

**[Idaho Code Ann. § 41-1846.]**

§ 41-1846. Health care policies – applicability – requirement: The Insurance Contract

(1) An insurer offering a health care policy that does not meet the definition of a managed care plan as provided in section 41-3903(15), Idaho Code:

(a) Must have the intent to render and the capability for rendering or providing coverage for good quality health care services, which will be and are readily available and accessible to its insureds both within and outside the state of Idaho, and such services must be reasonably responsive to the needs of insureds;

(b) When "emergency services" are provided, they shall be provided as set forth in section 41-3903(7), Idaho Code, and shall not require prior authorization;

(c) Shall include on its website and/or send annually to its policyholders:

(i) A statement as to whether the plan includes a limited formulary of medications and a statement that the formulary will be made available to any member on request;

(ii) Notification of any change in benefits; and

(iii) A description of all prior authorization review procedures for health care services;

(d) Shall adopt procedures for a timely review by a licensed physician, peer provider or peer review panel when a claim has been denied as not medically necessary or as experimental. The procedure shall provide for a written statement of the reasons the service was denied and transmittal of that information to the appropriate provider for inclusion in the insured's permanent medical record;

(e) When prior approval for a covered service is required of and obtained by or on behalf of an insured, the approval for the specific procedure shall be final and may not be rescinded after the covered service has been provided except in cases of fraud, misrepresentation, nonpayment of premium, exhaustion of benefits or if the insured for whom the prior approval was granted is not enrolled at the time the covered service was provided; and

(f) Shall not offer a provider any incentive that includes a specific payment made, in any type or form, to the provider as an inducement to deny, reduce, limit, or delay specific, medically necessary, and appropriate services covered by the health care policy.

(2) No health care provider shall require an insured to make additional payments for covered services under a policy subject to subsection (1) of this section, other than specified deductibles, copayments or coinsurance once a provider has agreed in writing to accept the insurer's reimbursement rate to provide a covered service.