LEGISLATURE OF THE STATE OF IDAHO

Sixty-fifth Legislature Second Regular Session - 2020

IN THE HOUSE OF REPRESENTATIVES

HOUSE BILL NO. 387

BY HEALTH AND WELFARE COMMITTEE

AN ACT

RELATING TO THE NO SURPRISES ACT; AMENDING TITLE 41, IDAHO CODE, BY THE ADDITION OF A NEW CHAPTER 66, TITLE 41, IDAHO CODE, TO PROVIDE A SHORT TITLE, TO PROVIDE LEGISLATIVE INTENT, TO DEFINE TERMS, TO ESTABLISH PROVISIONS REGARDING BILLING BY HEALTH CARE PROVIDERS IN CERTAIN FACILITIES, AND TO PROVIDE APPLICABILITY FOR SELF-FUNDED PLANS.

Be It Enacted by the Legislature of the State of Idaho:

SECTION 1. That Title 41, Idaho Code, be, and the same is hereby amended by the addition thereto of a NEW CHAPTER, to be known and designated as Chapter 66, Title 41, Idaho Code, and to read as follows:

CHAPTER 66

NO SURPRISES ACT

41-6601. SHORT TITLE. This chapter shall be known and may be cited as the "No Surprises Act."

41-6602. LEGISLATIVE INTENT. In enacting this chapter, it is the intent of the legislature to protect patients covered by a health benefit plan from surprise billing practices by certain health care providers.

41-6603. DEFINITIONS. As used in this chapter:

(1) "Contracted facility" means a facility as defined in section 41-5903, Idaho Code, that has a contract with the patient's health benefit plan regarding pricing of health care services.

(2) "Contracted provider" means a provider that has a contract with the patient's health benefit plan regarding pricing of health care services.

(3) "Health benefit plan" shall have the same meaning as provided in section 41-5903, Idaho Code.

(4) "Provider" means a provider of health care services.

41-6604. BILLING BY PROVIDERS IN CONTRACTED FACILITIES. (1) If a patient is covered by a health benefit plan, then a provider shall not bill or seek reimbursement for services rendered to the patient in a contracted facility for amounts that exceed the amounts set forth in paragraphs (a) and (b) of this subsection:

(a) Payment by the patient's health benefit plan for a covered service of the amount the health benefit plan would pay a contracted provider for the same services at the same time in the same geographic area; and

(b) Payment by the patient of the amount of the patient's coinsurance, deductible, and copayment for a contracted provider at the contracted facility under the patient's health benefit plan.

(2) The patient's health benefit plan shall pay the amounts described in subsection (1)(a) of this section directly to the provider. Upon receipt of written request from the provider to the director, the director is authorized to inquire of the patient's health benefit plan to verify whether or not the amount paid to the provider is consistent with subsection (1) of this section and so advise the provider in writing.

(3) Any provision in a consent form or other agreement that purports to permit a provider to bill or seek reimbursement for amounts in excess of the amounts permitted under this chapter is void and unenforceable.

(4) Notwithstanding the provisions of subsection (3) of this section, a patient may agree in writing to accept services at a contracted facility from a provider who is not a contracted provider if:

(a) The agreement does not apply to the provision of emergency medical services;

(b) The agreement is specific about the services to be rendered and the price to be paid for the services;

(c) At least seven (7) calendar days before the provision of services, the agreement is signed by the patient and the provider sends a copy of the executed agreement to the health benefit plan;

(d) The agreement expires and is of no binding effect within twelve (12) months of the date of the patient's signature;

(e) The agreement explains that, by signing it, the patient and provider will receive only out-of-network benefits and reimbursements; and

(f) The agreement explains that the patient is entitled to request and receive from the contracted facility other options to facilitate the services being rendered to the patient by an in-network provider.

General or ambiguous agreements will not be considered valid for purposes of this subsection.

(5) Any billing made in violation of this chapter shall be void and unenforceable. Any provider who violates this chapter shall reimburse the patient for any attorney's fees and costs the patient incurs to challenge the provider's actions or to defend against the provider's attempts to collect the bill or seek reimbursement in violation of this chapter.

41-6605. SELF-FUNDED PLAN PARTICIPATION. The provisions of this chapter apply to a self-funded group health plan governed by the provisions of the federal employee retirement income security act of 1974, 29 U.S.C. 1001 et seq., or to a self-funded plan exempt from the provisions of title 41, Idaho Code, only if the plan elects to participate in the provisions of this chapter. To elect to participate in this chapter, the plan shall provide notice, on an annual basis, to the director in a manner prescribed by the director, attesting to the plan's participation and agreeing to be bound by the provisions of this chapter. At least once annually, the director shall post a list on the department's website of those self-funded plans that have elected to participate in the provisions of this chapter. An entity administering a plan that elects to participate under this chapter shall comply with the provisions of this chapter but shall not be considered a carrier or health benefit plan subject to the jurisdiction of the director solely by virtue of an election made under this chapter.