

S-5063

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

3 1. Page 1, before line 1 by inserting:

4 <DIVISION I

5 PRIOR AUTHORIZATIONS AND EXEMPTIONS>

6 2. Page 3, after line 8 by inserting:

7 <DIVISION \_\_\_\_

8 COST CONTROLS FOR HEALTH CARE SERVICES

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

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

13 Sec. \_\_\_\_ . NEW SECTION. 514M.1 Short title.

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

16 Sec. \_\_\_\_ . NEW SECTION. 514M.2 Definitions.

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

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

27 a. A specific covered person's health plan.

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

30 c. Geographic area.

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

- 1 3. "*Covered benefits*" or "*benefits*" means health care  
2 services that a covered person is entitled to under the terms  
3 of a health benefit plan.
- 4 4. "*Covered person*" means a policyholder, subscriber,  
5 enrollee, or other individual participating in a health benefit  
6 plan.
- 7 5. "*Discounted cash price*" means the price an individual  
8 pays for a specific health care service if the individual pays  
9 for the health care service with cash or a cash equivalent.
- 10 6. "*Health benefit plan*" means a policy, contract,  
11 certificate, or agreement offered or issued by a health carrier  
12 to provide, deliver, arrange for, pay for, or reimburse any of  
13 the costs of health care services.
- 14 7. "*Health care provider*" means a physician or other  
15 health care practitioner licensed, accredited, registered, or  
16 certified to perform specified health care services consistent  
17 with state law, an institution providing health care services,  
18 a health care setting, including but not limited to a hospital  
19 or other licensed inpatient center, an ambulatory surgical  
20 or treatment center, a skilled nursing center, a residential  
21 treatment center, a diagnostic, laboratory, and imaging center,  
22 or a rehabilitation or other therapeutic health setting.
- 23 8. "*Health care services*" means services for the diagnosis,  
24 prevention, treatment, cure, or relief of a health condition,  
25 illness, injury, or disease.
- 26 9. a. "*Health carrier*" means an entity subject to the  
27 insurance laws and regulations of this state, or subject  
28 to the jurisdiction of the commissioner, including an  
29 insurance company offering sickness and accident plans, a  
30 health maintenance organization, a nonprofit health service  
31 corporation, a plan established pursuant to chapter 509A  
32 for public employees, or any other entity providing a plan  
33 of health insurance, health care benefits, or health care  
34 services.
- 35 b. For purposes of this chapter, "*health carrier*" does not

1 include an entity providing any of the following:

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

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

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

7 (4) Workers' compensation or similar insurance.

8 (5) Automobile medical-payment insurance.

9 (6) Credit-only insurance.

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

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

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

18 (1) Limited scope dental or vision benefits.

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

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

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

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

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

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

1 10. "Pharmacist" means the same as defined in section  
2 155A.3.

3 11. "Pharmacy" means the same as defined in section 155A.3.  
4 Sec. \_\_\_\_\_. NEW SECTION. 514M.3 Health care services — cost  
5 controls.

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

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

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

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

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

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

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

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

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

1 individual if the individual is a covered person.

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

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

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

20 5. a. If a covered person elects to pay cash price for  
21 a generic-brand covered prescription drug that results in a  
22 lower cost than the average allowed amount for the name-brand  
23 covered prescription drug under the covered person's health  
24 benefit plan, excluding any drug manufacturer's rebate or  
25 other discount from the average allowed amount, the health  
26 benefit plan shall apply any payments made by the covered  
27 person for the generic-brand covered prescription drug  
28 to the covered person's cost-sharing as specified in the  
29 covered person's health benefit plan as if the covered person  
30 purchased the generic-brand prescription drug from a network  
31 pharmacy using the covered person's health benefit plan. The  
32 health benefit plan shall credit half the difference in the  
33 cash price for the generic-brand covered prescription drug  
34 and the average allowed amount for the name-brand covered  
35 prescription drug, excluding any drug manufacturer's rebate

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

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

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

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

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

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

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

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

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

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

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



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

4 Sec. \_\_\_\_ . SAVINGS INCENTIVE PROGRAM AND DEDUCTIBLE CREDIT  
5 PROGRAM FOR STATE EMPLOYEES.

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

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

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

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

21 4. By renumbering as necessary.

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COMMITTEE ON HEALTH AND HUMAN SERVICES  
JEFF EDLER, CHAIRPERSON