HB 191 - AS INTRODUCED

2021 SESSION

21-0280
10/04

HOUSE BILL ***191***

AN ACT relative to prior authorizations and patient transfers under managed care group health insurance policies.

SPONSORS: Rep. Marsh, Carr. 8; Rep. Knirk, Carr. 3; Rep. Woods, Merr. 23; Rep. Weston, Graf. 8; Rep. Murphy, Graf. 12; Sen. Sherman, Dist 24; Sen. Cavanaugh, Dist 16; Sen. Kahn, Dist 10

COMMITTEE: Commerce and Consumer Affairs

ANALYSIS

This bill adds requirements for prior authorizations under managed care health benefit plans and the administration of patient transfers to another health care facility.

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Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

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STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Twenty One

AN ACT relative to prior authorizations and patient transfers under managed care group health insurance policies.

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

1 New Sections; Managed Care Law; Prior Authorization; Patient Transfers. Amend RSA 420-J by inserting after section 12 the following new sections:

420-J:12-a Exceptions to Prior Authorizations. When prior authorizations are required under a health benefit plan:

I. The authorization shall be valid for 6 months from the date the health care provider requests the prior authorization.

II. Additional medically necessary services or procedures required during an otherwise authorized service or services shall not be denied or require additional authorization.

III All notifications and disclosures of prior authorization requirements and written notices of new or amended requirements shall be provided to all impacted health care providers 60 days prior to the effective date.

IV. Nothing in this section shall be construed to require coverage for services that have been prior authorized if the health plan coverage is not effective on the date of service.

420-J:12-b Standards for Patient Transfers.

I. A health benefit plan shall respond to a request for a patient transfer within one business day.

II. When a health benefit plan has determined a lower level of care at a health care facility is clinically appropriate, the health benefit plan shall not require a prior authorization for medically necessary interfacility transport to the receiving health care facility.

III. When a health benefit plan has determined a lower level of care at a health care facility is clinically appropriate and does not provide accommodations to ensure the necessary transportation to the receiving facility, the health benefit plan shall reimburse the originating facility not less than the daily contracted reimbursement rate.

2 Effective Date. This act shall take effect January 1, 2022.