LEGISLATURE OF THE STATE OF IDAHO

Sixty-fifth Legislature Second Regular Session - 2020

IN THE HOUSE OF REPRESENTATIVES

HOUSE BILL NO. 506

BY HEALTH AND WELFARE COMMITTEE

1 AN ACT
2 RELATING TO THE NO SURPRISES ACT; AMENDING TITLE 41, IDAHO CODE, BY THE ADDI-
3 TION OF A NEW CHAPTER 66, TITLE 41, IDAHO CODE, TO PROVIDE A SHORT TITLE,
4 TO PROVIDE LEGISLATIVE INTENT, TO DEFINE TERMS, TO ESTABLISH PROVISIONS
5 REGARDING BILLING BY OUT-OF-NETWORK PROVIDERS FOR EMERGENCY SERVICES
6 AT IN-NETWORK FACILITIES, TO ESTABLISH PROVISIONS REGARDING BILLING
7 BY OUT-OF-NETWORK PROVIDERS FOR POST-EMERGENCY INPATIENT SERVICES AND
8 NONEMERGENCY HEALTH CARE SERVICES PERFORMED AT IN-NETWORK FACILITIES,
9 TO PROVIDE APPLICABILITY FOR SELF-FUNDED PLANS, AND TO PROVIDE FOR EN-
10 FORCEMENT.

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

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

15 CHAPTER 66
16 NO SURPRISES ACT

17 44-6601. SHORT TITLE. This chapter shall be known and may be cited as
18 the "No Surprises Act."

19 44-6602. LEGISLATIVE INTENT. In enacting this chapter, it is the in-
20 tent of the legislature to protect patients who are members of a health ben-
21 efit plan from surprise billing practices by out-of-network providers for
22 services provided at in-network facilities.

23 44-6603. DEFINITIONS. As used in this chapter:
24 (1) "Allowed amount" means the portion of a billed charge a health ben-
25 efit plan will pay, including any applicable cost-sharing responsibility of
26 the covered person, for a covered health care service or item rendered by a
27 participating provider or facility.
28 (2) "Covered benefits," "covered person," "facility," "health bene-
29 fit plan," "health care provider" or "provider," "health care services,"
30 and "health carrier" shall have the same meanings as provided in section
31 41-5903, Idaho Code.
32 (3) "Emergency medical condition" means a medical, mental health, or
33 substance use disorder condition manifesting itself by acute symptoms of
34 sufficient severity, including but not limited to severe pain or emotional
35 distress, such that a prudent layperson who possesses an average knowledge
36 of health and medicine could reasonably expect the absence of immediate med-
37 ical, mental health, or substance use disorder treatment attention to result
38 in:

(a) A condition placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
(b) Serious impairment to bodily functions; or
(c) Serious dysfunction of any bodily organ or part.

(4) "Emergency services" means a medical screening examination as required under section 1867 of the social security act, 42 U.S.C. 1395dd, that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate that emergency medical condition, and further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under section 1867 of the social security act to stabilize the patient. "Stabilize," with respect to an emergency medical condition, has the same meaning as provided in section 1867(e)(3) of the social security act.

(5) "In-network provider" or "in-network facility" means a provider or facility that is contracted with a health benefit plan or its contractor or subcontractor to provide health care services to covered persons for reimbursement by the health benefit plan at a contracted rate as payment in full for the health care services, including applicable cost-sharing obligations.

(6) "Out-of-network provider" or "out-of-network facility" means a provider or facility that is not contracted with a health benefit plan or its contractor or subcontractor to provide health care services to covered persons.

44-6604. BILLING BY OUT-OF-NETWORK PROVIDERS FOR EMERGENCY SERVICES AT IN-NETWORK FACILITIES. (1) An out-of-network provider that provides emergency services to a covered person at an in-network facility shall accept as payment in full the health benefit plan's allowed amount for in-network providers of the same specialty or type for the same covered service performed at the in-network facility. If there is no in-network provider of the same specialty at the facility, the out-of-network provider shall accept as payment in full the health benefit plan's allowed amount for in-network providers of the same specialty or type for the same covered service in the same geographic area of the state of Idaho, as defined in rules promulgated by the director under title 41, Idaho Code. The out-of-network provider shall not bill or seek reimbursement for amounts in excess of the allowed amount.

(2) In calculating the covered person's cost-sharing responsibility for amounts described in subsection (1) of this section, the health benefit plan shall apply its in-network benefit design.

(3) The covered person's health benefit plan shall pay directly to the provider the amounts described in subsection (1) of this section, less any applicable cost-sharing responsibility of the covered person.

(4) Any provision in a consent form or other agreement between a provider and a covered person that purports to permit an out-of-network provider to bill or seek reimbursement for covered emergency services in amounts in excess of the amounts permitted under this chapter is void and unenforceable.

1 44-6605. BILLING BY OUT-OF-NETWORK PROVIDERS FOR POST-EMERGENCY IN-
2 PATIENT SERVICES AND NONEMERGENCY HEALTH CARE SERVICES PERFORMED AT IN-NET-
3 WORK FACILITIES.
4 (1)(a) For a post-emergency situation where an out-of-network provider
5 provides nonemergency services to a covered person admitted to an
6 in-network facility through its emergency department, the out-of-net-
7 work provider shall accept as payment in full the health benefit plan's
8 allowed amount for in-network providers of the same specialty or type
9 for the same covered service performed at the in-network facility. If
10 there is no in-network provider of the same specialty at the facility,
11 the out-of-network provider shall accept as payment in full the health
12 benefit plan's allowed amount for in-network providers of the same spe-
13 cialty or type for the same covered service in the same geographic area
14 of the state of Idaho, as defined in the rules promulgated by the direc-
15 tor under title 41, Idaho Code. The out-of-network provider shall not
16 bill or seek reimbursement for amounts in excess of the allowed amount.
17 (b) For all other nonemergency situations where an out-of-network
18 provider provides nonemergency health care services to a covered
19 person at an in-network facility, the out-of-network provider shall
20 accept as payment in full the health benefit plan's allowed amount for
21 in-network providers of the same specialty or type for the same covered
22 service performed at the in-network facility. If there is no in-net-
23 work provider of the same specialty at the facility, the out-of-network
24 provider shall accept as payment in full the health benefit plan's al-
25 lowed amount for in-network providers of the same specialty or type for
26 the same covered service in the same geographic area of the state of
27 Idaho, as defined in the rules promulgated by the director under title
28 41, Idaho Code. The out-of-network provider shall not bill or seek re-
29 imbursement for amounts in excess of the allowed amount.
30 (2) In calculating the covered person's cost-sharing responsibility
31 for amounts described in subsection (1) of this section, the health benefit
32 plan shall apply its in-network benefit design.
33 (3) The covered person's health benefit plan shall pay directly to the
34 provider the amounts described in subsection (1) of this section, less any
35 applicable cost-sharing responsibility of the covered person.
36 (4) An out-of-network provider may bill and seek reimbursement for
37 amounts in excess of the amount set forth in subsection (1) of this section,
38 provided that the out-of-network provider and the covered person enter into
39 an agreement that satisfies the following requirements:
40 (a) The agreement is a separate agreement and not embedded in any other
41 form, including any consent form;
42 (b) The agreement is specific about the services the out-of-network
43 provider reasonably anticipates rendering, includes a good faith best
44 estimate of the amount the provider will charge for the services, and
45 includes, if applicable, an explanation that unanticipated services
46 may become necessary during the course of rendering the specified ser-
47 vices and, if so, additional charges may apply;
48 (c) The agreement is signed by the covered person and the out-of-net-
49 work provider as soon as practicable but no less than five (5) calendar

1 days before the provision of services, and the provider promptly sends a
2 copy of the fully executed agreement to the health benefit plan;
3 (d) The agreement expires and is of no binding effect after completion
4 of the imminent health care service for which the agreement is sought;
5 (e) The agreement explains that by signing it, the covered person and
6 the provider will receive only out-of-network benefits and reimburse-
7 ments; and
8 (f) The agreement explains that the covered person is entitled to re-
9 quest and receive from the in-network facility a list of providers who
10 could perform the service and is also entitled to request and receive
11 from the health benefit plan a list of those providers who are in the
12 network of the covered person's health benefit plan.

13 44-6606. SELF-FUNDED PLAN PARTICIPATION. The provisions of this chap-
14 ter apply to a self-funded group health plan governed by the provisions of
15 the employee retirement income security act of 1974, 29 U.S.C. 1001 et seq.,
16 or to a self-funded plan exempt from the provisions of title 41, Idaho Code,
17 only if the plan elects to participate in the provisions of this chapter. To
18 elect to participate in the provisions of this chapter, the plan shall pro-
19 vide notice, on an annual basis, to the director in a manner prescribed by the
20 director, attesting to the plan's participation and agreeing to be bound by
21 the provisions of this chapter. At least once annually, the director shall
22 post a list on the department's website of those self-funded plans that have
23 elected to participate in the provisions of this chapter. An entity admin-
24 istering a plan that elects to participate under this chapter shall comply
25 with the provisions of this chapter but shall not be considered a carrier
26 or health benefit plan subject to the jurisdiction of the director solely by
27 virtue of an election made under this chapter.

28 44-6607. ENFORCEMENT. (1) Any provider or health benefit plan that
29 violates the provisions of this chapter shall be liable to pay the reasonable
30 attorney's fees and costs that the injured party incurs to challenge the
31 provider's or health benefit plan's actions. Any billing by an out-of-net-
32 work provider to the covered person in violation of this chapter shall be
33 void and unenforceable. An out-of-network provider shall also be liable to a
34 covered person for reasonable attorney's fees and costs to defend against a
35 provider's attempts to collect amounts in excess of the amount for which the
36 covered person is personally responsible pursuant to this chapter.
37 (2) Upon receipt of written request from the out-of-network provider to
38 the director, the director is authorized to inquire of the patient's health
39 benefit plan to verify whether the amount paid to the provider is consistent
40 with this chapter.