LEGISLATURE OF THE STATE OF IDAHO

Sixty-fourth Legislature Second Regular Session - 2018

IN THE HOUSE OF REPRESENTATIVES

HOUSE BILL NO. 495

BY HEALTH AND WELFARE COMMITTEE

AN ACT

RELATING TO THE HEALTH CARE BILLING EQUITY ACT; AMENDING TITLE 41, IDAHO CODE, BY THE ADDITION OF A NEW CHAPTER 65, TITLE 41, IDAHO CODE, TO PROVIDE A SHORT TITLE, TO PROVIDE LEGISLATIVE INTENT, TO DEFINE TERMS, TO ESTABLISH PROVISIONS REGARDING EMERGENCY SERVICES AND TO ESTABLISH PROVISIONS REGARDING NONEMERGENCY HEALTH CARE SERVICES.

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 65, Title 41, Idaho Code, and to read as follows:

CHAPTER 65

HEALTH CARE BILLING EQUITY ACT

41-6501. SHORT TITLE. This chapter shall be known and may be cited as the "Health Care Billing Equity Act."

41-6502. LEGISLATIVE INTENT. In enacting this chapter, it is the intent of the legislature to protect Idaho residents from unexpected balance billing for health care services performed by out-of-network providers at in-network health care facilities.

41-6503. DEFINITIONS. As used in this chapter:

(1) "Balance billing" means the billing to a covered person by a health care provider of more than the coinsurance, copayment or deductible amounts owed by the covered person for covered benefits.

(2) "Covered benefits," "covered person," "facility," "health benefit plan," "health care provider" or "provider," "health care services" and "health carrier" shall have the same meanings as provided in section 41-5903, Idaho Code.

(3) "Emergency services" shall have the same meaning as provided in section 41-3903, Idaho Code.

(4) "In-network" means having a contract with a health carrier regarding pricing of and payment for health care services received by a covered person under a given health benefit plan.

(5) "Nonemergency health care services" means health care services that do not qualify as emergency services.

(6) "Out-of-network" means lacking a contract described in subsection (4) of this section.

41-6504. EMERGENCY SERVICES -- PROHIBITION -- RATE OF REIMBURSEMENT. (1) All out-of-network providers of emergency services provided to a covered person in an in-network facility under that person's health benefit

plan are prohibited from balance billing the covered person for emergency services.

(2) A covered person's health benefit plan shall reimburse an out-of-network provider for emergency services provided to the covered person at an in-network facility under that person's health benefit plan at the greater of the following rates for covered benefits:

(a) Eighty-five percent (85%) of the reimbursement rate for the nearest in-network provider licensed to provide the services under the covered person's health benefit plan; or

(b) One hundred forty-five percent (145%) of the medicare payment rate for the same services in the area where the services were provided.

41-6505. NONEMERGENCY CARE -- PROHIBITION -- EXCEPTION. An out-of-network health care provider shall not balance bill a covered person for nonemergency health care services performed at an in-network facility under the covered person's health benefit plan, provided that the provisions of this section do not apply to nonemergency health care services provided to a covered person who agrees to receive the services from an out-of-network provider in an in-network facility under a covered person's health benefit plan if:

(1) The covered person signed an agreement in writing with the provider on a date prior to the date of admission to the facility for health care services; and

(2) Such agreement states in a font at least twice as large as the next-largest font in the agreement that:

(a) The provider is out-of-network for the covered person;

(b) The covered person bears the risk that the covered person's health benefit plan reimbursement rate for the services may be less than expected; and

(c) The covered person agrees to be personally responsible for up to the full amount of the provider's bill less actual payment, if any, by the covered person's health benefit plan.