2022 CHANGES TO THE IDAHO PATIENT ACT

During the 2022 legislative session, Idaho Medical Association joined with other health care organizations to successfully author and pass HB 778 which will help practices comply with the Idaho Patient Act. Although the legislation represents a compromise with Melaleuca and isn't everything the IMA and other health care groups desire, the legislation will ease some of the major burdens on practices as they comply with the Idaho Patient Act. The below changes went into effect on March 25, 2022, see reverse for a more detailed overview of the changes.

PROTECTS PATIENT PRIVACY

Eliminates the requirement for practices to list a patient's insurance group and member number on notices; this will help protect patient privacy and reduce costs for providers

ALLOWS FOR CSS CORRECTIONS

Allows the opportunity to correct the Consolidated Summary of Services if a provider is inadvertently omitted

FIXES BAD CHECK DELAYS

Allows practices to respond more quickly when a patient passes a bad check

REPORTING TO CREDIT AGENCIES

Creates an expedited path – after multiple notices and required timeframes – to report information to a credit reporting agency (If the provider chooses this route they must agree to forgo litigation)

BUNDLED OR GLOBAL FEES

Allows providers to comply with the timelines in the Idaho Patient Act when a service is required to be billed as a bundled or global fee

RESOLVES INSURANCE CLAWBACKS

Allows providers to comply with the timelines in the Idaho Patient Act when a payment to the provider is clawed back by an insurance company

Changes to the Idaho Patient Act: What physicians need to know

Protects patient privacy and limits costs

Under HB 778, providers are no longer required to print the patient's insurance group and member number on statements (Page 2, Line 45).

This requirement could not be met by some software systems or was prohibitively expensive for some providers. It also created serious privacy and identity theft concerns for patients whose insurance information includes their social security numbers.

A provider who pursues an extraordinary collection action (ECA) must ensure that the claim was submitted to the patient's correct third-party payor and bears the burden of proof in doing so (Page 6, Lines 40-43). Providers can satisfy this requirement either by proof presented to a court or by listing the patient's insurance group number and the last four digits of the member number on an otherwise compliant notice to the patient (Page 5, Lines 9-19).

Allows for corrections on the Consolidated Summary of Services

HB 778 allows for up to six months for a health care facility to correct a mistake when a provider is erroneously excluded from the Consolidated Summary of Services (CSS). The facility is now allowed to re-send the CSS to the patient with updated information. Once a corrected CSS is received by the patient, the provider can then move forward in complying with IPACT to collect the amount owed from the patient (Page 2, Lines 1-5 and Page 6, Lines 25-26).

Allows providers to respond more quickly when a patient passes a bad check

In the event a patient passes a check with insufficient funds, the provider does not have to follow the extended timelines of IPACT and can instead follow current law concerning bad checks (Page 2, Lines 27-28). That means a provider must notify the patient and wait only 15 days before pursuing an extraordinary collection action.

Creates an expedited path for reporting debt to a credit agency

If a provider submits compliant notices to a patient and is willing to forgo the ability to pursue litigation, then the provider can report a patient to a credit agency if 45 days have passed since the patient received the compliant notice. The original law required the provider to wait 90 days before reporting a patient to a credit agency (Page 4, Lines 45-50 and Page 5 Lines 1-8).

Allows for flexibility with global fees/bundled services

Adjusts IPACT timelines when a service is required to be billed as a global fee or bundled service (such as maternity care). The provider can then move forward in complying with IPACT to collect the amount owed from the patient (Page 4, Lines 12-15 and 28-31).

Allows for flexibility when a payment is clawed back

Adjusts IPACT timelines if a payment is clawed back by a third-party payor. The provider can then move forward in complying with IPACT to collect the new amount owed from the patient (Page 3, Lines 5-9).