8-17-2009

Kootenai Medical Ctr. v. Bonner County Bd. of Comm'rs Respondent's Brief Dckt. 36217

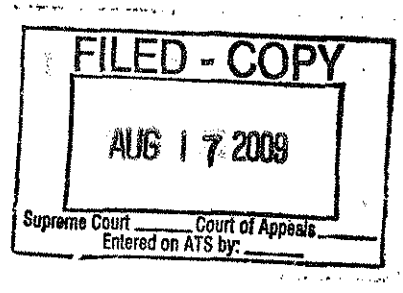
IN THE SUPREME COURT OF THE STATE OF IDAHO

KOOTENAI MEDICAL CENTER A quasi-municipal corporation and Operating a hospital by the name of KOOTENAI MEDICAL CENTER, (RE: David T.) Appellant, vs. BONNER COUNTY COMMISSIONERS, Respondent.	)	Docket No. 36217 **RESPONDENT'S BRIEF ON APPEAL**

RESPONDENT'S BRIEF ON APPEAL

Appeal from the District Court
of the First Judicial District of the
State of Idaho, in and for the
County of Bonner

The Honorable Steven C. Verby
District Judge, Presiding



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I. STATEMENT OF THE CASE

A. Nature of the Case

Respondent concurs with Appellant's statement of the nature of the case as set forth in appellant's brief.

B. Course of the Proceedings.

Respondent concurs with Appellant's statement of the course of the proceedings as set forth in appellant's brief.

C. Statement of Facts.

Respondent generally agrees with Appellant's statement of the facts, however certain details were omitted and therefore the statement of facts including omitted details is set forth herein:

The medical care at issue in this case was rendered January 26 and 27, 2006. (A.R. 93-94.) Approximately 2.5 months earlier on November 9, 2005, the patient applied for and obtained private medical insurance through an insurance company called Assurant. (A.R. 116-117). The enrollment form for acquiring the insurance required the patient to disclose all consultations, advice, or treatment he had had for heart or circulatory disorders for the preceding five (5) years. See id.

On November 9, 2005, Patient made application for the Policy by completing a policy enrollment form. (A.R. 116) According to the enrollment form, Patient was required to

disclose for a period of five years all prior medical consultations, advice, or treatment including medication for heart or circulatory system disorder and including heart attack or chest pain. See id. The enrollment form provided that any misrepresentations were grounds for rescission. See id. The enrollment form stated: "NOTE: The plan ... cannot be issued if YES is answered to any questions 2-4" See id. Patient answered "NO" and thereby failed to disclose any pre-existing conditions, consultations, or treatments over the past five years. See id.

On June 2, 2006, Assurant denied coverage and rescinded the entire Policy based on misrepresentations, denying prior medical services in the November 9, 2007 enrollment application. (A.R. p. 138). According to the denial letter, not only had Patient had significant, extensive, and undeclared medical services performed within one year of enrollment and he had also received such services as recently as seven days prior to completing the November 9, 2007 enrollment application. This denial letter states in pertinent part:

> "Question No. 4 was answered "no." However, during the normal course of investigating a claim for benefits, we received medical information showing that you received medical consultation, advice, or treatment for alcoholism, a heart disorder and elevated glucose/developing diabetes within the 5 years prior to the date the enrollment form was completed and was therefore ineligible for this coverage. Specifically, we are taking this action based upon medical records provided by Vintage Court Medical, Kootenai Medical Center and Bonner General Hospital for dates of service December 16, 2004, December 21, 2004, August 2, 2005 and November 2, 2005."

(A.R. 138-139)

Patient has never appealed the June 2, 2006 denial and rescission of Policy. (A.R. generally)

The basis for the denial of this claim by Bonner County is the untimeliness of the application. (See A.R. 13-14, ¶¶ 1, 2, 3.). Bonner County determined the application was untimely because it found that the patient knew, or should have known, that the patient's private insurance policy excluded coverage for "pre-existing conditions." The County found that the patient knew that he had a pre-existing heart condition at the time he applied for the private health insurance. Because I.C. §31-3505(4)(a)(ii) requires that the patient "reasonably be expected to meet the eligibility criteria" for the private health insurance coverage in order to justify a "delayed" application, and, because of the patient's actual knowledge of his health history and actual and/or imputed knowledge of the terms of the policy, the County concluded that the conditions precedent for the filing of a delayed application were not met, the rendering the application untimely. Also included in the basis for the denial was the fact that the patient did not appeal his denial by the insurance company, thus also rendering him not qualified to file a "delayed" application.

II. ISSUES PRESENTED ON APPEAL

1. Did the County Commissioners and District Court err in finding that the Patient failed to properly submit a "Delayed Application" as required by Idaho Code §31-3505(4)?

2. Does Bonner County have the right or authority to deny this application on remand or otherwise, on bases other than the issue of timeliness?

III. ATTORNEY FEES ON APPEAL

Respondent is claiming attorney fees both below and on this appeal based on Idaho Code §12-117, Idaho Code §12-121, and Idaho Appellate Rule 40.

IV. STANDARD OF REVIEW.

Pursuant to Idaho Code §31-3505, denial by a board of county commissioners of an application for indigent benefits is reviewed under the Administrative Procedures Act, Idaho Code, Title 67, Chapter 52. Judicial review of an administrative order is limited to the record. See *St. Alphonsus Medical Ctr. v. Canyon County*, 120 Idaho 420, 423, 816 P.2d 977, 980 (1991), overruled on other grounds by *University of Utah Hosp. & Medical Ctr. v. Twin Falls County*, 122 Idaho 1010, 842 P.2d 689 (1992). A reviewing court may not substitute its judgment for that of the administrative agency on questions of fact and will uphold an agency's finding of fact if supported by substantial and competent evidence. See *Boise Group Homes v. Dep't. of Health and Welfare*, 123 Idaho 908, 909, 854 P.2d 251,252 (1993). A reviewing court may reverse the agency's decision or remand for further proceedings only if substantial rights of the appellant have been prejudiced. See Idaho Code §67-5279(4). Historically, the Idaho Supreme Court has stated that it will review the decision of a Board independently, as if the case were directly appealed to this Court, while giving serious consideration to the district court's decision. *E. Idaho Reg'l Med. Ctr. v. Ada County Bd. of County Comm'rs (Application of Hamlet),* 139 Idaho 882, 884, 88 P.3d 701, 703 (2004).

V. ARGUMENT

A. Timeliness

1. Background

In the 1984 Idaho Supreme Court decision *Carpenter v. Twin Falls County*, 107 Idaho 575, 582-83, 691 P.2d 1190, 1197-98 (1984), the Court held that untimeliness of an application

for medical indigent assistance is not a per-se jurisdictional bar to a claim. In 1984 *Carpenter*, supra, the Court also ruled that a County must demonstrate prejudicial effects resulting from the delay in order to deny an application on the grounds of untimeliness. 107 Idaho at 583.

In 2003, the Idaho Supreme Court in *IHC Hosps., Inc. v. Teton County*, 139 Idaho 188, 75 P.3d 1198 (2003), acknowledged that *Carpenter* was statutorily superseded on the issue of the effect of an untimely application in light of 1996 revisions to the indigent statutes.

The Court in *IHC Hospitals*, supra, held:

> In 1996, the legislature amended I.C. § 31-3511 by adding penalties for failure to comply with technical requirements. In addition, I.C. § 31-3504 has been completely re-written since *Carpenter*, with that section now providing specific guidelines for submitting an application for financial assistance. The Court in *Carpenter* held that a claim which violated technical requirements should not be denied in the absence of a statutory mandate to do so. The current statutes mandate denial of a claim for failure to satisfy the express timelines.

139 Idaho at 191. [Emphasis added].

In 1996, I.C. §31-3511 was amended to provide:

> The board shall not have jurisdiction to hear and shall not approve an application for necessary medical services unless an application in the form prescribed by this chapter is received by the clerk in accordance with the provisions of this chapter.

I.C. §31-3511(2). [Emphasis added].

In 2004, Idaho Senate Bill 1301 (hereinafter "2004 S.B. 1301") intensified these 1996 requirements, previously recognized by *IHC Hospitals*, supra, by placing even stronger restrictive language squarely within the medical indigent statute pertaining to timeliness itself, and expressly providing that the language apply to the timeliness section, i.e., I.C. §31-3505, including I.C. 31-3505(4)(b) and I.C. §31-3505(5) which states:

> Failure by the patient and/or obligated persons to complete the application process described in this section [i.e., internally self-referencing the section primarily treating the subject matter of timing], up to and including any reasonable appeal of any denial of benefits, with the applicable program noted in paragraph (a) of this subsection, shall result in denial of the county assistance application.

I.C. 31-3505(4)(b) [Emphasis added.]

> (5) Any application or request which fails to meet the provisions of this section [i.e., internally self-referencing the section primarily treating the subject matter of timing], and/or other provisions of this chapter, shall be denied. [Emphasis added].

I.C. §31-3505(5)

The 2004 amended I.C. §31-3505 medical indigent code expressly imposes additional timeliness restrictive language without subtracting from the 1996 I.C. §31-3511(2) requirements. Therefore, 2004 I.C. §31-3505 can only be interpreted as imposing stricter technical requirements than those imposed by the 2003 IHC court.

2. Definition of "bona fide application"

Notwithstanding the fact that 2004 S.B. 1301 only intensified restrictive language, Appellant interprets the language as relaxing the 1996 restrictive language to the prejudicial impacts standard of the 1984 Carter court. (Appellant's brief p. 5-6).

Notwithstanding the above, Appellant argues that 2004 S.B. 1301 abrogates strict timelines. Appellant's argument implies that a small part of the definition of "bona-fide" or "good-faith", as articulated in I.C. §31-3505(4)(a), must be compatible with its lexical opposite "bad-faith", so long as there are no prejudicial impacts. This result is untenable as can be demonstrated by an analysis of I.C. §31-3505(4)(a). (Appellant's brief p. 5-6).

I.C. §31-3505(4)(a) provides a statutory conjunctive five part definition of the elements particularizing the definition of a 180-day delayed "bona-fide application" as follows:

(4) A delayed application for necessary medical services may be filed up to one hundred eighty (180) days beginning with the first day of the provision of necessary medical services provided that:

(a) Written documentation is included with the application or no later than forty-five (45) days after an application has been filed showing that a bona fide application or claim has been filed for social security disability insurance, supplemental security income, third party insurance, medicaid, medicare, crime victim's compensation, and/or worker's compensation. A bona fide application means that:

(i) The application was timely filed within the appropriate agency's application or claim time period; and

(ii) Given the circumstances of the patient and/or obligated persons, the patient and/or obligated persons, and given the information available at the time the application or claim for other resources is filed, would reasonably be expected to meet the eligibility criteria for such resources; and

(iii) The application was filed with the appropriate agency in such a time and manner that, if approved, it would provide for payment coverage of the bills included in the county application; and

(iv) In the discretion of the board, bills on a delayed application which would not have been covered by a successful application or timely claim to the other resource(s) may be denied by the board as untimely; and

(v) In the event an application is filed for supplemental security income, an Idaho medicaid application must also have been filed within the department of health and welfare's application or claim time period to provide payment coverage of eligible bills included in the county application.

I.C. 31-3505(4)(a). [Emphasis added].

In construing a statute, the words of the statute must be given their plain, usual and ordinary meaning. *Walker v. Hensley Trucking,* 107 Idaho 572, 691 P.2d 1187 (1984). I.C. 31-3505(4)(a) sets out to define the expression "bona fide application." The statute does so by setting forth a list of five conjunctive elements which explain or particularize the definition of the expression "bona-fide application." In construing a statute, words must be given their ordinary meaning, therefore these five elements should be read as explaining and qualifying, while not nullifying or doing violence to the ordinary legal meaning of the component expression "bona fide" found within the larger phrase, "bona fide application". The I.C. 31-

3505(4)(a)(iv) portion of I.C. §31-3505(4)(a) should be interpreted consistently with the ordinary legally accepted definition of "bona fide" or "good faith" as I.C. §31-3505(4)(a) sets the controlling preamble i.e., "bona-fide application" for the five Roman numeral subsections further explaining and/or qualifying the meaning of a "bona-fide application".

> Black's Law Dictionary (8th ed. 2004) defines "bona fide" as follows::
>
> bona fide - *adj.* [Latin "in good faith"] 1. Made in good faith; without fraud or deceit. 2. Sincere; genuine. See GOOD FAITH. — bona fide, *adv.*
>
> Black's Law Dictionary (8th ed. 2004), defines "good faith" as follows:
>
> *n.* A state of mind consisting in (1) honesty in belief or purpose, (2) faithfulness to one's duty or obligation, (3) observance of reasonable commercial standards of fair dealing in a given trade or business, or (4) absence of intent to defraud or to seek unconscionable advantage. — Also termed *bona fides*. Cf. bad faith. — **good-faith,** *adj.* "The phrase 'good faith' is used in a variety of contexts, and its meaning varies somewhat with the context. Good faith performance or enforcement of a contract emphasizes faithfulness to an agreed common purpose and consistency with the justified expectations of the other party; it excludes a variety of types of conduct characterized as involving 'bad faith' because they violate community standards of decency, fairness or reasonableness. The appropriate remedy for a breach of the duty of good faith also varies with the circumstances." *Restatement (Second) of Contracts* § 205 cmt. a (1979). [...].

[Emphasis added].

The plain, usual, and ordinary meaning of "bona fide" implies good faith and sincerity. Good faith and sincerity are closely linked to the applicant or responsible party's state of mind. The meaning of "good faith" and "bona fide", as defined in Black's Law Dictionary, supra, are facially opposed to a extra-mental standard such as extra-mental consequences, damages, or prejudicial effects. Notwithstanding the plain meaning of "good faith", as defined in Black's Law Dictionary, above, Appellant's argument implies that 2004 S.B. 1301 implies that a good faith application is conceptually consistent with a bad faith application where there are no demonstrated prejudicial effects. (Appellant's Brief p. 5-6). This interpretive outcome does

violence to the plain, usual, and ordinary meaning of "bona fide" as defined in Black's Law Dictionary, supra. Appellant only arrives at this reading of I.C. 31-3505(4)(a)(iv) by forgetting entirely that this subsection is merely an element of and imbedded, contextualized, and even devoted to the definition of "good faith" as set forth in I.C. §31-3505(4)(a). Furthermore, as stated above, I.C. §31-3505(4)(a) is imbedded within statutory language imposing stringent technical requirements and should not be interpreted at variance with those stringent requirements i.e., 1996 I.C. §31-3511(2) and 2004 I.C. §31-3504(4) and (5). Appellant's interpretation enables the submission of bad-faith applications in a good-faith application only statute. This interpretation twists the statutory language to arrive at a result patently opposite and contrary to the plain meaning of the statute and effects a result patently opposite of that expressed and intended by the legislature.

The legislature has constructive knowledge of existing case law when amending statutes. In the case at hand, the 2004 legislature had at least imputed prior knowledge of the *IHC Hospitals,* supra, holding acknowledging the existence of strict timelines within the indigence statutes. *Ultrawall, Inc. v. Washington Mut. Bank, FSB*, 25 P.3d 855 Idaho,2001. Had the 2004 legislature intended to abrogate the 2003 *IHC Hospitals* decision, supra, and intended on reinstating a 1984 prejudicial impacts test, it would have clearly added language identifying prejudicial impacts as the primary test and would not have utilized the expression "bona fide application" as argued above.

3. Limited Scope of Discretionary Exception

I.C. 31-3505(4)(a)(iv) does, in fact, articulate a discretionary exception to technical requirements. This discretionary exception is not a bad faith compatible discretionary exception. Therefore, the scope of this "discretionary exception" is not universally broad and expansive.

The discretionary exception cannot be read in the most general possible sense because it cannot be read inconsistently or in disharmony with the controlling and overriding I.C. 31-3505(4)(a) concept of good faith as defined in Black's Law Dictionary, supra e.g., The discretionary exception cannot be read as compatible with patently bad-faith applications. Furthermore, the discretionary exception cannot be read at a level of generality at variance with other parts of the Roman numeral i-v definitional elements, including, without limitation, subsection ii which states:

> "(ii) Given the circumstances of the patient and/or obligated persons, the patient and/or obligated persons, and given the information available at the time the application or claim for other resources is filed, would reasonably be expected to meet the eligibility criteria for such resources;"

[Underlining Emphasis added].

Therefore, whatever the precise scope of the I.C. 31-3505(4)(a)(iv) discretionary exception, that exception cannot apply where the application is not otherwise in good faith or without "reasonable expectation." Only after the board makes a threshold finding of good faith or reasonable expectation can the board exercise its judgment in applying the discretionary exception of e.g., prejudicial impact, for example. Once an otherwise non-qualified claim or bill has been determined to be in good-faith, and only once this has happened, can the board, in its discretion, decide to approve it, notwithstanding other errors not bearing on bad faith and reasonable expectation given the information available at the time of application filing.

4. **Separate claims or bills on an otherwise approved application.**

A viable way to preserve the natural meaning and harmonize all of the five conjunctive definitional elements of the "good-faith/bona-fide" definition under I.C. §31-3505(4)(a) is by reading I.C. §31-3505(4)(a)(iv) as identifying collateral bills or collateral claims which were

not originally joined with, primary claims which had been already successfully approved. These collateral claims may have been improperly separated or excluded for a variety of reasons. In other words, the types of ancillary bills subject to the discretionary exception addressed by I.C. §31-3505(4)(a)(iv) would or could be the subset of bills not properly presented or accompanying the primary original approved presenting ancillary bills pertaining to the same or similar underlying treatment. For example, medical invoices from known and identified providers may have been missed in the original billing statements or, alternatively, certain providers may have entirely failed to have been included as named providers on the original approved application. An alternative viable harmonization strategy would be to interpret I.C. §31-3505(4)(a)(iv) as allowing a discretionary denial when the programmatic requirements of e.g., Medicaid could never have been met at all.

5. **2004 S.B. 1301 legislative history**.

To the extent the plain language of the statute does not prove that I.C. 31-3505(4)(a) requires a bona-fide and good-faith application, then, when construing an ambiguous or vague statute, the focus of the Court is to determine and give effect to the intent of the legislature. *George W. Watkins Family v. Messenger,* 118 Idaho 537, 540, 797 P.2d 1385, 1388 (1990). In ascertaining this intent, not only must the literal words of the statute be examined but also the public policy behind the statute and its legislative history. *Messenger,* 86 Idaho at 29-30, 382 P.2d at 915.

In 2004 31-3505(4)(a) was amended by S.B. 1301 as follows:

> "31-3505. TIME AND MANNER OF FILING APPLICATIONS AND REQUESTS. [...] **(a) Written documentation is included with the application or no later than forty-five (45) days after an application has been filed showing** ~~the provider and/or~~

~~applicant demonstrates~~ that ~~an~~ **bona fide** application or claim **has been filed** for social security **disability insurance, supplemental security income**, third party insurance, medicaid, medicare, crime victim's compensation, and/or worker's compensation. **A bona fide application means that:**
(i) The application was timely filed within ~~ninety (90) days beginning with the first day of the provision of necessary medical services from the provider or, in the case of hospitalization, ninety (90) days beginning with the date of admission.~~ **the appropriate agency's application or claim time period; and**
(ii) Given the circumstances of the patient and/or obligated persons, the patient and/or obligated persons, and given the information available at the time the application or claim for other resources is filed, would reasonably be expected to meet the eligibility criteria for such resources; and
(iii) The application was filed with the appropriate agency in such a time and manner that, if approved, it would provide for payment coverage of the bills included in the county application; and
(iv) In the discretion of the board, bills on a delayed application which would not have been covered by a successful application or timely claim to the other resource(s) may be denied by the board as untimely; and
(v) In the event an application is filed for supplemental security income, an Idaho medicaid application must also have been filed within the department of health and welfare's application or claim time period to provide payment coverage of eligible bills included in the county application."

2004 Idaho Laws Ch. 300 (S.B. 1301).

[Underlining emphasis added].

As stated above, courts must assume that the Idaho Legislature had full knowledge of the existing judicial decisions and case law of the state when it amended a statute. This means that in order for Appellant's good-faith allows bad-faith position to work the legislative history should demonstrate that the Idaho Legislature knew they were superseding the most current case law acknowledged by 2003 *IHC Hospitals*, supra. However, the legislative history set forth below permits no such conclusion.

First, the 2004 S.B. 1301 Purpose Statement reads as follows:

> "The purpose of this legislation is to provide guidelines that clearly state when, how and who should be considered when filing a delayed application for medically indigent assistance. The original intent of the 180 day delayed application process was to encourage providers to pursue other legitimate avenues of payment before filing an application for county medical indigent assistance, so that fewer applications would be received requesting taxpayer assistance with an indigent's medical bills. This has worked well when the spirit as well as the law has been properly followed. In some areas of the State the purpose of the existing law has been thwarted by those who have begun using the delayed application process as a method of obtaining more time to file a request for assistance. When this occurs the indigent has sometimes dissipated assets that could have provided reimbursement to the property taxpayers for the assistance provided. Reliance on the property taxpayers should remain a last resort. This technical correction seeks to close the loophole in the process being exploited in some parts of the State while still meeting the original intent of the legislature to allow a delayed application to be filed when there is a demonstrated active pursuit of other sources of payment before a request for assistance from the property taxpayers is made."

2004 Idaho Law CH 300 – S.B. 1301. [Underlining emphasis added].

The Senate Health and Welfare Committee minutes pertaining to 2004 S.B. 1301 dated Friday, February 27, 2004, recount that Teresa Wolf, the Social Services director for Nez Perce County, presented the following:

> "This bill, **SB 1301 relating to Medical Indigency**, will amend Sections 31-3502 and 31-3505, Idaho Code, was presented by **Teresa Wolf**, Social Services director for Nez Perce County.
>
> The purpose of this bill is to close a loophole that exists in the current law dealing with the 180-day delayed application process. The original intent of the 180 day delayed application was to encourage a provider or applicant to seek other resources that the individual may legitimately qualify for.
>
> Generally, the process for applying to the county requires an application be submitted within 31 days after a person receives emergency services. However, the provider may choose to file a delayed county assistance application, if it is determined that the Applicant may qualify for one of 6 resources. The resources listed in the law are: medicaid, medicare, social security, crime victims, worker's comp, and 3rd party insurance. Because counties are the payers of last resort that resource should be applied

for before seeking property tax assistance. After determining that an individual may qualify for one of the listed resources, the provider or applicant can then file a county indigent application up to 180 days after the service is rendered by the provider. Hopefully, some time within the 180 days one of the resources may become available to the applicant or notify the applicant or provider they have been approved, thereby making it unnecessary to file with the county.

The problem that has occurred, primarily in the north without state providers, is that the law is vague in its description of the intended processes. Some providers have admitted that they use the section if they miss the 31-day filing window. Training has been provided by both the counties and the Idaho Hospital association to our out-of-state providers, but the practice still Continues.

The counties originally agreed to seek repeal of the section, but after further investigation it was determined that it would have caused a significant impact on some of our larger counties. The 180 day delayed application process does work when used properly and many of the providers comply with the intent. The change in the language clearly outlines the process for filing for other resources and what is expected of the applicant. Currently, the language makes it is only necessary to file for one of the six listed resources even if the applicant had no chance of qualifying. The unnecessary filings have at times caused an additional burden to be placed upon the Department of Health and Welfare due to these frivolous filings."

Senate Health and Welfare Committee minutes dated Friday, February 27, 2004 pertaining to SB 1301. [Underlining emphasis added].

After Teresa Wolf made her presentation, the Senate Health and Welfare Committee minutes recount that Tony Poinelli, the deputy director of the Idaho Association of Counties, testified and requested that the Committee support 2004 S.B. 1301 as follows:

> "**Tony Poinelli**, the deputy director of the Idaho Association of Counties, testified and requested the committee to **support SB1301**, with the following proposed amendments:
>
> - **First amendment**, Page 3, line 37- makes' it clear that counties will add appropriate documentation until the end of the investigative process (45 days).
> - **Second amendment**, Line 49 - clarifies that the information the provider has available at the time the resource is filed for can be accepted as long as the person

would reasonably be expected to meet the criteria for the resource.

- **Third amendment**, Line 53 - deletes "all."

- **Fourth amendment**, Page 4 - adds language to a new subsection that this clarifies that those bills not covered by the resource being applied for may be denied by the Board.

- A **final amendment** only changes the subsection numbering."

Senate Health and Welfare Committee minutes dated Friday, February 27, 2004 pertaining to SB 1301.

As stated in the purpose statement and Committee minutes cited above, the 2004 S.B. 1301, as it pertained to I.C. 31-3505(4)(a), was originally supported by the Idaho Association of Counties (hereinafter "IAC") in the Senate Health and Welfare Committee for the purpose of decreasing the number of frivolous and unnecessary 180-day applications. There is no indication that 2004 S.B. 1301 was introduced or accepted for the purposes of relaxing the strict timelines, but rather the purpose statement and minutes indicate that 2004 S.B. 1301 was introduced and passed by the legislature in order to add an additional "good faith" layer of protection against abuse of the 180-day delayed application process.

The reason IAC supported 2004 S.B. 1301 was to add and not to take away from existing requirements to ensure a demonstrated, active, and bona-fide and good faith effort to acquire these additional resources. In fact according to *Teresa Wolf*, supra, the counties originally agreed to seek repeal of the 180-day delayed application section altogether to avoid these abuses, but ultimately the counties decided not to pursue repeal of the 31-3505(4) section because it would have had a significant negative impact on some of Idaho's larger counties. The legislative history cited above illustrates that the purpose of 2004 S.B. 1301 is not to relax, nullify, or abrogate the

strict timelines recognized by *IHC Hosps.*, supra, but rather to make a "technical amendment" which "closes a loophole" by adding requirements rather than striking requirements for a successful 180-day delayed application in order to prevent frivolous applications by adding a good-faith layer to the 180-day delayed application process.

As argued above Appellant attempts to avoid the ordinary meaning of good faith by adopting an interpretation which virtually ignores the mental standard of good faith and looks instead myopically to prejudicial effects and case law which was nullified in 1996. Appellant's interpretation inverts the legislative purpose and the plain meaning of the text underwriting 2004 S.B. 1301. Interpretations that could lead to absurd results are disfavored. *Ada County v. Gibson*, 126 Idaho 854, 856, 893 P.2d 801 at 803.

6. **Conclusion.**

In conclusion the legislative history as well as the plain meaning of the I.C. 31-3505(4)(a) emendatory text support the proposition that 2004 S.B. 1301 was intended to add requirements to the strict timelines rather than lessen requirements for a successful 180-day delayed application.

B. Exhaustion of insurance company appeals

Respondent also based its denial on the grounds that patient never appealed his denial of coverage.

Idaho Code §31-3505(4)(b) provides in pertinent part:

> "(4) A delayed application for necessary medical services may be filed [...] provided that: (b) Failure by the patient and/or obligated persons to complete the application process described in this section, up to and including any reasonable appeal of any denial of benefits, with the applicable program noted in paragraph (a) of this subsection, shall result in denial of the county assistance application."

Idaho Code §31-3505(4)(b) requires reasonable appeals of denials. In the case at hand, Bonner County specifically found that: "Mr T. knew he had a preexisting condition. Patient's policy states 'no recovery for pre-existing conditions'." (A.R. 12, ¶26).

Appellant argues that "Given this finding it follows that any appeal by the patient to his insurance company upon its denial of coverage would be frivolous, and therefore, not "reasonable". (Appellant's brief p. 6-7).

Appellant's interpretation is formalistic and succeeds only by de-contextualizing I.C. §31-3505(4)(b) from the immediate context of I.C. §31-3505(4)(a) which supplies the good-faith presupposition for §I.C. 31-3505(5). I.C. §31-3505(4)(a)(ii) provides:

> (ii) Given the circumstances of the patient and/or obligated persons, the patient and/or obligated persons, and given the information available at the time the application or claim for other resources is filed, would reasonably be expected to meet the eligibility criteria for such resources;

I.C. §31-3505(4)(a)(ii). [Underlining emphasis added].

Appellant cannot advance its good faith argument that #1. The application was both in good faith and reasonable, as required by I.C. §31-3505(4)(a), while at the same time advancing its futility argument that #2. An appeal of the denial of insurance company benefits would be futile, because the application for insurance benefits was made in bad faith as provided in I.C. §31-3505(4)(b). If Appellant succeeds in its futility argument on the basis that the patient applied for a health insurance policy in bad faith, then the Appellant cannot at the same time assert that the patient applied for insurance benefits in good faith. In other words the patient could make no reasonable appeal under I.C. §31-3505(4)(b) because of the patient's bad faith in procuring the insurance policy in the first place. This implies that the patient could not have submitted a bona fide application under I.C. §31-3505(4)(a) because the patient knew that he

procured his insurance policy in bad faith in the first place as well as at the time patient applied for benefits under said insurance policy.

C. Income and Other Resources.

Bonner County concluded that since a timely 180-day delayed application was not submitted, the board did not need to make findings on other factors of eligibility such as the patient's indigency. Bonner County's Finding of Fact No. 29 supports this contention and reads as follows:

> Since there are no tax returns for 2006, this issue remains contested and unresolved. The Board decided not to make a decision based on projected income, since the numbers provided cannot be verified, and there is a lot of speculation as to what would be allowed per IRS rules on self employment. There was insufficient information to determine the financial aspect of the case, unable to prove or disapprove the numbers.

The Idaho Supreme Court in *Mercy Medical Center v. Ada County, Bd. of County Commissioners of Ada County,* 146 Idaho 226, 233, 192 P.3d 1050, 1057 (2008) has previously decided that a board need not decide all dispositive issues at once. *Mercy,* supra, also decided that the proper remedy when a board erroneously decides a dispositive issue, but leaves other issues undecided is remand for further proceedings and fact finding.

Mercy, supra, was a case in which the patient submitted a delayed application to Ada County for indigent medical assistance and the County denied the application, on the basis of non-residency. The Board did not address whether the treatment received by the patient was medically necessary, nor did the Board address whether she was indigent. The District Court vacated the Board decision after the county admitted error on its finding of non-residency and remanded it to the County for further proceedings. The *Mercy* Court reviewed the question of the district court's decision to remand the matter to the Board for further findings rather than remanding with directions to approve the application. The hospital argued that the appropriate

statutory remedy for the Board's error is to deem the application approved. The *Mercy* Court noted that the Board did not make findings as to all factors of eligibility:

> The determination whether an individual is entitled to medical indigency benefits requires consideration of other factors of eligibility besides residency. Since the Board summarily concluded that the Patient was not a resident because she was an undocumented alien, and thus ineligible for benefits, it did not make findings of the type normally considered when making a determination of residency, such as the Patient's personal and family circumstances, her length of stay in Ada County, her employment in Ada County, or her subjective intent to remain in Ada County. For the same reason, the Board made no findings as to the other factors of eligibility, i.e., the Patient's indigency and the medical necessity of the services provided. The absence of these critical findings requires us to consider the proper procedure for filling the lacunae.

146 Idaho 226 [Underlining emphasis added].

The *Mercy* Court then analyzed the importance of specificity of findings by the lower tribunal and determined that the board's duty to make reasonable inquiry is satisfied if the board makes a written determination denying the application based on any dispositive factor as follows:

> Under the APA, "specificity in the findings and reasons of the lower tribunal is vital." *Intermountain Health Care, Inc. v. Bd. of County Comm'rs of Caribou County,* 108 Idaho 757, 762, 702 P.2d 795, 800 (1985). While the applicant carries the initial burden of proof in establishing a prima facie showing of medical indigency, that burden of proof shifts to the county to rebut the applicant's claims, which carries with it a reciprocal duty to make a reasonable inquiry into the grounds for the application. *Salinas v. Canyon County,* 117 Idaho 218, 221, 786 P.2d 611, 614 (Ct.App.1990). [12] Mercy maintains that, due to the Board's failure to fulfill its reciprocal duties, the application must be deemed approved without remand. Mercy bases this contention on I.C. § 31-3511(4) which provides: "If the board fails to act upon an application within the time lines required under this chapter, the application shall be deemed approved and payment made as provided in this chapter." We have held that the failure to strictly comply with these time limits requires a county to pay the claims advanced in an application. *See e.g., Ottesen v. Bd. of Comm'rs of Madison County,* 107 Idaho 1099, 1100-01, 695 P.2d 1238, 1239-40 (1985) (applying I.C. § 31-3505, the previous penalty provision of the medical indigency statutes). This is not, however, an instance in which the County failed to act upon the application, thus triggering the penalty provision of I.C. § 31-3511(4). In the instant case, the Board did issue a written determination denying the application within the statutory timeframe, albeit solely upon an erroneous legal premise. Therefore, we conclude that the penalty provisions of the statute do not apply to this application, and consequently, the possibility of remand is not foreclosed.

146 Idaho 226 [Underlining emphasis added].

The *Mercy*, supra, Court then explained that Idaho Code § 67-5279 in conjunction with prior case law generally prohibit a reviewing court from making its own factual determination, but instead to remand the issue to the board for further proceedings as follows:

> Idaho Code § 67-5279 states: "If the agency action is not affirmed, it shall be set aside, in whole or in part, and remanded for further proceedings as necessary." Although reversal of the agency action is not expressly an option of the reviewing court under the language of I.C. § 67-5279, we have noted that "[t]he reviewing court can reverse or modify the county decision only in limited circumstances, such as when the county's decision is affected by error of law, is clearly erroneous in view of the whole record, or is found to be arbitrary and capricious." *IHC Hosp., Inc. v. Teton County,* 139 Idaho 188, 189, 75 P.3d 1198, 1199 (2003) (citing *Idaho County v. Idaho Dep't of Health & Welfare,* 128 Idaho 846, 848, 920 P.2d 62, 64 (1996)). [13] [14] We recognize that, despite the absence of formal findings by the Board, the agency record contains information submitted by the Patient regarding her financial resources, habitation history, employment, and medical documents, which would tend to support a finding of eligibility on remand. However, when a board fails to make a factual determination on a necessary issue, the district court must not make its own factual determination but must rather remand the case to the board to make that determination. *Univ. of Utah Hosp. v. Clerk of Minidoka County,* 114 Idaho 662, 665, 760 P.2d 1, 4 (1988); *accord, In re Application of Hayden Pines Water Co.,* 111 Idaho 331, 336, 723 P.2d 875, 880 (1986) [...]

146 Idaho 226 [Underlining emphasis added].

Finally the *Mercy*, supra, Court held:

> The resolution of factual issues cannot be made for the first time by the district court nor can they be made by this Court on appeal. *Univ. of Utah Hosp.,* 114 Idaho at 665, 760 P.2d at 4. Under the APA, those findings properly belong to the agency. *Id.*

146 Idaho 226.

Therefore, if this Court decides that Bonner County erroneously decided the issue of timeliness then the proper remedy is for this Court to remand for further proceedings and fact finding on the issue of indigency.

VI. CONCLUSION

There is substantial and competent evidence in the Record and Transcript in this matter to support the conclusions and determinations of the Bonner County Board of Commissioners in their denial of the Delayed Application due to the Patient's failure to submit a Delayed Application according to provisions of Idaho Code §31-3505(4).

Respectfully submitted this 31st day of July, 2009.

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CERTIFICATE OF DELIVERY

I hereby certify that on the 31st day of July, 2009, I caused to be served a true and correct copy of the foregoing document as addressed to the following:

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