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Idaho Patient Act Changes

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Idaho has enacted limited changes to the Idaho Patient Act (IPA) that make it somewhat easier for healthcare providers and facilities to jump through the IPA hoops before pursuing collection actions against patients. A copy of HB778 showing the changes is available here. The changes are generally effective for collection actions initiated on or after March 25, 2022.

IPA violations limit healthcare providers' ability to recover collection costs and related charges (including attorneys' fees) and may subject the provider to civil penalties, all of which may make medical debt collection financially impractical. (I.C. § 48-305).[1] Accordingly, this article summarizes key IPA provisions as well as the recent amendments.

Limits on "Extraordinary Collection Actions."

As more fully explained in our prior publications, the IPA requires healthcare providers and facilities[2] to take certain actions before they may engage in “extraordinary collection actions,” which are defined as:

- transferring or assigning an account to a third-party collection agency or entity within 60 days after sending the required notice to the patient;
- reporting adverse information about the patient to a consumer reporting agency;
- initiating any judicial or legal action or filing or recording any document in relation thereto, including but not limited to placing a lien on the person's property or assets, attaching or seizing a person's bank account or any other personal property, initiating a civil action against any person, or garnishing a person's wages.

(I.C. § 48-303(3)(a)). As amended, extraordinary collection actions do not include and the IPA does not prohibit actions against patients for dishonored checks so long as the provider or facility complies with the requirements for such checks in I.C. § 28-22-205.[3] (I.C. § 48-303(3)(b)).

Importantly, the IPA only applies to the extraordinary collection activities specified in the statute; it does not prohibit a provider from engaging in self-help to collect on past due accounts, including sending demands for payment, hiring someone to collect on the account on behalf of the provider, or dismissing the patient from the practice. The IPA will apply, however, to the extent that the provider files suit.

Modified Prerequisites for Extraordinary Collection Actions.

As amended, the IPA requires healthcare providers to do the following

before engaging in extraordinary collection actions:

1. Timely Submit Charges to Third-Party Payors or the Patient. The provider must submit its charges to third-party payors identified by the patient or, if no such payor was identified, to the patient. The IPA amendments confirm that the provider must submit the claim to multiple third-party payors if applicable. (I.C. § 48-303(9)). The charges must generally be submitted within 45 days from the latest of:

- the date the goods or services were provided to the patient;
- the date of discharge of the patient from the health care facility; or
- the first date permitted by the applicable billing code(s) and policies as published by the relevant national association.

(I.C. § 48-304(a)). By adding the reference to national billing guidelines, the IPA amendments reconcile potentially conflicting deadlines between IPA requirements and national billing standards.

A provider may take an additional 45 days (*i.e.*, a total of 90 days) to submit the claims to payors or the patient, but in such cases the provider is prohibited from recovering costs, expenses, or fees (including attorneys' fees) in any collection action. (I.C. § 48-306).

2. Timely Send a Consolidated Summary of Services. Unless excepted as described below, healthcare facilities must ensure that a patient receives a “consolidated summary of services” within 60 days from the latest of:

- the date the goods or services were provided to the patient;
- the date of discharge of the patient from the health care facility; or
- the first date permitted by the applicable billing code(s) and policies as published by the relevant national association.

(I.C. § 48-304(b)). The consolidated summary must still include:

- The patient's name and contact information, including telephone number;
- The health care facility's name and contact information, including telephone number;
- The date and duration of the patient's visit to the health care facility;
- A general description of the goods and services provided to the patient during the visit to the health care facility, including the name, address, and telephone number of each billing entity whose health care providers provided the services and goods to the patient; and
- A clear and conspicuous notification at the top of the notice that states: "This is Not a Bill. This is a Summary of Medical Services You Received. Retain This Summary for Your Records. Please Contact Your Insurance Company and the Health Care Providers Listed on this Summary to Determine the Final Amount You May Be Obligated to Pay."

(I.C. § 48-303(1)(a)). The IPA amendments clarify that if there are multiple notices, for purposes of calculating IPA timelines the consolidated summary of services is the first notice that contains the required elements set forth above unless the elements are changed in subsequent notices. (I.C. § 48-303(1)(b)). The corollary appears to be that any changes to the services will require a new consolidated summary.

Significantly, the deadlines associated with the consolidated summary depend on when the patient receives the consolidated summary, not when the provider or facility sends it. Accordingly, providers must factor in mailing time when they calculate the deadline. Under the IPA, a patient is presumed to have received the consolidated summary three days after the summary was sent to the patient by first class mail to the patient's address as confirmed by the patient during their last visit or as updated by the patient in subsequent written or electronic communications. (I.C. § 48-308). To confirm compliance, providers and facilities should document when, where, and how the summary was delivered. A patient may agree to receive the consolidated summary via e-mail or other means. (*Id.*).

As with the time for submitting claims, the IPA allows a provider extra time to submit the consolidated summary, but this grace period also comes with a price: providers taking the additional time will not be able to recover costs, expenses, or fees (including attorneys' fees) in any collection action. (I.C. § 48-306). The IPA amendments extended this grace period for providing the consolidated summary from 90 to 180 days. (*Id.*). A provider may now take an additional 180 days (*i.e.*, a total of 240 days) to submit the consolidated summary to the patient, but in such cases, the provider will not be able to recover collection costs and fees.

The consolidated summary rule does contain an exception: a facility is not required to send a consolidated statement prior to engaging in extraordinary collection action if:

- the patient will receive a final notice before extraordinary collection action (described below) from a single billing entity for all goods and services provided to the patient at the facility;
- the patient was clearly informed in writing of the name, phone number and address of the billing entity; and
- the facility otherwise complies with the IPA requirements.

(I.C. § 48-309). Facilities that fit within the exception need only send the final notice described below, not the consolidated summary.

3. Send Final Notice Before Extraordinary Collection Action. The original IPA required that the patient receive a “final statement” before extraordinary collection actions were initiated. To avoid confusion, the new IPA renamed the document as the “final notice before extraordinary collection action”; however, the content of the notice is essentially the same. The notice must still contain:

- The patient's name and contact information, including its telephone number;

- The health care facility's name and contact information, including its telephone number;
- A list of the goods and services that the health care provider provided to the patient during the patient's visit to the health care facility, including the initial charges for the goods and services and the date the goods and services were provided, in reasonable detail;
- A statement that a full itemized list of goods and services provided to the patient is available upon the patient's request;
- The name of the third-party payors to which the charges for health care services were submitted;
- A detailed description of all reductions, adjustments, offsets, third-party payor payments, including payments already received from the patient, that adjust the initial charges for the goods and services provided to the patient during the visit; and
- The final amount that the patient is liable to pay after taking into account all applicable reductions.

(I.C. § 48-303(4)(a)). The IPA amendments confirm that to engage in extraordinary collection actions, the final notice must also include the patient's group number and at least four digits of the patient's membership number unless the health care provider submitted all charges to the patent's correct third-party payor. (I.C. § 48-304(e)(3)).

Unlike the consolidated summary, there is no deadline for sending the final notice, but a provider or facility may not initiate extraordinary collection actions until after the patient has received the final notice as described below. Like the consolidated summary, a patient is presumed to have received the final notice three days after the notice was sent to the patient by first class mail to the patient's address confirmed by the patient during their last visit or as updated by the patient in subsequent written or electronic communications. (I.C. § 48-308). And like the consolidated summary, a patient may agree to receive the final notice via electronic or other means. (*Id.*).

4. Wait to Charge Interest or Fees. A health care provider may not charge interest, fees, or other ancillary charges until at least 60 days after the patient received the consolidated summary of services or the final notice, whichever is received later by the patient. (I.C. § 48-304(d)).

5. Wait to Initiate Extraordinary Collection Actions. In most cases, a health care provider may not initiate extraordinary collection actions until at least 90 days after:

- the patient received the consolidated summary of services or the final notice, whichever is received later by the patient; and
- final resolution of all internal reviews, good faith disputes, and appeals of any charges or third-party payor obligations or payments.

(I.C. § 48-304(e)(1)).

The IPA amendments shortened the time to report a patient to consumer reporting agencies if certain conditions are satisfied but there is a cost in doing so. As amended, a healthcare provider need only wait 45 days after the patient receives the consolidated summary or final notice to report a patient to a consumer reporting agency if at least 30 days before the report, the provider ensures the patient receives written notice that the provider may make such a report. Importantly, any provider who reports a patient to a credit reporting agency before 90 days after the patient receives the consolidated summary or final notice is prohibited from pursuing any judicial action to collect on the bill, file a lien, or garnish the patient's wages. (I.C. § 48-304(e)(1)-(2)).

6. Prove and Plead IPA Compliance. Providers engaging in extraordinary collection actions have the burden of proving that they complied with the IPA, including the foregoing requirements. (I.C. § 48-307). Accordingly, providers and facilities should establish a process to document compliance in case they need to pursue a collection action. Under the new IPA, a party bringing a judicial action must plead with particularity its compliance and specifically identify the name, group, and policy numbers of the third-party payors to which the health care provider submitted the charges along with the dates of each submission. (I.C. § 48-307).

Relation to the No Surprise Billing Rules. Many providers have asked how the IPA relates to the new federal No Surprise Billing Rules (NSBR), which generally requires providers to give a good faith estimate to self-pay patients.[4] (*See* 45 C.F.R. § 149.610 *et seq.*). In response, the two rules are separate and, while somewhat similar, they do not overlap: the NSBR generally applies to good faith estimates provided before services are rendered; the IPA applies to actual charges billed after the services are rendered. The NSBR's good faith estimate may help a provider generate a consolidated summary and/or final notice, but the required notices and statements are separate.

[1]As amended, I.C. § 48-305 states:

> FEES AND COSTS FOR EXTRAORDINARY COLLECTION ACTION. (1) [A] patient shall have no liability to any party taking extraordinary collection action for costs, expenses, and fees, including attorney's fees, unless the party has complied with [I.C. § 48-304], and then subject to the following limitations:
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> (a) In the case of an uncontested judgment against the patient, the court may award, in addition to the outstanding principal, up to three hundred fifty dollars ($350) or an amount equal to one hundred percent (100%) of the outstanding principal amount, whichever is less, plus any prejudgment interest accrued in accordance with [I.C. § 48-304(1)(d)], and any postjudgment interest awarded by the court;
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> (b) In the case of a contested judgment against the patient, the court may award, in addition to the outstanding principal, up to seven hundred fifty dollars ($750) or an amount equal to one hundred percent (100%) of the outstanding principal amount, whichever is less, plus any prejudgment interest accrued in accordance with [I.C. § 48-304(1)(d)], and any postjudgment interest awarded by the court;
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> (c) In the case of postjudgment motions and writs, the court may award up to seventy-five dollars ($75.00) for any successful motion or application for a writ of attachment to any particular garnishee and twenty-five dollars ($25.00) for any subsequent application for a writ to the same garnishee. In the case of garnishments, the court may also award service fees ….
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> (2) In the case of a contested judgment, if a party taking extraordinary collection action against a patient prevails against a patient and incurs costs, expenses, and fees, including attorney's fees, that are grossly disproportionate to the award amounts set forth in subsection (1)(b) of this section, then the party may petition the court for a supplemental award for costs, expenses, and fees. Upon an affirmative showing that the incurred costs, expenses, and fees are grossly disproportionate to the award amounts set forth in subsection (1)(b) of this section, and that fees were incurred because of the patient's willful attempt to avoid paying a bona fide debt, then the court may take into account the factors outlined in rule 54(e)(3) of the Idaho Rules of Civil Procedure and may, in its discretion, award supplemental costs, expenses, and reasonable attorney's fees.
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> (3) Notwithstanding any provision of law or agreement to the contrary, if a patient in a contested judgment is a prevailing party, then the patient shall be entitled to recover from a nonprevailing party all costs, expenses, and fees, including attorney's fees, incurred by the patient in contesting the action, and the patient shall have no liability to any nonprevailing parties for any costs, expenses, and fees, including attorney's fees and prejudgment interest incurred

by a nonprevailing party.

[2]The IPA applies to “health care providers” and “health care facilities.” “'Health care provider' means … a physician or other health care practitioner [or] [a] health care facility or its agents.” (I.C. § 48-303(1)(6)). “'Health care facility' means a person, entity, or institution operating a physical or virtual location that holds itself out the public as providing health care services through itself, through its employees, or through third-party health care providers.” (I.C. § 48-303(1)(5)). Accordingly, as a practical matter, the IPA applies to virtually all health care entities who may wish to engage in collection activities.

[3]I.C. § 28-22-105 states:

> CHECKS DISHONORED BY NONACCEPTANCE OR NONPAYMENT — LIABILITY FOR INTEREST — COLLECTION COSTS AND ATTORNEY'S FEES. Whenever a check … has been dishonored by nonacceptance or nonpayment and has not been paid within fifteen (15) days and after the holder of such check sends such notice of dishonor as provided in section 28-22-106, Idaho Code, to the drawer, then if the check does not provide for the payment of interest, or collection costs and attorney's fees, the drawer of such check shall also be liable for payment of interest at the rate of twelve percent (12%) per annum from the date of dishonor and cost of collection not to exceed twenty dollars ($20.00) or the face amount of the check, whichever is the lesser; provided however, that if the holder of the dishonored check has the right to collect a set fee under a written agreement or has notified the drawer by a posted notice at the point of sale that the drawer will be required to pay a set collection fee if the check is dishonored, the holder is not required to give the notice of dishonor as provided in section 28-22-106, Idaho Code, and may assess a collection cost of the notice amount regardless of the size of the check, but the set fee may not exceed twenty dollars ($20.00). In addition, in the event of court action on the check, the court, after such notice and the expiration of said fifteen (15) days, shall award reasonable attorney's fees as part of the damages payable to the holder of the check….

[4]For more information about the No Surprise Billing Rules, see our article here.

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depending on the jurisdiction or circumstances. If you have specific questions as to the application of the law to your activities, you should seek the advice of your legal counsel.