THE PATIENTS RIGHT TO SAVE ACT

SECTION 1. Title.

This bill shall be known and may be cited as the "The Patient's Right to Save Act"

SECTION 2. Definitions.

A. ''De-identified minimum negotiated charge'' means the lowest charge that a health care entity has negotiated with all third-party payers for an item or service in a patient's particular third-party payer plan.

B. ''Discounted cash price'' means the price charged to individuals who pay cash (or cash equivalent) for an individual item or service or service package.

C. "Health care entity" means:

i. A hospital;

ii. A clinic, facility, or location that provides health care items and services to patients paying themselves or whose care will at least partially be paid for by a private third party.

(Drafter's Note on C: The intent is to not require a publicly run facility that only see public patients, like a clinic in a jail, from having to comply with this price transparency requirement)

D. "Items and services" includes both individual items and services and service packages, that could be provided to a patient in connection with an inpatient admission or an outpatient visit.

SECTION 3. Ending patient discrimination to access more affordable care

A. All health care entities and providers licensed by the state shall set and disclose the discounted cash price(s) they would accept for items and services in a machine-readable format.

B. Such disclosure shall specify when the discounted cash price varies for reasons such as, but not limited to, the time of day the item and service is provided, day of service, office location, if the patient is filling a last minute cancelled appointment, or the promptness of the payment, if items and services are billed individually or by a service package, or if the price varies by income level, or for any ancillary services or amenities provided during the service.

C. Such discounted cash price shall be available to all patients regardless of insurance plan or insurance status.

D. Health care entities shall publish such information on their website, if they have one, and/or provide a link to a third-party that provides patients free access to discounted cash prices for items and services, including those offered through that entity.

E. Patients shall be informed of their ability to access discounted cash prices during any intake process to make an appointment, or when checking in for a service.

i. That disclosure should inform the patient or potential patient insured on a plan regulated under {*insert reference to individual and small group insurance code*}

that the patient would quality under Section 3 of this Act for deductible credit if they have not exceeded their deductible to date if

a. The patient were to pay the discounted cash price and
b. The discounted cash price is below the de-identified minimum negotiated charge

F. Discounted cash pricing information shall be updated at least annually, or within 10 days of pricing changes.

G. Limit on contractual obligations to avoid disclosure

i. Health care entities licensed in the state may not sign contracts that prevent them from offering a discounted cash price below other contracted rates with either commercial and public payers, or that prevents the health entity from disclosing their discounted cash price to patients. Such a clause of any current contract that does so is void and shall be stricken from subsequent versions of the contract.

ii. A health insurance plan or pharmacy benefits manager may not impose on an enrollee a copayment or other charge that exceeds the claim cost of a prescription drug. If information related to an enrollee's out-of-pocket cost or the clinical efficacy of a prescription drug or alternative medication is available to a pharmacy provider, a carrier or pharmacy benefits manager may not penalize a pharmacy provider for providing that information to an enrollee. Out-of-pocket pricing shall be displayed via an interface to prescribers at the point of prescribing with the patient.

SECTION 4. Ending enrollee penalties for accessing more affordable care

A. Beginning upon approval of the next health insurance rate filing after enactment, an enrollee covered under*{insert reference to individual and small group insurance code}* that elects to receive medically necessary covered items or services at a discounted cash priced that is below the de-identified minimum negotiated charge shall receive credit toward the enrollee's deductible and out-of-pocket maximum as specified in the enrollee's health plan as if the health care services had been provided by a network provider.

B. Health plans licensed under *{insert reference to individual and small group insurance code}* shall disclose to the enrollee the de-identified minimum negotiated charge for their particular health plan. If health care entities do not disclose the de-identified minimum negotiated charge, then enrollees can reference a benchmark selected by the *{insert Insurance Department / Commissioner / Superintendent}* as a substitute for the minimum negotiated charge, which may be drawn from a third-party.

C. Anti-discrimination enrollee protection**:** A health plan may not discriminate in the form of payment for any network health care item or service covered under an enrollee's health plan based solely on the basis that the enrollee's referral was made by a provider who is not a member of the carrier's provider network.

D. If an enrollee elects to utilize a pharmacy discount program, drug manufacturer rebate, or other discount or rebate program from a U.S.-based seller, including purchasing from a licensed prescribing provider such as a direct primary care

provider, that results in a lower cost than would have been paid for a covered prescription medication had the enrollee utilized their health insurance policy to purchase the drug, the health plan shall apply the payments made by the enrollee for that covered prescription medication toward the enrollee's deductible and out-of-pocket maximum as specified in the enrollee's health plan as if the prescription medication had been purchased from a network pharmacy utilizing the enrollee's health plan. The insurer may recognize the value of a discount or coupon towards a patient's deductible. Notwithstanding prescribed services that are not covered or considered non-formulary to the health plan, the health plan shall grant this credit, but nothing in this section shall be construed to restrict a health plan from requiring standard preauthorization or other precertification requirements that are currently required.

E. The health plan shall provide a downloadable or interactive online form for the purpose of submitting proof of payment, and inform enrollees of their options under this section annually.

F. Annually at enrollment or renewal, a carrier shall provide notice to enrollees in plan benefit material and on their website of the availability of the program with a description of how they may utilize the program.

G. To ensure maximum enrollee choice but protect health plans, if the enrollee utilizes a discounted cash price option that is above the de-identified minimum negotiated charge, then the health plan shall only give credit toward the enrollee deductible and out-of-pocket responsibility equal to the discounted cash price or de-identified minimum negotiated charge, whichever is lowest.

I. Appeals of denials of claims

i. If a carrier denies a claim submitted by an enrollee pursuant to this act, the carrier must notify the {*Insurance Department / Commissioner / Superintendent}* and provide supporting evidence for the denial to the enrollee and {*Insurance Department / Commissioner / Superintendent}*.

ii. An enrollee may appeal any denial of a claim submitted pursuant to this act to the {*Insurance Department / Commissioner / Superintendent}* within 60 days of such denial. Such appeal shall be adjudicated within 30 days.

iii. If the {*Insurance Department / Commissioner / Superintendent}* determines that the carrier improperly denied a claim, the carrier must pay enrollee's costs and attorney's fees associated with the appeal, must accept the filed claim, and must provide cash compensation equal to the amount of the claim to the enrollee.

J. Investigation of excessive claim denials

i. If a carrier denies more than twenty claims in one quarter under this act, the {*Insurance Department / Commissioner / Superintendent}* shall notify the State Attorney General's office of {Insurance}. The Attorney General shall have authority to investigate any unfair trade practices in denying claims under this act.

ii. Should the Attorney General find that the carrier is wrongly denying claims under this act on an unreasonable basis, the Attorney General's office may prosecute improper denials as an unfair trade practice under {STATE CODE}.

SECTION 5. Assisting patients with chronic conditions to save on health care

A. Beginning upon approval of the next health insurance rate filing after enactment, for spending that exceeds a patient's deductible, the patient shall have access to a program in which enrollees are directly rewarded with a saving incentive for medically necessary covered items and services received at health care entities that have a discounted cash price below the de-identified minimum negotiated charge.

i. The savings incentive will be calculated as the difference between the discounted cash price and the de-identified minimum negotiated charge.
ii. Such a saving incentive shall be divided between the enrollee and the health plan.
iii. The enrollee may split a portion of their savings incentive with a third-party that helps facilitate finding the discounted cash price,
iv. A third-party may also provide services including but not limited to, making appointments for patients, and filing paperwork with health plans to receive their portion of any savings incentives.
v. The third-party shall only be compensated if they save money for the patient.

B. Savings incentives may include cash payments.

C. Once an enrollee has exceeded their deductible, a health plan shall notify the enrollee of the savings incentive program and how it works.

D. A savings incentive payment made by a health plan in accordance with this section is not an administrative expense of the health plan for rate development or rate filing purposes.

SECTION 6. Severability and effective date.

A. It is the intention of the legislature that the provisions of this section shall be severable. If any provision of this section or its application to any person or circumstance is held invalid, the remainder of the section or the application of the provision to other persons or circumstances is not affected, including but not limited to the applicability of this section to the provisions of future agreements subject to this section.

B. The provisions of this Act take effect following the next approval of health plan rate filings after enactment.

SECTION 7. Prohibiting collection action of debt against patients for non-compliant facilities.

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

A. "Collection action" means any of the following actions taken with respect to a debt for items and services that were purchased from or provided to a patient by a hospital on a date during which the hospital was not in material compliance with hospital price transparency laws:

i. Attempting to collect a debt from a patient or patient 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 hospital;

ii. Suing the patient or patient guarantor, or enforcing an arbitration or mediation clause in any hospital documents including contracts, agreements, statements, or bills; or

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

B. "Collection agency" means any:

i. Person who engages in a business the principal purpose or which is the collection of debts; or

ii. Person who regularly collects or attempts to collect, directly or indirectly, debts owed or due or asserted to be owed or due to another; takes assignment of debts for collection purposes; or directly or indirectly solicits for collection debts owed or due or asserted to be owed or due to another.

C. "Consumer reporting agency" means any person that, for monetary fees, dues, or on a cooperative nonprofit basis, regularly engages, in whole or in part, in the practice of assembling or evaluating consumer credit information or other information on consumers for the purpose of furnishing consumer reports to third parties.

i. Includes any person defined in 15 U.S.C. sec. 1681a (f) or section 5-18-103 (4) but d

ii. Does not include any business entity that only provides check verification or check guarantee services.

D. "Debt" means any 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. It does not include a debt for business, investment, commercial, or agricultural purposes or a debt incurred by a business.

E. "Debt collector" means any person employed or engaged by a collection agency to perform the collection of debts owed or due or asserted to be owed or due to another.

F. "Federal Centers for Medicare & Medicaid Services" or "CMS" means the Center for Medicare & Medicaid Services in the United States Department of Health and Human Services.

i. "Hospital" means, consistent with 45 CFR 180.20, a hospital

ii. Licensed or certified by the Department pursuant to (*insert reference to state law related to hospital licensing*); or

H. Approved by the Department as meeting the standards established for licensing a hospital.

I. "Hospital price transparency laws" means 42 U.S. Code § 300gg-18(e). ~~Section 2718(e)~~, as amended, and rules adopted by the United States Department of Health and Human Services implementing section 2718(e) of the "Public Health Service (PHS) Act," Pub.L. 78-410.

J. "Items and services" includes both individual items and services and service packages, that could be provided to a patient in connection with an inpatient admission or an outpatient visit. .

SECTION 8. Failure to comply with hospital price transparency laws – prohibiting collection of debt – penalty.

A. On and after the effective date of this section, a hospital shall not initiate or pursue a collection action against the patient or patient guarantor for a debt owed for the items or services unless the hospital is in material compliance with hospital price transparency laws on the date that items or services are purchased from or provided to a patient by the hospital.

B. If a patient believes that a hospital was not in material compliance with hospital price transparency laws on a date on or after the date that items or services were purchased by or provided to the patient, and the hospital takes a collection action against the patient or patient guarantor, the patient or patient guarantor may file declaratory judgment suit to determine if the hospital was materially out of compliance with the hospital price transparency laws and rules and regulations on the date of service, and the noncompliance is related to the items or services. The hospital must not take a collection action against the patient or patient guarantor while such lawsuit is pending.

C. A hospital found by the court to be materially out of compliance with hospital price transparency laws and rules and regulations:

i. Must refund the payer any amount of the debt the payer has paid and must pay a penalty to the patient or patient guarantor in an amount equal to the total amount of the debt;

ii. Must dismiss or cause to be dismissed any court action with prejudice and pay any attorney fees and costs incurred by the patient or patient guarantor relating to the action; and

iii. Remove or cause to be removed from the patient's or patient guarantor's credit report any report made to a consumer reporting agency relating to the debt.

D. Nothing in this Act prohibits a hospital from billing a patient, patient guarantor, or third-party payer, including health insurer, for items or services provided to the patient or to require a hospital to refund any payment made to the hospital for items or services provided to the patient, so long as no collection action is taken in violation of this Act.

SECTION 9. Effective Date

A. The provisions of this Act take effect ninety-days after signature.