Fiscal Note

Fiscal Services Division

SF 2455 – Non-Network Medical Billing (LSB6871SV.1)
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Fiscal Note Version – Revised

Description

Senate File 2455 relates to insurance coverage for emergency services, reimbursement for out-of-network providers, and complicating factors, and does the following:

- Requires policies, contracts, and plans that provide for third-party payment or prepayment of medical expenses to provide coverage for health care services provided to a covered person by an out-of-network provider in any of the following circumstances:
  - The health care services are emergency services.
  - The health care services were provided at a participating facility, and the covered person did not have the ability or opportunity to receive the services from a participating provider.
- Includes exceptions for the uniformity of treatment requirements in Iowa Code section 514C.6.
- Requires an out-of-network provider to submit claims to the covered person's health carrier within 60 days of providing the service.
- Requires, within 60 days of receiving a claim, the covered person's health carrier to reimburse the out-of-network provider with the greater amount of the following:
  - The median amount that would have been paid to a participating provider who practices in the same specialty as the out-of-network provider for providing the same health care services, excluding any cost sharing.
  - 150.0% of the most recently published federal Centers for Medicare and Medicaid Services (CMS) fee schedule for the health care services provided by the out-of-network provider, excluding any cost sharing.
- Authorizes out-of-network providers who provide health care services that involve complicating factors, as defined in the Bill, to submit a claim for reimbursement in addition to the amounts permitted above. Includes additional documentation requirements.
- Requires health carriers, within 30 days of receiving a claim for additional reimbursement from an out-of-network provider, to pay an additional 25.0% of the amount paid on the initial claim or to issue a denial and explain the basis for the denial.
- Authorizes an out-of-network provider whose claim for additional reimbursement has been denied by a health carrier to file with the Iowa Insurance Commissioner a request for binding arbitration.
- Provides additional requirements for arbitration related to notification, the selection of arbitrator, documentation, factors for consideration, timeline, and the even split of arbitration costs between the carrier and the provider.
- Authorizes the Commissioner to adopt administrative rules to administer the Bill.

The Bill is applicable to specified classes of third-party payment provider contracts, policies, and plans delivered, issued for delivery, continued, or renewed beginning January 1, 2027.

Fiscal Impact

The LSA received updated information on March 16, 2026, and the Bill no longer requires a Fiscal Note.

Sources

Board of Regents
Department of Administrative Services
Iowa Insurance Division
Wellmark

/s/ Jennifer Acton
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The Fiscal Note for this Bill was prepared pursuant to Joint Rule 17 and the Iowa Code. Data used in developing this Fiscal Note is available from the Fiscal Services Division of the Legislative Services Agency upon request.