Senate Study Bill 3177 - Introduced

SENATE FILE _____
BY (PROPOSED COMMITTEE
ON COMMERCE BILL BY
CHAIRPERSON BOUSSELOT)

A BILL FOR

An Act relating to insurance coverage for emergency services, reimbursements for out-of-network providers, and complicating factors.

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

Section 1. NEW SECTION. **514C.16A Emergency services — coverage.**

1. As used in this section, unless the context otherwise requires:

a. "Arbitrator list" means a list maintained by the commissioner of arbitrators approved in the state who are listed in the American arbitration association roster or the American health law association candidate list to provide binding arbitration for purposes of this section.

b. "Commissioner" means the commissioner of insurance.

c. "Complicating factor" means an element incident to the provision of a health care service that is not typically involved in the provision of a health care service and is not reflected in the medical procedure code submitted by a health care professional. *"Complicating factor"* includes but is not limited to the severity of a covered person's condition, or the special technical, physical, or mental effort required by a health care professional to provide a health care service.

d. "Cost sharing" means any coverage limit, copayment, coinsurance, deductible, or other out-of-pocket cost obligation imposed by a health benefit plan on a covered person.

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

f. "Emergency medical condition" means a medical condition that manifests by symptoms of sufficient severity, including but not limited to severe pain, that an ordinarily prudent person, possessing average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in one of the following:

(1) Placing the health of the individual in serious jeopardy.

(2) Serious impairment to bodily function.

(3) Serious dysfunction of a bodily organ or part.

g. "Emergency services" means covered inpatient and outpatient health care services that are furnished by a health

care professional who is qualified to provide the services that are needed to evaluate or stabilize an emergency medical condition.

h. *"Facility"* means the same as defined in section 514J.102.

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

j. *"Health care professional"* means the same as defined in section 514J.102.

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

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

m. *"Out-of-network provider"* means a health care professional that is not a participating provider who provides health care services to a covered person.

n. *"Participating facility"* means a facility that has entered into a contract with a contracting entity to provide health care services to a covered person with the expectation of receiving payment for providing the health care services either directly from the contracting entity or from a health carrier affiliated with the contracting entity.

o. *"Participating provider"* means a health care professional who has entered into a contract with a contracting entity to provide health care services to a covered person with the expectation of receiving payment for providing the health care services either directly from the contracting entity or from a health carrier affiliated with the contracting entity.

2. Notwithstanding the uniformity of treatment requirements of section 514C.6, a policy, contract, or plan providing for third-party payment or prepayment of medical expenses shall provide coverage for health care services provided to a covered person by an out-of-network provider in any of the following circumstances:

a. The health care services are emergency services.

b. The health care services were provided at a participating

facility and the covered person did not have the ability or opportunity to receive the health care services from a participating provider.

3. An out-of-network provider who provides health care services under subsection 2 shall submit a claim to the covered person's health carrier no later than sixty calendar days after the date the out-of-network provider provided the health care services. No more than sixty calendar days after receipt of a claim, the health carrier shall reimburse the out-of-network provider in an amount that is the greater of either of the following:

a. 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.

b. One hundred fifty percent of the most recently published federal centers for Medicare and Medicaid services fee schedule for the health care service provided by the out-of-network provider, excluding any cost sharing.

4. An out-of-network provider who provides health care services under subsection 2 shall not bill, attempt to collect from, or collect from, a covered person any amount other than the cost sharing required by the covered person's health benefit plan.

5. *a.* An out-of-network provider who provides a health care service under subsection 2 that involves a complicating factor may submit, as part of an initial claim submitted under subsection 3, a claim for reimbursement in addition to the amount of reimbursement provided by subsection 3. The claim for additional reimbursement must be accompanied by medical records and other clinical documentation necessary to demonstrate the complicating factor and justify the additional reimbursement.

b. A health carrier that receives a claim for additional reimbursement from an out-of-network provider shall, no more

than thirty calendar days after the date of receipt of such claim, either pay the out-of-network provider an additional reimbursement in an amount equal to twenty-five percent of the amount paid on the initial claim under subsection 3, or issue a letter of denial to the out-of-network provider that explains the basis for denying the claim for additional reimbursement.

c. If a health carrier denies a claim for additional reimbursement, the out-of-network provider may file with the commissioner a written request for binding arbitration that includes all of the following:

(1) The name and contact information of the health carrier.

(2) The medical records and clinical documentation demonstrating the complicating factor and justifying the request for additional reimbursement that the out-of-network provider submitted to the health carrier.

(3) The letter from the health carrier denying the claim for additional reimbursement.

d. The commissioner shall notify an out-of-network provider that files a written request for binding arbitration under paragraph "*c*" and the health carrier that denied the claim for additional reimbursement, no later than thirty calendar days after receipt of the request, of the acceptance or denial of the request.

e. No more than thirty calendar days after the date of receipt of the notice under paragraph "*d*", the health carrier shall submit written documentation to the commissioner that either reconfirms the health carrier's denial of the claim for additional reimbursement, or provides an alternative payment offer for consideration during arbitration.

f. Prior to an arbitration, the out-of-network provider and health carrier shall agree upon an arbitrator from the arbitrator list, and submit all documentation provided under paragraphs "*c*" and "*e*" to the selected arbitrator. The arbitrator shall provide a written decision regarding the outcome of the arbitration to the out-of-network provider and

health carrier no later than forty-five calendar days after the date of receipt of all documentation submitted by both parties. In making a determination as to the outcome of the arbitration, the arbitrator shall consider all of the following:

(1) The complicating factor at issue.

(2) The medical records and clinical documentation demonstrating the complicating factor and justifying additional reimbursement that the out-of-network provider submitted to the health carrier.

(3) The letter from the health carrier to the out-of-network provider denying the claim for increased reimbursement.

(4) The written documentation provided by the health carrier that reconfirms the health carrier's denial of the claim for increased reimbursement, if any.

(5) All alternative payment offers the health carrier offered to the out-of-network provider, if any.

g. The costs of arbitration shall be paid equally by the health carrier and the out-of-network provider.

6. This section does not prohibit an out-of-network provider and a health carrier from agreeing, through private negotiations or an internal dispute resolution process, to a reimbursement amount that is greater than the reimbursement amount required by this section.

7. *a.* This section applies to the following classes of third-party payment provider contracts, policies, or plans delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2027:

(1) Individual or group accident and sickness insurance providing coverage on an expense-incurred basis.

(2) An individual or group hospital or medical service contract issued pursuant to chapter 509, 514, or 514A.

(3) An individual or group health maintenance organization contract regulated under chapter 514B.

(4) A plan established for public employees pursuant to chapter 509A.

b. This section shall not apply to accident-only, specified disease, short-term hospital or medical, hospital confinement indemnity, credit, dental, vision, Medicare supplement, long-term care, basic hospital and medical-surgical expense coverage as defined by the commissioner of insurance; disability income insurance coverage; coverage issued as a supplement to liability insurance, workers' compensation or similar insurance; or automobile medical payment insurance.

8. The commissioner of insurance may adopt rules pursuant to chapter 17A to administer this section.

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 insurance coverage for emergency services, reimbursements for out-of-network providers, and complicating factors.

The bill requires a policy, contract, or plan providing for third-party payment or prepayment of medical expenses to provide coverage for health care services (services) provided to a covered person by an out-of-network provider if the services are emergency services, or the services were provided at a participating facility and the covered person could not receive the services from a participating provider. "Emergency services", "out-of-network provider", "participating facility", and "participating provider" are defined in the bill.

An out-of-network provider that provides services to a covered person under the bill shall submit a claim to a health carrier (carrier) no later than 60 days after providing services. No more than 60 days after receipt of a claim, the carrier shall reimburse the out-of-network provider in an amount that is the greater of the median amount that would have been paid to a participating provider for providing the same services, or 150 percent of the fee schedule for the service, excluding any cost sharing.

An out-of-network provider who provides services shall not

bill, attempt to collect from, or collect from a covered person any amount other than the cost sharing required by the covered person's health benefit plan.

An out-of-network provider who provides a service to a covered person that involves a complicating factor may submit, as part of an initial claim, a claim for an additional reimbursement. "Complicating factor" is defined in the bill. The claim for additional reimbursement must be accompanied by medical records and clinical documentation sufficient to demonstrate the complicating factor and justify the request for additional reimbursement.

A carrier that receives a claim for additional reimbursement shall, within 30 days, either pay the out-of-network provider an additional reimbursement in an amount equal to 25 percent of the initial claim reimbursement, or issue a letter denying the claim for additional reimbursement.

If a carrier denies a claim for additional reimbursement, the out-of-network provider may file a written request for binding arbitration with the commissioner of insurance (commissioner) that includes the information detailed in the bill. The commissioner shall notify the out-of-network provider and carrier within 30 days whether the request has been accepted or denied. A carrier that receives notice of arbitration shall submit written documentation to the commissioner, within 30 days of the notice, that either reconfirms the carrier's denial of additional reimbursement, or provides an alternative payment offer for consideration during arbitration.

Prior to an arbitration, the out-of-network provider and carrier shall agree upon an arbitrator from the arbitrator list, and submit documentation required by the bill to the arbitrator. The arbitrator shall provide a written decision regarding the outcome of the arbitration within 45 days. The arbitrator shall consider the complicating factor at issue and documentation required by the bill. The costs of arbitration

shall be paid equally by the carrier and the out-of-network provider.

The bill does not prohibit an out-of-network provider and a carrier from agreeing to a reimbursement amount that is greater than the reimbursement amount required by the bill.

The bill applies to third-party payment provider contracts, policies, or plans delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2027, by the third-party payment providers enumerated in the bill. The bill specifies the types of specialized health-related insurance which are not subject to the bill's coverage requirements.

The commissioner may adopt rules to administer the bill.