable basis for providers to expect any amount of guaranteed revenue from Cigna, especially if a new provider can provide equal services at less cost, or initiatives to improve customer health outcomes are successful, ultimately requiring less care. So while it is understandable that the proponents of this legislation would seek to protect themselves against customers electing to receive their services elsewhere, providing such protection through legislation will only serve to drive the cost of health care higher and give the providers a de facto revenue guarantee that they would never be able to contractually obtain.

The practice of allowing changes through administrative guidelines is a well-established and transparent process. It provides for advance notification of any changes, a portal to pull information from and a point of contact if any questions arise from providers. Administrative guidelines and provider manuals are the key to communicating beneficial changes in a rapidly evolving health care field. If equal or better services can be delivered to members at decreased cost to them and the system as whole, then we have an obligation to pursue those options while improving the quality of, and access to, care.

This legislation would impede an insurer's ability to innovate and adapt as better care develops and would impact our ability to implement policies that align with customer benefit plans. If enacted, this legislation would give New Hampshire providers the ability to impact the adoption of national coverage and reimbursement policies, would increase the total cost of care, and would require constant negotiation of provider contracts at enormous operational expense.

We hope you will consider the detrimental impact this unnecessary legislation could have on the health care system as whole, but most importantly on customers and patients.

Once again, thank you for the opportunity to weigh in on this proposed bill.

If you have any questions, please do not hesitate to contact me at (804.904.3473) or Christine.Cooney@cigna.com.

Sincerely,

Christine M. Cooney

Christine Cooney
Cigna, State Government Affairs Manager, New England

NH Community Behavioral Health Association

1 Pillsbury Street, Suite 200
Concord, NH 03301
603.225.6633
www.nhcbha.org

Senator Jeb Bradley, Chair
Senate Health & Human Services Committee
Room 101, Legislative Office Building
Concord NH 03301

February 8, 2022

RE: SB 320 - relative to health care provider contract standards.

Via email: Jeb.Bradley@leg.state.nh.us
James.Gray@leg.state.nh.us
Kevin.Avard@leg.state.nh.us
Becky.Whitley@leg.state.nh.us
Tom.Sherman@leg.state.nh.us
cameron.lapine@leg.state.nh.us

Dear Senator Bradley and members of the Committee:
The NH Community Behavioral Health Association (CBHA), representing the state's ten non-profit community mental health centers (CMHCs), is writing to register our members' support for SB 320 and our request for you to act favorably on the bill.

The CMHCs make up the community-based safety net for outpatient mental health system in the state of New Hampshire. Since the start of the COVID pandemic, all ten of the centers have seen and continue to see rapid increases in the need for mental health services in their respective catchment areas. Complicating this need for services is the fact that workforce constraints are a continuing concern for all health care providers. CBHA tracks and reports monthly to the state on workforce numbers from the ten centers, including staff vacancies and loss of staff; one of the key areas that routinely appears as a problem in staff retention is the issue of administrative burdens. This not only takes clinical staff away from patients; it causes burnout.

While we continue to work collaboratively with our public payment system, we have noticed a rise in issues associated with commercial payers that include denial of claims, changes to policy manuals, credentialling-related issues and other areas that seem to be inconsistent with state rules, laws, and contracts/agreements between CMHCs and commercial carriers. We have begun to work with the Department of Insurance to address some of these concerns, but often times commercial carriers use carve out vendors to circumvent agreements or statutory obligations. We hope that this legislation will extend to those carve out carriers and mitigate these concerns.

Thank you for your consideration of our comments.

Sincerely,

Brian Collins

Brian Collins, President, CBHA

Provider Manual

The online Provider Manual represents the most up-to-date information on Harvard Pilgrim products, programs, policies and procedures. Information found online may differ from your print version. Contact the Provider Call Center at 1-800-708-4414, if you have questions.

— Important Provider Manual Information

This manual contains information intended for all Harvard Pilgrim Health Care providers, including Medicare supplement providers. To the extent that any provision of this Harvard Pilgrim Health Care manual is inconsistent with any provision of your contract with Harvard Pilgrim Health Care, the terms of the contract shall control.To the extent that any provision of this Harvard Pilgrim Health Care manual is inconsistent with any provision of our Harvard Pilgrim Health Care Member Agreement, the terms of the member agreement shall control.

Purpose

This Harvard Pilgrim Provider Manual has been developed as a reference tool for physician, facility and ancillary office staff who serve Harvard Pilgrim Health Care and Harvard Pilgrim Health Care of New England members. References to Harvard Pilgrim Health Care, Harvard Pilgrim or HPHC in this manual also apply to its affiliate, Harvard Pilgrim Health Care of New England. Use this manual to find information on a range of products including the Harvard Pilgrim HMO, POS, PPO, national plans, and senior plans.

New Hampshire Hospital Association

SENATE HEALTH AND HUMAN SERVICES COMMITTEE

Wednesday, February 9, 2022

SB 320 – Relative to Health Care Provider Contract Standards

Testimony

Good morning, Mr. Chairman, and members of the committee. My name is Paula Minnehan, Senior Vice President, State Government Relations with the New Hampshire Hospital Association (NHHA), representing all 26 of the state's community hospitals as well as all specialty hospitals.

The NHHA is in strong support of SB 320, and we appreciate Senator Soucy sponsoring the bill as well as all the cosponsors with strong bi-partisan support. This bill modifies provider contract standards for purposes of the managed care law.

The bill before you is straight-forward. The intent of the bill is to ensure that no substantive contract changes can be made unilaterally by the health insurer outside the terms of the negotiated contract with hospitals or providers. Unfortunately, our hospital members have had this occur many times and we are asking the legislature to ensure that negotiated contract terms are adhered to. The consequence of unilateral contract changes that are imposed by health insurers means that there are service disruptions for patients, loss of anticipated revenue that was negotiated in good faith and uncertainty with future patient volume needs due to steerage to other sites of service.

The bill components include the following provisions:

- The provider manual shall **only** include administrative provisions, and "shall not be used to effectuate changes that conflict with health benefit plan member certificates that impact consumer health care coverage or the economic arrangement between a health care provider and health carrier." Unfortunately, it has been the experience of our hospitals that, in fact, that is how the provider manual has been used by carriers.

- The carrier cannot make changes, unless they enter into good faith negotiations with the health care provider, that would result in either 1) disruption of coverage or site of care chosen by the policy holder for health care services during a health benefit plan year; or 2) uniliteral changes to the terms, including economic terms, of a health care provider contract for health care services contemplated pursuant to a current agreement for which a payment rate has already been established in the health care provider contract.

- There is a provision for remedies if, in fact, these actions of unilateral contract changes were to occur. The Commissioner of Insurance could also be involved in remedial actions.

Some may ask why not seek remedy in the courts if there has been a breach of contract. While that is an option, it is our position that contracts are negotiated in good faith and, when it comes to hospital/health carrier negotiations, these are extensive and time consuming. What is the point of going through all those negotiations if one party can make a substantive change, unilaterally, that negatively impacts the other party, including the patients / beneficiaries during the term of the contract?

On behalf of our hospitals, we strongly urge you to support this bill and vote Ought to Pass.

Thank you for the opportunity to provide our comments in support of SB 320.

Senator Donna Soucy, Senate District 18
Testimony in Support of SB 320, relative to health care provider contract standards.
Senate Health and Human Services Committee

Thank you, Mister Chair, and members of the Committee.

For the record, I am Senator Donna Soucy, proudly representing Senate District 18. I am here today as the prime sponsor of Senate Bill 320, relative to health care provider contract standards. This bill seeks to modify provider contract standards for purposes of the managed care law.

Contract negotiations between health insurance carriers and health care providers are negotiated in good faith, and the terms that are agreed to should be honored.

Volume Matters:

When a provider and health insurance carrier negotiate a contract, volume is a major consideration for what will be contemplated during those contract negotiations. Those factors are significant – especially for larger health insurance carriers that have many covered members throughout the state. The volume of care anticipated by a carrier to a provider has a direct and significant impact on the economic terms of the negotiations.

Our payment system is complicated and at times can be deemed irrational, but the purpose of the good faith negotiation is to agree on areas where some payments may be insufficient and other areas where payments may be sufficient. The aggregate economic impact is of most importance. If a health carrier has a concern with price points in a particular service line, it should engage in a good faith negotiation, not use a unilateral provider manual adjustment to circumvent the negotiation. This action jeopardizes the health of our system of care at a time when workforce demands and costs to maintain quality care are higher than ever.

Provider Manual Complexities:

In some cases, the provider manual, which is the guidebook that documents all aspects of the contract between the health insurance carrier and the provider, can be over 800 pages long – it is very cumbersome and nearly impossible for the hospital and health care provider staff to keep up with all the extensive components of the provider manual.

The Manual should not be used as a means for the health carrier to refuse payment for medically necessary services rendered to a patient. If a hospital contracts with 12 different carriers, all have unique provider manuals, which are all over 800 pages with

different rules and terms, can any hospital really keep up with this? This has created a "gotcha" moment with respect to paying for services that are medically necessary.

Continuity of Care:

Hospitals believe there is a potential for disruption of care when there is a significant change in the plan program – such as site of service changes that get imposed mid-contract. If the program changes imposed by the carrier results in redirecting the member outside of the network of hospital providers, then the continuity of care could be disrupted. In fact, health carriers speak all the time about the need for health systems to "manage patients" more efficiently, how can they do that when patients are directed away from their community hospital? If we continue to allow this to occur, community-based health care will be in jeopardy.

Thank you for your time and consideration. I'm happy to answer questions, but would defer the technical questions to the experts behind me.

NH Community Behavioral Health Association

1 Pillsbury Street, Suite 200
Concord, NH 03301
603.225.6633
www.nhcbha.org

Senator Jeb Bradley, Chair
Senate Health & Human Services Committee
Room 101, Legislative Office Building
Concord NH 03301

February 8, 2022

RE: SB 320 - relative to health care provider contract standards.

Via email: Jeb.Bradley@leg.state.nh.us
James.Gray@leg.state.nh.us
Kevin.Avard@leg.state.nh.us
Becky.Whitley@leg.state.nh.us
Tom.Sherman@leg.state.nh.us
cameron.lapine@leg.state.nh.us

Dear Senator Bradley and members of the Committee:
The NH Community Behavioral Health Association (CBHA), representing the state's ten non-profit community mental health centers (CMHCs), is writing to register our members' support for SB 320 and our request for you to act favorably on the bill.

The CMHCs make up the community-based safety net for outpatient mental health system in the state of New Hampshire. Since the start of the COVID pandemic, all ten of the centers have seen and continue to see rapid increases in the need for mental health services in their respective catchment areas. Complicating this need for services is the fact that workforce constraints are a continuing concern for all health care providers. CBHA tracks and reports monthly to the state on workforce numbers from the ten centers, including staff vacancies and loss of staff; one of the key areas that routinely appears as a problem in staff retention is the issue of administrative burdens. This not only takes clinical staff away from patients; it causes burnout.

While we continue to work collaboratively with our public payment system, we have noticed a rise in issues associated with commercial payers that include denial of claims, changes to policy manuals, credentialling-related issues and other areas that seem to be inconsistent with state rules, laws, and contracts/agreements between CMHCs and commercial carriers. We have begun to work with the Department of Insurance to address some of these concerns, but often times commercial carriers use carve out vendors to circumvent agreements or statutory obligations. We hope that this legislation will extend to those carve out carriers and mitigate these concerns.

NH Community Behavioral Health Association

1 Pillsbury Street, Suite 200
Concord, NH 03301
603.225.6633
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Thank you for your consideration of our comments.

Sincerely,

Brian Collins, President, CBHA

Harvard Pilgrim Health Care
1 Wellness Way
Canton, MA 02021
harvardpilgrim.org

Harvard Pilgrim Health Care

February 10, 2022

Senator Jeb Bradley
Chairman
Senate Health and Human Services Committee
New Hampshire Legislature
Concord, NH 03301

RE: SB 320 – An Act relative to health care provider contract standards

Dear Mr. Chairman and Honorable Members of the Committee:

Harvard Pilgrim Health Care (Harvard Pilgrim) appreciates the opportunity to provide comments on SB 320 – An Act relative to health care provider contract standards. Harvard Pilgrim, a Point32Health company, is a leading not-for-profit health services company that currently serves more than 86,000 New Hampshire residents. Harvard Pilgrim has significant concerns with SB 320. Not only will this bill significantly raise the cost of health care for consumers and employers in New Hampshire, it inappropriately, and in an unprecedented way, interferes with private contracts agreed upon by a health insurer and a provider and separately by a health insurer and its members.

SB 320 would prohibit health insurers from implementing any policy changes that "conflict with…the economic arrangement between a health care provider and health carrier" without first negotiating the change with each individual provider. This would include policy changes made through the provider manual and any other notice made to the provider by the insurer. The provider manual is largely a reference tool for physicians, facilities and other ancillary office staff and includes documents like practice site standards, credentialing policies, payment policies, and information on how to submit a claim or an authorization for a covered service or file an appeal. The policies outlined in the provider manual and other insurer policies are specifically designed to be nimble documents that can easily adapt to changing circumstances. For example, in early 2020, Harvard Pilgrim was able to quickly update our telehealth payment policy to adapt to the changing circumstances of COVID-19 and the shift to telehealth care. Outside of the provider manual, Harvard Pilgrim also periodically creates new or updates existing prior authorization policies. Prior authorization policies are in place to evaluate requests for health care services, treatments, and procedures against evidence-based medical guidelines to ensure that patients receive the right care at the right time in the right setting. Prior authorization policies require periodic updating as national medical standards evolve. Without the flexibility to update these documents as necessary, health insurers would not be able to adapt to changing external circumstances.

Insurer-provider contracts are typically for a three-year period, but they don't all begin and end at the same time. Thus, it would be operationally impossible for insurers to implement this requirement because we would not be able to make policy updates on different timelines for each provider. Three years is a long time for insurers to not be able to make necessary policy changes or establish new cost saving initiatives, which will severely impact our ability to control medical costs. If an insurer did implement a new policy without first going through contract negotiations, we would be subject to penalties that would result in an assessment of damages and could potentially be required to reimburse providers twice for the same service – the provider who performed the service and the provider who was "harmed" by the insurer's "failure to meet the standards outlined in this section".

The insurer-provider contract always includes language that requires the provider to abide by the provider manual and any other insurer policy as periodically amended throughout the contract period. Providers acknowledge and agree to this when they sign the contract. Providers are given 60-days' notice when a new policy is being implemented or an existing policy is being updated. Insurers are within our contractual rights to make amendments as needed. If providers have concerns with any of the policies, their concerns should be raised with the insurer.

In addition to the insurer-provider contract, this bill interferes in the contract established between the insurer and the member. It prohibits health insurers from "engaging in any practice...through notice to consumers...which results in...disruption of coverage or site of care chosen by the policy holder". It is important to note that Harvard Pilgrim is not disrupting care for any member. We are not telling members that they cannot receive medically necessary covered services at in-network facilities that are contracted to provide that service. While we do educate members about various sites of care and the costs associated with them, members make the decision on where and when they want to receive their care. This does not constitute a change in member benefits nor is it a disruption in coverage or site of care.

However, it appears that this bill would prohibit insurers from educating members about lower cost sites of care. As part of the managed care framework, insurers have a responsibility to ensure our members have access to high quality care while simultaneously managing or reducing the cost of that care. We manage care by educating members about various, high quality in-network sites of care available to them and how their financial obligation could be lower depending on where they elect to receive their care. We continuously monitor all of our providers to ensure they are providing high quality care to our members.

If insurers are prohibited from periodically updating policies or directing members to lower cost sites of care without first going through the negotiation process with providers, it would be impossible for costs not to go up for employers and consumers in this state. Insurers do not guarantee volume or revenue for any in-network health care provider because it is up to the member where they receive their care. However, we are obligated to direct members to lower cost sites of care because the prices charged by some providers are exceptionally high. And no provider is going to agree contractually to comply with more payment policies or allow insurers to divert care without somehow being kept financially whole. Any increase in provider costs will result in higher premiums for individuals and employers in this state at a time when health care costs are already too high. Ensuring the reasonable cost of health care should be a goal for everyone. It is vital that insurers have the flexibility to update policies as needed and appropriately react to changing circumstances.

Harvard Pilgrim appreciates the opportunity to provide comments on SB 320. For the reasons outlined above, we respectfully urge you to find SB 320 Inexpedient to Legislate. Should you have any questions, please contact me at any time.

Sincerely,

Stefani Reardon
Government Affairs Manager
Harvard Pilgrim Health Care
Stefani.Reardon@point32health.org
(781) 612-4745

ConvenientMD
Quality Care. Fast & Easy. URGENT CARE

February 15, 2022
Senator Jeb Bradley
Chair, Senate Health and Human Services
107 N. Main Street, Room 302
Concord, NH 03301

Dear Senator Bradley,

On behalf of ConvenientMD and our twelve urgent care clinics across New Hampshire, I am writing to express our opposition to SB 320, relative to health care provider contract standards. We believe the legislation will severely limit, or even ban, competition, leading to increased costs for health care consumers across the state. Furthermore, SB 320 would prohibit insurers from adjusting specific provisions in provider manuals based on medical best practices or other economic considerations, a long-standing practice that allows for flexibility to keep pace with ever changing health care standards.

At ConvenientMD, we offer an innovative approach to high-quality healthcare in an efficient and welcoming environment while saving money for patients, employers, insurance companies, and the government. Our affordable, full-service system allows for a broad array of services to satisfy our patients' demands for convenient, compassionate treatment of episodic urgent care needs. If adopted, SB 320 would functionally freeze patient care in time and place in the hospital setting and serve to eliminate patient choice. Consumers and carriers would be forced to pay inflated rates for medical care and procedures that can be provided at a reduced cost, clinically appropriate site, such as imaging and infusion. At ConvenientMD we can provide infusions at as low as one third of the cost of a hospital infusion center.

We respectfully ask that SB 320 be recommended Inexpedient to Legislate. Not only would New Hampshire be the first state in the country to adopt such a proposal, it would undermine utilization management and consumer choice, two key tools in reducing overall health care costs.

We thank you in advance for your time and consideration. I would welcome the opportunity to make myself available should you have any questions.

Sincerely,

Mark A. Pundt

Dr. Mark Pundt
President and Chief Medical Officer

ConvenientMD LLC
111 New Hampshire Avenue Suite 200, Portsmouth, NH 03801
Office: (603) 319-4490 | Fax: (603) 501-0864

Voting Sheets

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

Bill # SB 310

Hearing date: 2-9-22

Executive Session date: 3-9-22

Motion of: IS **Vote:** 5-0

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

Motion of: _____ **Vote:** _____

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

Motion of: _____ **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. Bradley

Notes: _____

Committee Report

STATE OF NEW HAMPSHIRE

SENATE

REPORT OF THE COMMITTEE

Wednesday, March 9, 2022

THE COMMITTEE ON Health and Human Services

to which was referred **SB 320**

AN ACT relative to health care provider contract standards.

Having considered the same, the committee recommends that the Bill

BE REFERRED TO INTERIM STUDY

BY A VOTE OF: 5-0

Senator Jeb Bradley
For the Committee

Cameron Lapine 271-2104

HEALTH AND HUMAN SERVICES

SB 320, relative to health care provider contract standards.
Interim Study, Vote 5-0.
Senator Jeb Bradley for the committee.

General Court of New Hampshire - Bill Status System

Docket of SB320

Docket Abbreviations

Bill Title: relative to health care provider contract standards.

Official Docket of **SB320.**:

Date	Body	Description
12/14/2021	S	To Be **Introduced** 01/05/2022 and Referred to Health and Human Services; **SJ 1**
2/1/2022	S	**Hearing:** 02/09/2022, Room 100, SH, 09:15 am; **SC 6**
3/9/2022	S	Committee Report: Referred to Interim Study, 03/17/2022; **SC 11**
3/17/2022	S	Sen. Gray Moved Laid on Table, MA, VV; 03/17/2022; **SJ 5**
3/17/2022	S	Pending Motion Interim Study; 03/17/2022; **SJ 5**

NH House NH Senate

Other Referrals

Senate Inventory Checklist for Archives

Bill Number: SB 320 **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 #_____ ___ - amendment #_____
___ - amendment #_____ ___ - amendment #_____

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 #_____
___ - 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)

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

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

Cameron M. LaPine 6-23-22
Committee Aide Date

Senate Clerk's Office _____