LEGISLATURE OF THE STATE OF IDAHO

Sixty-first Legislature First Regular Session - 2011

IN THE HOUSE OF REPRESENTATIVES

HOUSE BILL NO. 266

BY EDUCATION COMMITTEE

AN ACT

RELATING TO THE HEALTH CARE TRANSPARENCY ACT; PROVIDING A SHORT TITLE; PROVIDING LEGISLATIVE INTENT; AND AMENDING CHAPTER 2, TITLE 41, IDAHO CODE, BY THE ADDITION OF A NEW SECTION 41-241, IDAHO CODE, TO PROVIDE THAT THE DIRECTOR OF THE DEPARTMENT OF INSURANCE SHALL ESTABLISH A WEBSITE FOR HEALTH CARE DATA, TO PROVIDE WHAT SHALL BE ON THE WEBSITE AND TO DEFINE TERMS.

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

SECTION 1. SHORT TITLE. This act shall be known and may be cited as the "Health Care Transparency Act."

SECTION 2. LEGISLATIVE INTENT. It is the intent of the "Health Care Transparency Act" to assist and allow consumers to make educated choices regarding their health care needs and to require health care providers and insurance carriers to share more information on prices and reimbursement rates.

SECTION 3. That Chapter 2, Title 41, Idaho Code, be, and the same is hereby amended by the addition thereto of a NEW SECTION, to be known and designated as Section 41-241, Idaho Code, and to read as follows:

41-241. WEBSITE FOR HEALTH CARE DATA. (1) The director of the department of insurance in conjunction with an organization representing hospitals and an organization representing physicians shall annually compile data and launch a website to assist consumers in making informed decisions. The first website shall be launched no later than January 1, 2012, and shall be updated no less frequently than annually. The director of the department of insurance, in consultation with an organization representing hospitals and an organization representing physicians with four (4) or more physicians in a clinic, shall determine the charges for the twenty-five (25) most common procedures based upon the most commonly reported diagnostic-related groups for which there are at least ten (10) cases rendered by the hospital, health care provider or clinic during the calendar year immediately preceding the release of the hospital charge, health care provider or clinic report. If a hospital, health care provider or clinic with four (4) or more physicians does not have twenty-five (25) of the most common diagnostic-related groups with at least ten (10) or more cases rendered, the hospital, health care provider or clinic shall report only on those most common diagnostic-related groups that have at least ten (10) cases rendered.

(2) Each insurance carrier issuing policies regarding accident, health or insurance of human beings against bodily injury, disablement, or death by accident or accidental means, or the expense thereof, or against disablement or expense resulting from sickness, and every insurance appertaining

thereto shall remit to the director reimbursement rate or rates for the twenty-five (25) most common inpatient procedures based upon the most commonly reported diagnostic-related groups.

(3) As used in this section:

(a) "Charge" means the amount that a hospital, outpatient facility or clinic with four (4) or more physicians expects to charge for an inpatient or outpatient diagnostic-related group. A charge that is required to be reported to the public shall be the mean charge for all cases of the diagnostic-related group occurring in the calendar year prior to the release of the hospital charge, outpatient facility or clinic report.

(b) "Diagnostic-related group" means the classification assigned to an inpatient or outpatient hospital service claim or clinic claim based on the patient's age and sex, the principal and secondary diagnoses, the procedures performed and the discharge status.

(4) The director shall post the information submitted pursuant to this section on the department's website. The director shall ensure that the website and information is easy to navigate, contains consumer-friendly language and fulfills the intent of this section. At a minimum, the website shall contain the following information: charge information that includes the number of discharges; average length of stay; average charge; median charge; demographic information; payer mix; charges not paid and charges paid by medicare, medicaid and other government programs, private insurance and uncompensated care.