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pulse

Idaho Legislation on Medical Debt Extraordinary Collection Actions is in Effect

The Idaho Collectors Association advocated with key lawmakers on the impact of the new requirements before the bill was passed.

New requirements for medical debt collectors took effect Jan. 1 under the Idaho Patient Act (HB 515).

The Idaho Patient Act was the subject of an ongoing grassroots campaign by the Idaho Collectors Association to educate key lawmakers about the potential impact of the requirements.

The law includes requirements on timing to submit a bill to a patient's insurance company as well as interest rates and a cap on attorneys' fees.

It applies to extraordinary collection actions in connection with a patient's debt, including, according to the law, prior to 60 days from the patient's receipt of the final statement, selling, transferring, or assigning any amount of a patient's debt to any third party, or otherwise authorizing any third party to collect the debt in a name other than the name of the health care provider.

Extraordinary collection actions under the law also include reporting adverse information about the patient to a consumer reporting agency or commencing any judicial or legal action or filing or recording any document in relation to: placing a lien on a 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 an individual's wages.

The intent of the law is to govern the fair collection of debts owed to health care providers and increase visibility to Idaho citizens about medical billing practices and debts they may be unaware of.

The law also prohibits any individual from engaging, directly or indirectly, in any extraordinary collection action against a patient unless:

- Within 45 days from the date of providing goods or services to the patient or from the date of discharge of the patient from a health care facility, whichever is later; a health care provider submits its charges related to the provision of goods or services to the third-party payor or payors of the patient, identified by the patient to the health care provider in connection with the services, if any, or, in the event no third-party payor was identified, to the patient;
- Within 60 days from the date of the provision of goods or services to the patient or from the date of discharge, whichever is later, the patient receives from the health care facility that the patient visited, a consolidated summary of services, free of charge, unless the health care facility is exempted from providing a consolidated summary of services;
- The patient receives, free of charge, a final statement from the billing entity of the health care provider;
- The health care provider does not charge or cause to accrue any interest, fees, or other ancillary charges until at least 60 days have passed from the date of receipt of the final statement; and
- At least 90 days have passed from receipt of the final statement 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.

Overall, under the Idaho Patient Act, health care providers and their third-party partners are required to adhere to deadlines for sending a bill to collections and to provide transparency in services being billed to patients on new timelines.

ACA International members can find more information on health care collections in the ACA SearchPoint library, https://www.acainternational.org/searchpoint, using the tag health care.

Health and Human Services Proposes HIPAA Privacy Rule Changes

By Katy Zillmer

Last month, the Office for Civil Rights at the U.S. Department of Health and Human Services (HHS) announced a notice of proposed rulemaking (NPRM) for changes to the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule to support consumers' "engagement in their care, remove barriers to coordinated care, and reduce regulatory burdens on the health care industry," according to a news release.

The NPRM was initiated under HHS Secretary Alex Azar's value-based transformation agenda and led by HHS Deputy Secretary Eric Hargan, with the goal to review federal regulations that limit efforts by health care providers and health plans and foster value-based health care.

At press time, several nominees were under consideration for a new HHS secretary appointed by President-elect Joe Biden, including California Attorney General Xavier Becerra.

"Our proposed changes to the HIPAA Privacy Rule will break down barriers that have stood in the way of commonsense care coordination and value-based arrangements for far too long," Azar said in the news release. "As part of our broader efforts to reform regulations that impede care coordination, these proposed reforms will reduce burdens on providers and empower patients and their families to secure better health."

Proposed changes to the rule include:

- Strengthening individuals' rights to access their own health information, including electronic information.
- Improving information sharing for care coordination and case management for individuals.
- Facilitating greater family and caregiver involvement in the care of individuals experiencing emergencies or health crises.
- Enhancing flexibilities for disclosures in emergency or threatening circumstances.
- Reducing administrative burdens on HIPAA covered healthcare providers and health plans, while continuing to protect individuals' health information privacy interests.

"These proposed changes reduce burdens on providers and support new ways for them to innovate and coordinate care on behalf of patients, while ensuring that we uphold HIPAA's promise of privacy and security," HHS Deputy Secretary Eric Hargan said in the news release.

The OCR is accepting public comments from stakeholders including patients and their families, HIPAA covered entities (health plans, health care clearinghouses, and most health care providers) and their business associates, consumer advocates, health care professional associations, health information management professionals, health information technology vendors, and government entities.

More information: https://bit.ly/343ULaq

CMS Floats Changes to Health Care Data Exchange in New Rules

The Centers for Medicare and Medicaid Services (CMS) issued a proposed rule in December to improve the electronic distribution of health care data among payers, providers and patients, and simplify processes related to prior authorization to reduce burdens on providers and patients, according to a news release.

The goal is to improve data processes and allow providers more time to focus on their patients' care.

"This proposed rule ushers in a new era of quality and lower costs in health care as payors and providers will now have access to complete patient histories, reducing unnecessary care and allowing for more coordinated and seamless patient care. Each element of this proposed rule would play a key role in reducing onerous administrative burden on our frontline providers while improving patient access to health information," CMS Administrator Seema Verma said in the news release.

As an addition to the CMS proposed rule, the U.S. Department of Health and Human Services is also looking to improve prior authorization for health care payments.

"Prior authorization is an administrative process used in healthcare for providers to request approval from payers to provide a medical service, prescription, or supply. This process takes place before a service is rendered. The rule proposes significant changes to improve the patient experience and alleviate some of the administrative burden prior authorization causes health care providers," according to the news release.

CMS and HHS also seek to reduce the wait time for prior authorization to a maximum of 72 hours for payers, providers and patients and allow access to more information on prior authorization decisions.

The comment deadline for the rule was Jan. 4, 2021.

More information: *https://go.cms.gov/3a2druR*

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>
> *- CMS Administrator Seema Verma*

NEWS & NOTES

Lawmakers Reach Bipartisan Agreement on Surprise Medical Billing

In December, leaders on both sides of the aisle in the House and Senate announced an agreement to protect patients from "surprise medical bills" that would also establish guidelines for health care providers and health insurance companies to resolve payment disputes. https://bit.ly/3qSdHCZ

FCC Hospital Robocall Protection Group Issues Best Practices

The Federal Communications Commission's Hospital Robocall Protection Group, a federal advisory committee, recommended best practices that voice service providers, hospitals, and federal and state governments can follow to prevent unlawful robocalls from disrupting communications in hospitals. The best practices were required under the Telephone Robocall Abuse Criminal Enforcement and Deterrence Act (TRACED) Act. https://bit.ly/386vNrZ

We Want to Hear From You

Pulse is published for ACA International health care collection agencies to provide current industry information for health care providers. ACA welcomes article ideas and submissions for consideration in *Pulse* to the Communications Department at comm@acainternational.org.

For more health care collections news, visit ACA's Health Care Collections page at www.acainternational.org/pulse.

datawatch

Health Care Consumerism

According to a survey from TransUnion Healthcare, consumers' feelings on costs and payments did not change significantly from 2019 to 2020.

49%	of consumers said the type of treatment received doesn't impact likelihood to make a payment at time of service, down 5% from 2019.
65%	of consumers are willing to make at least a partial payment if an estimate is given at time of service, unchanged from 2019.
53%	of consumers were provided with clear information about out-of-pocket costs before receiving medical care, up 3% from 2019.
48%	of consumers had partial to no understanding of their financial responsibility for a medical bill, down 1% from 2019.
80%	of consumers used either the health care provider or payer/insurance website, among other resources, to research health care costs, up 5% from 2019.

Source: TransUnion HealthCare https://bit.ly/381LfWp

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