Senate File 431 - Introduced

SENATE FILE 431
BY BOUSSELOT

A BILL FOR

An Act relating to certain cost controls for health care services, and including penalties.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

Section 1. Section 507B.4, subsection 3, Code 2023, is amended by adding the following new paragraph:

NEW PARAGRAPH. *u. Improper denial of claims.* A health carrier improperly denying claims under chapter 514M.1.

Sec. 2. NEW SECTION. **514M.1 Short title.**

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

Sec. 3. NEW SECTION. **514M.2 Definitions.**

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

1. *"Collection action"* means any of the following actions taken with respect to a debt for health care services purchased from, or provided to a covered person by, a health care provider on a date on which the health care provider was not in material compliance with this chapter:

a. Attempting to collect a debt from a covered person or a covered person's guarantor by referring the debt, directly or indirectly, to a debt collector, a collection agency, or other third-party retained by or on behalf of the health care provider.

b. Suing a covered person or a covered person's guarantor, or enforcing an arbitration or mediation clause in a health care provider's contract, agreement, statement, or bill.

c. Directly or indirectly causing a report to be made to a consumer reporting agency.

2. *"Collection agency"* means a person that regularly collects or attempts to collect, directly or indirectly, debts owed, due, or asserted to be owed or due; that takes assignment of debts for collection purposes; or that directly or indirectly solicits for collection debts owed, due, or asserted to be owed or due.

3. *"Consumer reporting agency"* means a person that for monetary fees, dues, or on a cooperative nonprofit basis, regularly engages in assembling or evaluating consumer credit information, or other consumer information, for the purpose of

providing consumer reports to third parties, and that uses any means or facility of interstate commerce for the purpose of preparing or furnishing consumer reports. "*Consumer reporting agency*" does not include any person that only provides check verification or check guarantee services.

4. "*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.

5. "*Covered person*" means the same as defined in section 514J.102.

6. "*Debt*" means an obligation or alleged obligation of a consumer to pay money arising out of a transaction, whether or not the obligation has been reduced to judgment. "*Debt*" does not include a consumer debt incurred for business, investment, commercial, or agricultural purposes, or a debt incurred by a business.

7. "*Debt collector*" means a person employed or engaged by a collection agency to perform debt collection.

8. "*Deidentified minimum negotiated charge*" means the lowest charge for a specific health care service that a health care provider has negotiated with a health carrier.

9. "*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.

10. "*Health benefit plan*" means the same as defined in section 514J.102.

11. "*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.

12. *"Health care services"* means the same as defined in section 514J.102.

13. *"Health carrier"* means the same as defined in section 514J.102.

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

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

Sec. 4. 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.

b. A health carrier shall post all discounted cash prices via a secure internet site that is easily accessible to all covered persons. A health carrier shall update any change in a discounted cash price within five calendar days of the change, and shall review each discounted cash price at least annually.

c. (1) During the appointment scheduling process, and any intake process prior to the provision of a health care service, covered persons and uninsured individuals shall be informed of their right to pay for the health care service via the discounted cash price.

(2) During the appointment scheduling process, and any intake process prior to the provision of a health care service, a covered person shall be advised that they qualify for a deductible credit if they have not exceeded their deductible to date, and all of the following are true:

(a) The covered person pays the discounted cash price for the health care service.

(b) The discounted cash price is below the deidentified minimum negotiated charge for the specific health care service that the covered person will receive.

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

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

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

3. A covered person who elects to receive a covered health care service at a discounted cash price that is below the deidentified minimum negotiated charge shall receive credit toward the covered person's 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 use a pharmacy discount program, a drug manufacturer's rebate, or other discount or rebate program that results in a lower cost for a covered prescription drug than if the covered person uses their health benefit plan, the health benefit plan shall apply any payments made by the covered person for the 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 prescription drug from a network pharmacy using the covered person's health benefit plan. The health benefit plan shall credit the value of the rebate or other discount 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 the value of the rebate or other discount 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 below the deidentified minimum negotiated charge.

7. If a covered person pays a discounted cash price that is above the deidentified minimum negotiated charge, the health benefit plan shall credit the covered person's cost-sharing an amount equal to the discounted cash price.

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 to the commissioner within sixty calendar days of the denial. The appeal shall be adjudicated within thirty calendar days of the covered person's request for an appeal. If the commissioner determines that the health carrier improperly denied the covered person's claim, the health carrier shall pay the covered person's costs and attorney fees associated with the appeal, shall accept the covered person's claim, and shall provide cash compensation to the covered person in an amount equal to the amount of the claim.

c. If a health carrier denies twenty or more claims in any one quarter, the commissioner shall have the authority to investigate the denials. If the commissioner finds that a health carrier has improperly denied claims under this chapter, or committed an unfair or deceptive act or practice under section 507B.4, subsection 3, paragraph *"u"*, the commissioner may conduct a hearing under section 507B.6.

9. *a.* For costs that exceed a covered person's deductible, the 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 deidentified minimum negotiated charge. 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 deidentified minimum negotiated charge. 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.

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. *a.* A health care provider shall not initiate or pursue a collection action against a covered person, or a covered person's guarantor, for a debt owed for a health care service unless the health care provider is in material compliance with this chapter on the date that the health care provider provided the health care service to the covered person.

b. If a health care provider initiates or pursues a collection action in violation of paragraph "*a*", the covered person or the covered person's guarantor may file for a declaratory judgment with a court of competent jurisdiction and the health care provider shall not continue the collection action against the covered person, or the covered person's guarantor, while the lawsuit is pending. If the court finds in favor of the covered person, or the covered person's guarantor, the court shall order the health care provider to do all of the following:

(1) Refund a payor any amount the payor paid for the debt that is the subject of the lawsuit.

(2) Pay a penalty to the covered person, or the covered person's guarantor, in an amount equal to the total amount of the debt that is the subject of the lawsuit.

(3) Dismiss with prejudice, or cause to be dismissed with prejudice, any court action related to the collection action

or the lawsuit.

(4) Pay any attorney fees and costs incurred by the covered person, or the covered person's guarantor, related to the collection action or the lawsuit.

(5) Remove or cause to be removed from the covered person's or the covered person's guarantor's credit report any report made to a consumer reporting agency related to the debt that is the subject of the lawsuit.

11. Provided that a health care provider does not initiate or pursue a collection action in violation of this chapter, 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.

12. 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.

EXPLANATION

The inclusion of this explanation does not constitute agreement with the explanation's substance by the members of the general assembly.

This bill relates to certain cost controls for health care services and may be cited as "The Patient's Right to Save Act".

Under the bill, all health care providers (providers) are required to establish and disclose the discounted cash price (cash price) the provider will accept for specific health care services (services). "Discounted cash price" is defined in the bill as the price an individual pays for a specific service if the individual pays with cash or a cash equivalent. The cash price shall be available to all covered persons (persons) and to all uninsured individuals. A health carrier (carrier)

shall post the cash prices via an easily accessible and secure internet site, update any change in a cash price within five days of the change, and review each cash price at least annually.

During the appointment scheduling process, and any intake process prior to the provision of a service, persons and uninsured individuals shall be informed of their right to pay for the service via the cash price. A person shall also be advised that they qualify for a deductible credit if they have not exceeded their deductible to date, and the criteria in the bill is satisfied.

A carrier shall not enter into a contract that prevents the carrier from offering a cash price below the contracted rates the carrier has with other commercial or public payors, or that prevents the carrier from disclosing the carrier's cash price to persons.

A person's out-of-pocket pricing for each drug on a carrier's formulary shall be available to a provider via an easily accessible and secure internet site hosted by the carrier at the point the provider prescribes drugs to a person.

Each plan shall disclose to the plan's covered persons the negotiated charge for each service that is covered under the person's plan. If a plan fails to disclose each negotiated charge, a person may substitute a benchmark selected by the commissioner of insurance (commissioner) for the negotiated charge. A person who elects to receive service at a cash price that is below the deidentified minimum negotiated charge (negotiated charge) shall receive credit toward the person's cost-sharing as if the service had been provided by a network provider. "Deidentified minimum negotiated charge" is defined in the bill as the lowest cost for a specific service that a provider has negotiated with a carrier for a person's plan.

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

If a person elects to use a pharmacy discount program, a drug manufacturer's rebate, or other discount or rebate program that results in a lower cost for a drug than if the person uses the person's plan, the plan shall apply any payments made by the person for the drug as detailed in the bill. A plan is required to provide an online form for the purpose of a person submitting proof of payment, and to annually inform persons of their options related to discounts and rebates.

Annually at enrollment or renewal, a carrier shall provide notice to persons via the carrier's health plan materials and on the carrier's internet site of the option and the process to receive a covered service at a cash price below the negotiated charge. If a person pays a cash price that is above the negotiated charge, the plan shall give the person credit toward the person's cost-sharing in an amount equal to the cash price.

If a carrier denies a claim submitted by a person, the carrier shall notify the commissioner and provide evidence to support the denial to the person and the commissioner. A person may appeal a denial of a claim to the commissioner as detailed in the bill. If the commissioner determines that the carrier improperly denied the person's claim, the carrier shall pay the person's costs and attorney fees, accept the person's claim, and provide cash compensation to the person as detailed in the bill. If a carrier denies 20 or more claims in any one quarter, the commissioner shall have the authority to investigate the denials. If the commissioner finds that a health carrier has improperly denied claims under this chapter or committed an unfair or deceptive act or practice under Code section 507B.4(3)(u), the commissioner may conduct a hearing under Code section 507B.6. If, after hearing, the commissioner determines that a person has engaged in an unfair or deceptive act or practice, the commissioner shall reduce the findings to writing and shall issue and cause to be served upon the person charged with the violation a copy of such findings, an order requiring such person to cease and desist from engaging in

such act or practice, and may at the commissioner's discretion order any one or more penalties, license suspension, or license revocation as detailed in the bill.

For costs that exceed a person's deductible, the person shall have access to a program that directly rewards the person with a savings incentive as detailed in the bill.

A provider shall not initiate or pursue a collection action (action) against a person, or a person's guarantor, for a debt owed for a service unless the provider is in material compliance with the bill on the date that the service is provided to the person. If a provider initiates or pursues an action, the person may file for a declaratory judgment with a court of competent jurisdiction and the provider shall not continue the collection action while the suit is pending. If the court finds in favor of the person, the court shall order the provider to comply with the requirements detailed in the bill.

Provided the provider does not initiate or pursue an action in violation of the bill, the bill shall not be construed to prohibit a provider from billing a person, a person's guarantor, or a third-party payor, including a health insurer, for a service provided to the person, or to require a provider to refund any payment made to the provider for a service provided to a person.

If a provision of the bill or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the bill which can be given effect without the invalid provision or application.