Senate Amendment to
House File 2488

H-8252

Amend House File 2488, as amended, passed, and reprinted by the House, as follows:

1. Page 1, before line 1 by inserting:

<DIVISION I

PRIOR AUTHORIZATIONS AND EXEMPTIONS>

2. Page 3, after line 8 by inserting:

<DIVISION ___

COST CONTROLS FOR HEALTH CARE SERVICES

Sec. ___. Section 507B.4, subsection 3, Code 2024, is amended by adding the following new paragraph:

NEW PARAGRAPH. *v. Improper denial of claims.* A health carrier improperly denying claims under chapter 514M.

Sec. ___. NEW SECTION. **514M.1 Short title.**

This chapter shall be known and may be cited as *"The Patient's Right to Save Act"*.

Sec. ___. NEW SECTION. **514M.2 Definitions.**

As used in this chapter, unless the context otherwise requires:

1. *"Average allowed amount"* means the average of all contractually agreed upon amounts paid by a health benefit plan or a health carrier to a health care provider or other entity participating in the health carrier's network. The average shall be calculated according to payments within a reasonable amount of time not to exceed one calendar year. The commissioner may approve methodologies for calculating the average allowed amount that are based on any of the following:

a. A specific covered person's health plan.

b. All health plans offered in the state by a specific health carrier.

c. Geographic area.

2. *"Cost-sharing"* means any coverage limit, copayment, coinsurance, deductible, or other out-of-pocket expense obligation imposed on a covered person by a policy, contract, or plan providing for third-party payment or prepayment of health or medical expenses.

3. *"Covered benefits"* or *"benefits"* means health care services that a covered person is entitled to under the terms of a health benefit plan.

4. *"Covered person"* means a policyholder, subscriber, enrollee, or other individual participating in a health benefit plan.

5. *"Discounted cash price"* means the price an individual pays for a specific health care service if the individual pays for the health care service with cash or a cash equivalent.

6. *"Health benefit plan"* means a policy, contract, certificate, or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

7. *"Health care provider"* means a physician or other health care practitioner licensed, accredited, registered, or certified to perform specified health care services consistent with state law, an institution providing health care services, a health care setting, including but not limited to a hospital or other licensed inpatient center, an ambulatory surgical or treatment center, a skilled nursing center, a residential treatment center, a diagnostic, laboratory, and imaging center, or a rehabilitation or other therapeutic health setting.

8. *"Health care services"* means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

9. *a. "Health carrier"* means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, including an insurance company offering sickness and accident plans, a health maintenance organization, a nonprofit health service corporation, a plan established pursuant to chapter 509A for public employees, or any other entity providing a plan of health insurance, health care benefits, or health care services.

b. For purposes of this chapter, *"health carrier"* does not

include an entity providing any of the following:

(1) Coverage for accident-only, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Liability insurance, including general liability insurance and automobile liability insurance.

(4) Workers' compensation or similar insurance.

(5) Automobile medical-payment insurance.

(6) Credit-only insurance.

(7) Coverage for on-site medical clinic care.

(8) Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance coverage or benefits.

c. For purposes of this chapter, "*health carrier*" does not include an entity providing benefits under a separate policy including any of the following:

(1) Limited scope dental or vision benefits.

(2) Benefits for long-term care, nursing home care, home health care, or community-based care.

(3) Any other similar limited benefits as provided by the commissioner by rule.

d. For purposes of this chapter, "*health carrier*" does not include an entity providing benefits offered as independent noncoordinated benefits including any of the following:

(1) Coverage only for a specified disease or illness.

(2) A hospital indemnity or other fixed indemnity insurance.

e. For purposes of this chapter, "*health carrier*" does not include an entity providing a Medicare supplemental health insurance policy as defined under section 1882(g)(1) of the federal Social Security Act, coverage supplemental to the coverage provided under 10 U.S.C. ch. 55, and similar supplemental coverage provided to coverage under group health insurance coverage.

10. *"Pharmacist"* means the same as defined in section 155A.3.

11. *"Pharmacy"* means the same as defined in section 155A.3.

Sec. ___. NEW SECTION. **514M.3 Health care services — cost controls.**

1. *a.* All health care providers shall establish and disclose the discounted cash price the health care provider will accept for specific health care services. The disclosure shall specify if the discounted cash price varies due to different circumstances, including but not limited to the day or time a health care service is provided, the office or location at which the health care service is provided, how quickly an individual pays the discounted cash price for a health care service the individual received, the income level of the individual who received the health care service, or the ancillary services or amenities provided to an individual at the same time the health care service is provided. The discounted cash price shall be available to all covered persons and to all uninsured individuals. A health care provider may satisfy the requirements of this paragraph by complying with the centers for Medicare and Medicaid services of the United States department of health and human services hospital price transparency final rule published in the federal register on November 22, 2023, or any amendment thereto.

b. A health care provider shall post all discounted cash prices on the health care provider's internet site in a manner that is easily accessible to the public. A health care provider shall update any change in a discounted cash price within ten calendar days of the change, and shall review each discounted cash price at least annually.

c. (1) Prior to the provision of a scheduled health care service, a health care provider shall inform all covered persons and uninsured individuals of the right of the covered person or uninsured individual to pay for a health care service via the discounted cash price. The notice may be provided

electronically, verbally, in writing, or posted at the physical location of the health care provider.

(2) Prior to the provision of a scheduled health care service, a health care provider shall inform a covered person that the covered person may qualify for a deductible credit if the covered person pays the discounted cash price for the health care service and if the discounted cash price is below the average allowed amount paid by the health carrier to network providers for a comparable health care service. The notice may be provided electronically, verbally, in writing, or posted at the physical location of the health care provider.

d. A health care provider shall not enter into a contract that prohibits the health care provider from offering a discounted cash price below the contracted rates the health care provider has with a health carrier, or that prohibits the health care provider from disclosing the health care provider's discounted cash price under paragraph *"b"*.

e. A health carrier shall not enter into a contract with a health care provider that prohibits the health care provider from offering a discounted cash price below the contracted rates the health care provider has with a health carrier, or that prohibits the health care provider from disclosing the health care provider's discounted cash price under paragraph *"b"*.

f. A covered person's out-of-pocket pricing for each prescription drug on a health carrier's formulary shall be available to a pharmacist via an easily accessible and secure internet site hosted by the health carrier at the point the pharmacist fills a prescription drug to the covered person.

g. A health care provider shall provide an individual with an itemized list of all health care services provided to the individual, a statement that the individual paid out-of-pocket for the health care services, and a statement that the health care provider will not make a claim against a health carrier for payment for the health care services provided to the

individual if the individual is a covered person.

2. Each health benefit plan shall disclose to the health benefit plan's covered persons the average allowed amount for each health care service that is covered under the covered person's health benefit plan. If a health benefit plan fails to disclose the average allowed amount for a health care service, a covered person may substitute a benchmark selected by the commissioner.

3. A covered person who elects to receive a covered health care service at a discounted cash price that is below the average allowed amount shall receive credit toward the covered person's in-network cost-sharing as specified in the covered person's health benefit plan, as if the health care service is provided by an in-network health care provider.

4. A health benefit plan shall not discriminate in the form of payment for any covered in-network health care service solely on the basis that the covered person was referred for the health care service by an out-of-network health care provider.

5. *a.* If a covered person elects to pay cash price for a generic-brand covered prescription drug that results in a lower cost than the average allowed amount for the name-brand covered prescription drug under the covered person's health benefit plan, excluding any drug manufacturer's rebate or other discount from the average allowed amount, the health benefit plan shall apply any payments made by the covered person for the generic-brand covered prescription drug to the covered person's cost-sharing as specified in the covered person's health benefit plan as if the covered person purchased the generic-brand prescription drug from a network pharmacy using the covered person's health benefit plan. The health benefit plan shall credit half the difference in the cash price for the generic-brand covered prescription drug and the average allowed amount for the name-brand covered prescription drug, excluding any drug manufacturer's rebate

or other discount from the average allowed amount, toward the covered person's cost-sharing for health care services that are covered or that are considered formulary under the covered person's health benefit plan. The health benefit plan may credit half the difference in the cash price for the generic-brand covered prescription drug and the average allowed amount for the name-brand covered prescription drug, excluding any drug manufacturer's rebate or other discount from the average allowed amount, toward the covered person's cost-sharing for health care services that are not covered or that are considered nonformulary under the covered person's health benefit plan. This paragraph shall not be construed to restrict a health benefit plan from requiring a preauthorization or other precertification normally required by the health benefit plan.

b. A health benefit plan shall provide a downloadable or interactive online form for a covered person to submit proof of payment under paragraph *"a"*, and shall annually inform covered persons of their options under this subsection.

6. Annually at enrollment or renewal, a health carrier shall provide notice to covered persons via the health carrier's health benefit plan materials and the health carrier's internet site of the option, and the process, to receive a covered health care service at a discounted cash price.

7. If a covered person pays a discounted cash price that is above the average allowed amount, the health benefit plan shall credit the covered person's cost-sharing an amount equal to the lesser of the discounted cash price or the average allowed amount.

8. *a.* If a health carrier denies a claim submitted by a covered person pursuant to this chapter, the health carrier shall notify the commissioner and provide evidence to support the denial to the covered person and to the commissioner.

b. A covered person may appeal a claim denial pursuant to chapter 514J.

9. *a.* A covered person shall have access to a program that directly rewards the covered person with a savings incentive for medically necessary covered health care services received from health care providers that offer a discounted cash price below the average allowed amount. Annually at enrollment or renewal, a health carrier shall provide notice to covered persons via the health carrier's health benefit plan materials and the health carrier's internet site of the savings incentive program and how the savings incentive program works. If a covered person exceeds the covered person's annual deductible, the covered person's health benefit plan shall notify the covered person of the savings incentive program and how the savings incentive program works.

b. A covered person's savings incentive for a specific health care service shall be calculated as the difference between the discounted cash price and the average allowed amount. A savings incentive shall be divided equally between the covered person and the covered person's health benefit plan, and may include a cash payment to the covered person. If a third party helps facilitate a covered person in utilizing a discounted cash price that saves money for the covered person, the covered person may share a portion of their savings incentive with the third party.

c. Savings incentives under this subsection shall not be an administrative expense of the health benefit plan for rate development or rate filing purposes.

10. This chapter shall not be construed to prohibit a health care provider from billing a covered person, a covered person's guarantor, or a third-party payor including a health insurer, for health care services provided to a covered person; or to require a health care provider to refund any payment made to the health care provider for a health care service provided to a covered person.

11. If a provision of this chapter or its application to any person or circumstance is held invalid, the invalidity does

not affect other provisions or applications of this chapter which can be given effect without the invalid provision or application.

Sec. ___. SAVINGS INCENTIVE PROGRAM AND DEDUCTIBLE CREDIT PROGRAM FOR STATE EMPLOYEES.

1. Before August 1, 2025, the department of administrative services shall conduct an analysis of the cost-effectiveness of offering a savings incentive program and deductible credit for state employees and retirees.

2. On or before September 1, 2025, the department of administrative services shall submit a report to the general assembly that contains an explanation as to the decision to implement, or not implement, a savings incentive program or deductible credit program.

3. Any savings incentive program or deductible credit found to be cost-effective shall be implemented for the 2026 state employee health insurance open enrollment period.>

3. Title page, line 2, by striking <organizations> and inserting <organizations, and certain cost controls for health care services>

4. By renumbering as necessary.